

**Exploring perceptions around the implementation of cognitive behavioural  
intervention by school staff following training and support.**

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Exploring perceptions around the implementation of cognitive behavioural intervention by school staff following training and support.

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Abstract

Theory and research supports the implementation of cognitive and behavioural interventions (CBI's) to address social, emotional and behavioural difficulties (SEBD) in children. The literature argues that schools are an ideal place in which to implement such interventions. As part of a county initiative, school staff were trained and offered follow up support by 2 Educational Psychologists (EPs) around the use of school-based CBI to support children who have SEBD. The 10 participants (from 5 schools) in this research were part of this initiative: they received 4 sessions of training followed by either monthly individual supervision, or group supervision, around their use of CBI. Training and supervision targeted implementation of key CB competences, selected from a competency framework recommended by 'Improving Access to Psychological Therapies' (IAPT, 2011). The research explored staff perceptions around the CB competences that they implemented, their methods of implementation and the barriers and facilitators to their implementation.

The research used a mixed methodology design. Qualitative data was analysed using thematic analysis and quantitative data was analysed using descriptive statistics. Data was gathered through interviews, supervision sessions, intervention diaries and training evaluations. Exploration of facilitators and barriers to implementation was based on Durlak and DuPre's (2008) model of intervention implementation. Facilitators/barriers discrete from this model were also identified. Identification and exploration of such factors can assist in ensuring quality implementation of school-based interventions in the future. This study demonstrates how school staff can implement a range of CB competences and through multi-levels of intervention in schools. The potential role of the EP in supporting school staff to implement CBI is also discussed.

**Keywords:** social, emotional and behavioural difficulties; cognitive and behavioural intervention; intervention implementation; thematic analysis

## Declaration

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## Preface

Following my degree in Psychology, I completed a Post Graduate Certificate in Education and practiced as a Primary School Teacher for four years. In 2004 I returned to University to fulfil my ambition to become an Educational Psychologist, by completing a Masters Degree in Educational Psychology. In 2008 I commenced a Professional Doctorate in Educational Psychology. Leading up to this thesis, I have completed three projects related to emotional wellbeing in schools. One research project was co-published (Squires & Caddick, 2012). Abstracts for the three projects which preceded this thesis are below.

### **1/ What evidence is there to support the existing use of Cognitive Behavioural Therapy (CBT) by Educational Psychologists (EPs) with pupils in school?**

Recently, CBT has been promoted as the therapeutic approach of choice to address mental health problems, at least with adults. Meanwhile, concerns around children's mental health, and a focus on the role of schools in addressing this, have increased. This has led to the opportunity for EPs to reflect on their role in relation to supporting the mental wellbeing of pupils, particularly through the use of therapeutic interventions such as CBT. This paper presents a review of literature evidence for the use of CBT by EPs with pupils in school. A systematic review methodology is used to assess literature in response to the reviews research

questions. Results indicate that there is limited literature available which evaluates the existing use of CBT by EPs. A number of literature papers are available which debate the role of the EP in terms of therapeutic interventions and the potential for EPs use of CBT. Recommendation for further research in this area is strongly indicated.

## **2/ What is the impact of using a group Cognitive Behavioural Therapy (CBT) based intervention with pupils who have externalizing behavioural difficulties?**

CBT has been promoted as the therapeutic approach of choice to address mental health problems with adults (NICE, 2008). Meanwhile, concerns around children's mental health, and a focus on the role of schools in addressing this, have increased. This paper presents a study which investigated the effectiveness of a school based, eight session, CBT intervention for 12 – 13 year old children with externalising behavioural difficulties. 12 High School Year 8 – nine pupils were referred by a school's Pastoral Manager as having externalizing behavioural difficulties, according to set criteria. Pupils were assigned to groups of equal number (N=6), which received either cognitive-behavioural intervention or no treatment. All participants and their teachers completed a pre- and post- assessment taken from the Behaviour Assessment System for Children (BASC-2). Results demonstrate that composite scores for 'Externalising Behaviours' (teacher rating) and 'Hyperactivity/Inattention' (pupils rating) for the intervention group reduced post intervention, with effect sizes of -0.325 and -0.689 respectively. For the no treatment group, reduced composite scores were found for teacher ratings but increased composite scores for pupil ratings, with effect sizes of -0.670 and 0.636 respectively. Between groups measures showed that the experimental group had fewer symptoms post intervention, with effect sizes of -0.280 and -0.818. The same pattern of results was found from a 'School Problems' composite. Implications for supporting vulnerable pupils are explored.

## **3/ What is the impact of Teaching Assistants using a SEAL based group intervention on pupil's emotional literacy skills?**

In recent years there has been an increasing interest in emotional intelligence, especially regarding its application in education. This is most evident in the development of the Department for Education and Skills' SEAL (Social and Emotional Aspects of Learning,

2005) strategy. This strategy offers a whole school curriculum, including a group intervention for pupils with identified needs in this area. Teaching assistants from six primary schools were trained and supported to deliver and evaluate the group SEAL intervention within their schools. A total of 31 pupil's emotional literacy skills were measured quantitatively, pre and post intervention, using the 'Emotional Literacy: Assessment and Intervention' (ELAI) teacher and pupil rating scales. Qualitative data was collected via a focus group and intervention session observations. Analysis of data using the related t-test, effect size and thematic analysis showed positive effects of the intervention on children's emotional literacy skills. Effect size based on the Teaching Rating scale was +0.778 (large) and findings were significant at the  $<0.0001$  level of significance. Effect size based on the Pupil Rating scale was +0.075 (very small); possible reasons for this are discussed. It is concluded that the SEAL group intervention is a valid approach to promoting emotional literacy skills in primary schools and that educational psychologists can have a vital role to play in its implementation and evaluation.

## Abbreviations

CB	Cognitive Behavioural
CBI	Cognitive and Behavioural Intervention
CBT	Cognitive Behavioural Therapy
DCSF	Department for Children, Schools and Families
DfE	Department for Education
DfEE	Department for Education and Employment
DOH	Department of Health
EBI	Evidence-based Interventions
EBP	Evidence-based Practice
EP	Educational Psychologist
LA	Local Authority
NICE	National Institute for Health and Care Excellence
RQ	Research Question
SEAL	Social and Emotional Aspects of Learning
SEBD	Social, Emotional and Behavioural Difficulties
SENCo	Special Educational Needs Coordinator
TA	Thematic Analysis

For the purpose of this thesis, the word ‘children’ will be used to refer to: all children and young people, including ‘pupils’/‘students’.



## Chapter 1: Rationale

### Children's Social and Emotional Wellbeing

At the time of this study, the researcher was working in a Local Authority (LA) Educational Psychology (EP) service which covered a wide geographical area and a range of economic status. In particular, areas of low socio-economic status, with high levels of social, emotional and behavioural difficulties (SEBD), were being targeted for further intervention. This was in line with the national focus on children's mental health. That is, data around prevalence rates of mental health issues suggested that around 10% of children were thought to have a mental disorder that would meet criteria for clinical diagnosis (DOH, 2004). The National Health Service (CSIP Choice and Access Team., 2007) reported that 700, 0000 children in England and Wales had mental health problems. Moreover, there had been increasing concern expressed about the impact of children's mental health difficulties and the effect that this had on their schooling and adult life chances (Allen, 2011; Burns, Hoagwood, & Mrazek, 1999; DCSF & DOH, 2008; Layard, 2008; Meltzer, Gatward, Goodman, & Ford, 2000). Research suggests that children with SEBD have the poorest outcomes, both educationally and socially, of any other SEN group, with no apparent improvements over time (Bradley, Doolittle, & Bartolotta, 2008). Consequently children's mental health was seen as a key aspect of the UK government's educational policy, as Maxwell, Aggleton, Warwick, Yankah, Hill and Mehmedbegovic (2008) stated: "promoting emotional wellbeing and mental health of children is a key aspect of English government policy" (p. 272). Similarly, Liddle and Macmillan (2010) state that: "Emotional well-being among children has become a key public health challenge nationally and internationally" (p. 53). Considering the prevalence of children experiencing SEBD, research into this area was considered beneficial, in particular around interventions that can mitigate against the poor outcomes for this population.

The overlap between 'mental health difficulties' and 'SEBD' is acknowledged by many sources (DCSF, 2008; DfES, 2001). For example, like SEBD, some of the likely sources of mental health difficulties lie within the social systems in which they are embedded (Greig, 2004<sup>a</sup>; Humphrey & Brooks, 2006). Greig (2004<sup>a</sup>) suggested the term 'emotional and behavioural difficulties' as being helpful in describing many of the mental health difficulties experienced by children. However, Cole (2007) highlights the importance of social difficulties on behaviour difficulties, thus promoting the term 'SEBD'; the term predominantly used in this study.

## Addressing SEBD in School Settings

A number of researchers argue the school setting to be a beneficial setting for targeting children's SEBD (see Aggett, Boyd, & Fletcher, 2006; Beidas, et al., 2012; Cole, Treadwell, Dosani, & Frederickson, 2012; DCSF & DoH, 2009; Gregory, Henry, & Schoeny, 2007; Health Advisory Service, 1995; Maxwell, et al., 2008; Mychailyszyn, Brodman, Read, & Kendall, 2012; Rait, Monsen, & Squires, 2010; Squires, 2001; Squires, 2006; Squires, 2010; Yeo & Choi, 2013). Benefits highlighted by research include: larger numbers of children can be reached as school is where they naturally congregate and where they are more likely to utilise mental health services; providing support within an environment where the problems often occur (ecological validity); schools can offer more affordable programmes; teachers' can have a considerable impact on a children's life; and teacher's believe in the value of social and emotional learning in an educational setting (see Allen, 2011; Beidas, et al., 2012; Buchanan, Gueldner, Tran, & Merrell, 2009; Children and Young People's Mental Health Coalition, 2010; Cole, et al., 2012; Mychailyszyn, et al., 2012; Poulou, 2005; Stallard & Buck, 2013). School-based universal programmes, in particular, have the potential to reach the majority of children (Gregory, et al., 2007; Stallard & Buck, 2013). Mennuti and Christner (2005) argued that school was a natural entry point for addressing the mental health needs of children and families and that the need for comprehensive school-based psychological services had never been greater. Greig (2004 and 2007) stated that education professionals had received explicit recognition of the important role they could serve in addressing childhood mental health difficulties. Both authors indicated that although the primary aim of schools was education, early intervention to mental health factors could prevent greater problems from occurring, many of which relate to school success. The benefits of school-based interventions could provide non-stigmatising access to mental health care for children (Stein et al., 2003; Ehntholt et al., 2005). Finally, Beidas et al. (2012) state that: "Schools are an ideal access point for youth and an ideal setting for early identification and intervention" (p. 204). For the reasons given above, the researcher for this study considered the school setting to be a beneficial setting for targeting children's SEBD.

A number of national initiatives, designed to address the emotional wellbeing of children, were already impacting on the schools within the LA that the researcher of this study worked. Such initiatives emphasised schools being a key agency in meeting the needs of children

(DCSF & DoH, 2009; NICE, 2008; Pettitt, 2003). The national framework for working together (DOH, 2004) promoted the link between schools and Child and Adolescent Mental Health Services (CAMHS) in particular. Initiatives such as ‘Targeted Mental Health in Schools’ (DCSF, 2010) and ‘SEAL’ (DCSF, 2005) in the UK aimed to enable schools to meet the wellbeing needs of children through promoting universal and targeted interventions. Government promotion of schools part in addressing children’s emotional wellbeing was not confined to the UK, with Australian and US governments also promoting this (Jaycox, et al., 2006; Mychailyszyn, et al., 2012). Attempts were being made to devise an educational agenda which was concerned about educating the children as a ‘whole person’ rather than focusing on their academic attainments in isolation, and the importance of promoting the affective growth of children had been recognized (Jennings & Greenberg, 2009). As Elias (2003) stated, what was wanted for our children was for them to be literate and understand academic subjects but also to be able to have successful relationships, problem solve and to be responsible and caring individuals. He claimed that this combination was the true standard for effective education.

Despite schools providing an ideal environment to address children’s emotional wellbeing, the school context is complex and dynamic, making delivery of relevant interventions a challenge. This refers to the issue of intervention implementation in real world settings, addressed under Chapter 3 of this study. The need for further research around intervention implementation is evidenced, particularly with the aim of facilitating school success of intervention implementation. This study focuses on the process of intervention implementation in schools, rather than the outcome of intervention. The LA was interested in knowing how intervention implementation could be optimised in other schools following this pilot. Consequently, as part of the LA initiative, two EPs planned, delivered and evaluated training and supervision to a total of 30 school staff (from 16 schools).

## Cognitive Behavioural Intervention (CBI) in Schools

Around the time of this study, therapeutic interventions were being identified as having potential for school implementation to address the emotional wellbeing of children. For example, Lines (2007) considered the use and need for counselling based interventions within school and Pattison and Harris (2006) indicated the contribution that counselling was having in the curriculum for initial teacher training. Hoagwood and Erwin (1997) argued that in the US, the value of providing mental health services in schools had been recognised since the late 1800s, and by the late 1900s counselling and cognitive behavioural therapy (CBT) were seen as key methods of intervention provided by such services. Despite its recognition, several researchers had identified that literature around the use of therapeutic based interventions within a school system was minimal and much needed (e.g. Burns et al., 1999 and Mennuti and Christner, 2005). Meanwhile, the need to provide evidence-based interventions (EBI's) in school settings was also recognised (Allen, 2011).

EBI's are interventions whose efficacy has been demonstrated by a credible body of scientific work (Kratonchwill & Shernoff, 2004). CBT, in particular, had been identified as having a relatively good evidence-base compared to other therapeutic interventions. Whilst a considerable amount of the evidence to support CBT related to its use with adults, there was growing research to suggest its effectiveness with children at the time of this study. Moreover, the literature indicated the benefits of using CBT in the school setting. This is evidenced under Chapter 2. As the EP role calls for a balance between an appreciation for scientific rigour and EBI's, and an appreciation for real world research and practical applications of psychology within multi-dimensional systems (such as schools), CBT was considered particularly suitable for this study. In addition, the researcher/EP in this study had prior training and interest in CBT. Therefore, CBI was selected by the researcher for school implementation in this study.

CBI's in this study will refer to interventions that are based on CBT, in terms of their underpinning theory, approach and strategies. CBI can be delivered by non-therapists and aims to increase awareness of thoughts, feelings, body signals and actions, and utilises cognitive and behavioural strategies. What makes CBT distinct from CBI is the involvement of a therapist who develops with the client a shared formulation of the client's problems, which will inform treatment to promote change (Seiler, 2008). Improving Access to

Psychological Therapies (IAPT) describe the various activities which need to be brought together in order to carry out CBT effectively, and in line with best practice: this is described in a competency framework (University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014). The CBI in this study was based on selected competencies from this framework. Competences were selected on the basis that they were deemed appropriate for use by school staff with training and support. Chapter 4 discusses how EPs are well placed to support school staff to develop such competences.

The next three Chapters will consider key areas in relation to this research: Cognitive Behavioural Therapy (Chapter 2), Intervention Implementation (Chapter 3) and the role of the Educational Psychologist (Chapter 4). Chapter 5 will give the aims of the current research with a view to demonstrating how the present research builds on and extends existing research.

### **Research Questions (RQ's)**

The RQ's addressed in this thesis are:

RQ1. What CB competences do school staff believe they implement with training and support?

RQ2. How do school staff implement CB competences with training and support?

RQ3. What are the perceived barriers and facilitators to school staff implementing CBI?

## Chapter 2: Cognitive Behavioural Therapy (CBT)

This chapter provides a background to the intervention used in this study, and sets out the rationale for its use: with children who have SEBD; in the school setting; and by school staff.

### **What is CBT?**

CBT was founded by Beck et al. in the late 1970s (e.g. Beck, Rush, Shaw, & Emery, 1979). CBT is an approach that helps individuals understand how their cognitions, feelings and behaviours link, and how they interpret events and experiences, in order to help them manage and modify their unhelpful thoughts, feelings and behaviours. One of the principles of CBT is that thinking precedes feelings and behaviours and that faulty or unhelpful thinking occur as a result of an individual's cognitive processing (how they perceive events); that this can lead to strong feelings and to behaviours that are not appropriate for the context. Hence, one of the aims of CBT is to modify the individuals thinking in order to modify their feelings and behaviours. Key cognitive elements of CBT are core beliefs, cognitive assumptions and negative automatic thoughts (e.g. McNamara, 1998). CBT relies on the therapist providing a supportive framework within which the individual can actively test out and gather evidence (using tasks and behavioural activities) to support or reject possible thoughts and beliefs, with the aim to assist in building new, more adaptive ways of functioning. It is concerned, largely, with the individual's current situation. CBT sessions are typically; well structured, task oriented and time limited (generally no more than 16 sessions).

CBT has grown in popularity and is now arguably the most widely used therapeutic approach to support adults with a variety difficulties, including anxiety and depression. The reasons for its popularity include it being an intervention which is relatively cheap, of low intensity and with a strong evidence base. It is also considered to provide an empowering experience for individuals due to the self-management aspect of it. For reasons such as this, the National Institute for Health and Clinical Excellence (NICE) recommends CBT as the treatment of choice for adults and has recommended that Primary Care Trusts adopt a stepped care model of service delivery, using CBT. Indeed this is the vision adopted by the DOH and set out in the 'Improving Access to Psychological Therapies' programme (Turpin, Hope, Duffy, Fossey, & Seward, 2006).

## **Use of CBT with SEBD - Theoretical Evidence**

SEBD's encompass strong behavioural, cognitive, physiological and emotional components. For example, individuals with SEBD may hold cognitive distortions which determines how they perceive and interpret events (e.g. they may be more likely to perceive an ambiguous event as threatening), which then leads to them experiencing negative feelings and dysfunctional behaviours. Recognising how such cognitive, behavioural and emotional components are linked and how cognitive deficits can be addressed form a crucial part of CBT interventions. CBT programmes aim to address the processing deficits held by many through supporting them in: identifying stimuli before a 'trigger' event; perceiving ambiguous situations as non-hostile; challenging distortions in thinking; moderating emotional responses; and generating solutions to problems. Hence, it can be argued that the underpinning aims of CBT match the underpinning deficits associated with SEBD.

Novaco (1979) provides an additional insight into addressing anger, in that in his model, he also stresses the importance of expectation and inner voice. To illustrate: a person may expect a friend to behave towards them with respect, but interpret their actual behaviour as being hostile: this difference may then lead to them feeling anger. Novaco describes the appraisal of the difference occurring in 'private speech'. The importance of inner speech as a mediating cognitive effect can be seen in Figure 1. Part of the management of anger could involve increasing a person's awareness of their inner voices and considering whether their expectations are justified and their appraisals accurate. Alternatively, self-talk could be directed to deal with increased arousal or distraction to break ruminating cycles. CBT lends itself to this model of anger. Squires and Caddick (2012) argue that the approach can be applied with children experiencing SEBD.

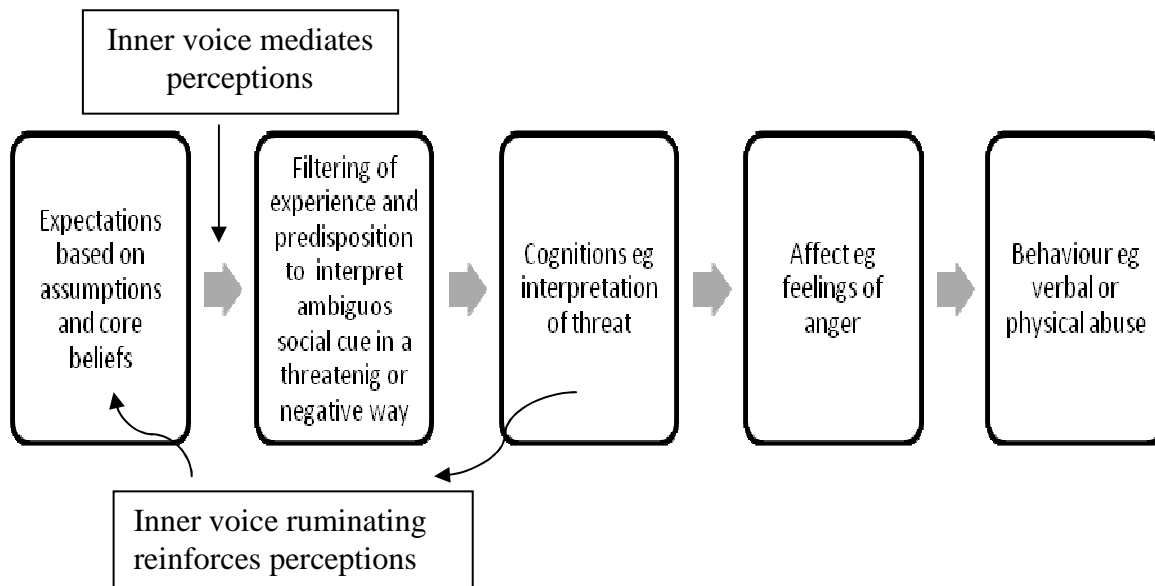


Figure 1: The Role of Inner Voice in Mediating Cognitions (Squires and Caddick, 2012)

Lochman et al. (2001) suggest that interventions for anger difficulties should aim to develop better perspective-taking skills, increase their awareness of the physiological signs of anger and improve social problem-solving skills. Indeed, most CBT interventions cover these elements: they typically include social skills training, self-control approaches, relaxation training, cognitive-restructuring approaches and problem solving approaches. Ghafoori and Tracz (2001) report that CBT interventions have the goal of mitigating disruptive behaviour problems by building appropriate social competencies in children before aggression becomes a deeply established method of problem solving. It is argued here that the above principles also make CBT appropriate for use with other SEBDs, such as anxiety.

According to Kendall and Panichelli-Mindel (1995) research, as well as theory, supports CBT as a promising treatment for children with a variety of SEBD. We will now turn to the research evidence for using CBT to address children's SEBD.

### Use of CBT to Support Children with SEBD

As Ruttledge and Petrides (2011) state, whilst much of the research into the efficacy of CB approaches has been done with adults, there is a growing body of evidence showing how they might be used with children.



A number of researchers report on empirical support for the use of CBT with a range of children's SEBD, including: anxiety disorders; conduct disorders; depression; obsessive-compulsive disorder; chronic fatigue syndrome; school refusal; post traumatic stress; self-esteem difficulties; behaviour difficulties; anger difficulties; and social difficulties (Cole, et al., 2012; Cuyper, Timbremont, Braet, Backer, & Wullaert, 2004; Graham, 2005; Greco & Morris, 2001; Gregor, 2005; Greig, 2007; Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011; Maxwell, et al., 2008; Mennuti & Christner, 2005; Pattison, 2006; Poirier, Marcotte, Joly, & Fortin, 2013; Prins & Manen, 2005; Probst, 2008; Seligman & Ollendick, 2005; Sukhodolsky, Kassinove, & Gorman, 2004; Toland, 2008; Yeo & Choi, 2013).

Kendall and Panichelli-Mindel (1995) present numerous individual studies that demonstrate positive implementation of CBT with different childhood SEBD related disorders. Whilst Kendall and Choudhury (2003) report on research which points to the benefits of using CBT to address externalizing problems (e.g. disruptive behaviours), Robin and Kendall (2005) argue that outcomes for CBT with children have been more consistent for internalizing difficulties over externalizing difficulties.

In addition to individual studies being reported, a number of meta-analyses have been reported which support the effectiveness of using CBT with children experiencing various SEBD, including externalising and internalising difficulties (Beck & Fernandez, 1998; Cole, 2008; Fossum, Handegard, Martinussen, & Mørch, 2008; Ghafoori & Tracz, 2001; Hoagwood, 1997; Mychailyszyn, et al., 2012; Pattison, 2006; Sukhodolsky, et al., 2004).

Sukhodolsky, Solomon and Perine (2000) conclude that: "Overall, cognitive-behavioural interventions for children with anger related problems were shown to reduce aggression" (p. 161), whilst Mychailyszyn et al. (2012) conclude that school-based CBT interventions for youth anxiety and depression hold considerable promise.

Graham (2005), Pattison and Harris (2006) and Ollendick and King (2004) refer to CBT, out of all psychotherapies, as having one of the best research bases and as offering the best approach with children for a variety of disorders. Zyromski and Joseph (2008) state: "...empirical research suggests that CBT interventions have shown effectiveness as therapeutic interventions for children" (p. 5). Similarly, Mennuti et al. (2006) argue that CBIs demonstrate the largest beneficial effects across levels of intervention, and Poirier, Marcotte, Joly and

Fortin (2013) argue that CB programmes have proven to be one of the most used and effective approaches for intervention with children. However, all authors refer to the need for further quality research to strengthen evidence for its effectiveness. For example, Cole et al. (2012) stat: “Although CBT based anger management programmes have an extensive research base, with child, adolescent , and adult populations...there are clear gaps in the research” (p. 84).

### ***Adapting for children***

Despite its growing evidence, many have questioned the effectiveness of CBT with particular age groups, particularly younger children. For example, studies have demonstrated the greater impact of CBT for adolescents over younger children (e.g. Prins & Manen, 2005; Toland, 2008; Sukhodolsky et al, 2004; and Cole, 2008). Kendall and Choudhury (2003) argue; “...there seems to be a consensus that treatments cannot be applied with equal effectiveness across individuals of all ages” (p. 98).

The reasons given for CBT being, potentially, less effective with children over adults vary. Boyle (2007) argues that few children seek help from professional sources for their mental health problems; they are usually referred by adults. This has implications for their levels of engagement in therapy. Similarly, Dunsmuir and Iyadurai (2007) argue that children are more likely to adopt a passive role, expecting to be told what to do when working with an adult, and Weisz and Jensen (1999) point out that therapists often rely on the adults involved (e.g. parents) to gather information about the child and to influence the child’s interpersonal behaviours. Such factors can make CBT with children more complex and challenging.

Pattison and Harris (2006) and Dunsmuir and Iyadurai (2007) suggest that CBT may be more effective with older children over younger children due to their higher levels of cognitive functioning. Indeed, Durlak, Fuhrman and Lampman (1991) conducted a meta-analysis of the effectiveness of CBT for children and found that children’s cognitive developmental level was the most important indicator of outcome. They conclude that CBT appears to be effective for children aged 11 to 13, assuming that they are operating at an age-appropriate cognitive level. It could be that by this age children have sufficient cognitive and emotional knowledge to reflect on their own feelings and thoughts and to understand the relationship between their thoughts, feelings and behaviours. However, Greig (2007) highlights research which points

towards children as young as three being able to understand differences between their own thoughts, feelings and resulting actions.

Greig (2007) argues that children's cognitive skills should not automatically be seen as a barrier to CBT intervention given Vygotsky's concept that a child can learn anything presented in a developmental appropriate way. That is, children can be guided by the same principles as adult therapy whilst adapting strategies and concepts to the child's level of cognitive development and style. This view is in line with Reynolds et al. (2006) who argue that with adaptation and 'scaffolding' by an adult, children's access to CBT can be improved.

The importance of tailoring the content and techniques used in CBT to suite the developmental level and cognitive skills of a child has been widely argued (see Cuyper, et al., 2004). The literature offers various methods of adapting CBT. Several researchers (Gleaves & Latner, 2008; Greco & Morris, 2001; Greig, 2007; Macklem, 2008; Mennuti & Christner, 2005; Robin & Kendall, 2005; Seligman & Ollendick, 2005; Zyromski & Joseph, 2008) argue that CBT interventions for children based more on behaviour modification over cognitive restructuring are more effective. Ginsburg et al. (2008) and Boyle (2007) discusses modifying programmes to suit various styles, abilities and experiences of children. Dunsmuir and Iyadurai (2007) suggest developing child friendly materials to reduce task demands and increase stimulation and motivation.

Evidence suggests that adaptations are necessary when using CBT with children. There are a number of interventions that have made these adaptations for children with SEBD, yielding promising results. For example, numerous studies demonstrate the effectiveness of manualised CBT based interventions for children (Bernstein, 2008; Cole, et al., 2012; Liddle & Macmillan, 2010; Lochman, 1985; Lochman, 1989, 2001; Nugent, Champlin, & Wiinimaki, 1997; Positive Psychology Centre, 2007; Prins & Manen, 2005; Stallard & Buck, 2013; Zyromski & Joseph, 2008). Other studies have reported the positive effects of implementing less prescriptive CBT interventions for children (Ruttledge & Petrides, 2011; Squires, 2001; Sukhodolsky, et al., 2000). This provides further support for the efficacy of adapting CBT for use with children.

Not all studies support the evidence-base for CBT with children. For example, Bloomquist et al. (1991) conducted a study into the effectiveness of using school-based CBT programmes

with children who had Attention Deficit Hyperactivity Disorder and found them to have minimal short-term effects.

## **Use of CBI in Schools**

As described earlier, CBI's in this study will refer to interventions that are based on CBT, in terms of their underpinning theory, approach and strategies. CBI can be delivered by non-therapists and aims to increase awareness of thoughts, feelings, body signals and actions, and utilises cognitive and behavioural strategies. This section considers the use of CBI in the school setting.

Whilst more research into the use of CBI with children has taken place in the clinical settings (Cole, et al., 2012), there has been a building evidence base for CBI in school settings. Studies have investigated the positive impact of school-based CBI on factors such as: emotional wellbeing (Ruini, 2007), emotional regulation (Augustyniak, Brooks, Rinaldo, Bogner, & Hodges, 2009), anxiety (Bernstein, 2005; Gregor, 2005), anger (Cole, 2008; Humphrey and Brooks, 2006; Lowry-Webster, 2001), depression (Ruffolo, 2006; Shirk, Kaplinski, & Gudmundsen, 2009), trauma in refugee children (Ehnholt, 2005), posttraumatic stress (Kataoka, 2003; Stein, 2003), smoking habits (Cavallo, 2007), school refusal (Tolin, et al., 2009), learning difficulties and self esteem (Toland, 2008) and academic achievement (Zyromski & Joseph, 2008).

A number of more recent authors explore the potential use of CBI in school settings to address various childhood difficulties including: anger; disruptive behaviour; internalizing difficulties; anxiety; post-traumatic stress; depression; autism; and 'ADHD' (see Cole, et al., 2012; Elkins, McHugh, Santucci, & Barlow, 2011; Feindler & Engel, 2011; Forman & Barakat, 2011; Goodkind, Lanoue, & Milford, 2010; Levine & Anshel, 2011; Mychailyszyn, et al., 2011; Mychailyszyn, et al., 2012; Poirier, et al., 2013; Putwain, Connors, & Symes, 2010; Rait, et al., 2010; Rotheram-Fuller & MacMullen, 2011; Ruttledge & Petrides, 2011; Schultz, Storer, Watabe, Sadler, & Evans, 2011; Squires, 2010; Squires & Caddick, 2012; Squires & Dunsmuir, 2011; Stallard & Buck, 2013; Stark, Arora, & Funk, 2011; Taylor & Weems, 2011; Yeo & Choi, 2013). Yeo and Choi (2013) refer to meta-analyses which support the use of school-based CBT interventions and Zyromski and Joseph (2008) conclude: "The overall benefit and effectiveness of CBIs in school settings was clearly illustrated".

As well as having a growing evidence base, many argue that there is good rationale for implementing school-based CBI. Christner et al. (2007) and Mennuti et al. (2006) suggest that CBT offers a flexible, solution-focused and time-limited model that fits well into the problem-solving approach used by many schools. Similarly, Platts and Williamson (2000) argue that CBT mirrors many of the familiar structures and processes of school such as exploration, homework and learning new information. They consider reframing CBT in schools as opportunities for 'personal development' rather than counselling per se. Zyromski and Joseph (2008) argue that CBT interventions are especially appropriate for school use as they can involve: a relatively small number of sessions for counselling; psycho-educational elements; and transparent treatment plans between school, counsellor and teacher. They provide several examples of how CBT can be incorporated at an individual, group and whole class intervention level. Gottfredson et al. (2002) state: "One kind of intervention to prevent problem behaviour is particularly suited to implementation in schools: CBI can be applied through instructional programs, and instruction is what schools do" (p. 43).

Buckley, Sheehan, Shochet and Chapman (2013) outline how CBT can inform school-based interventions. They argue that the use of CBT in school-based programmes is supported in its demonstrated effect outside the therapeutic context. They also argue that the school environment provides a unique and appropriate setting for CBT based intervention, particularly as programmes can be conducted on a larger scale, by implementing them in existing core curriculum, and thus reaching a large number of adolescents at one time. Whilst they recognise that delivering programmes to whole populations risks diluting messages within it; they also recognise that this risk is balanced by the potential to reach large numbers of individuals.

Squires and Caddick (2012) argue that school-based interventions, such as CBIs, should be particularly effective for improving outcomes for children for several reasons, including:

- The social network (school staff and peers) can help the child practice skills learnt in therapeutic sessions (Burton, 2006, 2008; Squires, 2010)
- The social network can provide important information to aid case formulation and information gathering (Greco & Morris, 2001; Maxwell, et al., 2008; Robin & Kendall, 2005)

- Information from therapeutic sessions can trigger systemic school development work (Squires, 2010)
- There are opportunities for generalization of skills beyond the target group as school staff apply CBT principles to other children with similar difficulties (Burton, 2006; Squires, 2001)
- Where professional external support to schools for individual pupil work is in limited supply, schools can work with professionals to implement group-based interventions as a cost-effective solution (Squires, 2001)

The potential for use of CBI across school-based categories of intervention, including at an individual, group and whole school level, has been implied in this thesis. Liddle and Macmillan (2010) and Greenberg et al.'s (2005) describe preventative interventions under three categories: universal, referring to interventions targeted at whole populations (e.g. whole class school interventions); selective, referring to interventions targeted at those with an increased risk of developing an emotional disorder; and indicated, referring to interventions for those who are already displaying symptoms of a given condition. Similarly, Hawken (2006) recommend a continuum of behaviour support in schools involving three levels of intervention: Primary level (school-wide behaviour plan), Secondary level (involving additional targeted intervention and Tertiary level (involving functional behavioural assessment and an individualised behaviour support plan). It is argued here that school-based CBI can influence each of these levels.

Indeed, the importance of using a whole school approach, involving a combination of universal and targeted approaches, to address mental health issues has been identified in literature. For example, Maxwell et al.'s (2008) findings suggest that in order to offer evidence as an effective approach, school-based programmes need to involve modification of the school environment for all children as well as the development of counselling strategies for children with identified needs. Similarly, Burns et al. (1999) argue that a multi-tiered strategy is necessary to reduce suffering from childhood disorders, including targeted programmes for youth at risk and universal programmes to promote positive mental health for all.

Mychailyszyn et al. (2012) conclude that: "schools would be wise to consider a more complete integration of mental health education and coping strategies into the curriculum" (p. 146).

They suggest school staff weaving interventions into the regular curriculum in order to address the mental health needs of youth in a sustainable and meaningful way. Weare and

Gray (2003) state that there is strong international evidence to suggest that a whole school approach, combined with more targeted support for children with difficulties in this area, is needed to effectively improve children's social and emotional competence and wellbeing. Marulanda (2010) argues that adopting a programme school-wide is beneficial in that, through such programmes, new attitudes, beliefs and skills enhance learning, reshape school culture and facilitate school-wide development.

Despite the rationale for, and growing evidence around, the application of CBT based interventions in schools, Silverman, Pina and Viswesvaran (2008b), Zyromski and Joseph (2008) and Mychailyszyn et al. (2012) identify the need for further research. Stallard and Buck (2013) argue that whilst schools provide a natural and convenient location for the delivery of mental health prevention programmes, little research has evaluated the feasibility of delivering interventions in this setting. They argue that undertaking robust research evaluations of prevention programmes in schools is complicated but feasible. Indeed, in their study of a school-based CBT intervention, they achieved high levels of intervention consent, good reach, reasonable retention and intervention sessions delivered as intended, thus demonstrating its feasibility for further robust research. In Evans et al.'s (2004) systematic review of strategies to support children with SEBD, they found very few studies with sound methodology describing positive findings from primary school research. Moreover, very few of those studies were based in the UK. Allen (2011) states:

“Although there is a large body of research on universal prevention programs, the field is only beginning to implement CBT in the school setting for children at risk or currently diagnosed with a mental health disorder” (p. 219).

Finally, Forman and Barakat (2011) argue that researchers have established the efficacy of many school-based CBIs that support SEBD. However, they state that despite the potential for CBIs to prevent or ameliorate a number of children's mental health problems, their use in schools remains low. That is, although CBIs have been shown to have a positive impact in controlled research, translating this implementation into school practice is low.

Whilst this section has focussed on the potential for schools to be a sound base for CBI, it also recognises that this is by no means without its challenges, as will be identified in Chapter

3. For example, Stallard and Buck (2013) identify that in a busy school, limited space and time to deliver such interventions is an issue.

### **Use of CBI by School Staff**

According to the Mental Health Foundation (1999) all agents who work with children are required by law to address the needs and rights of all children by providing interventions known to be supportive. Delivery of mental health services to children is therefore seen as being the responsibility of all professionals within children's workforce. Teachers have a clear role to play in supporting this agenda (Rait, et al., 2010; Squires, 2010) with children's mental health defined as 'everybody's business' (DfES, 2001; Health Advisory Service, 1995). Despite this, there are differing views on the appropriateness and capacity of teachers to deliver therapeutic interventions, such as those based on CBT.

Lochman et al. (2001) argue that lead CBT programme deliverers should have a Masters Degree/Doctorate in Psychology or similar fields and experience of working with behaviourally difficult children. However, Rait et al. (2010) argue that the application of CBT approaches is no longer seen as being discretely for specialist CAMHS, counsellors or therapists. Indeed, a survey conducted by Stallard, Udwin et al. (2007) revealed a significant shortfall in the provision of CBT within CAMHS and in the availability of qualified CBT therapists: they suggested an urgent need for further training and supervision around CBT. This led to IAPT (2011) which trains practitioners from a variety of backgrounds to use CBT to various levels. Squires (2010) points out that whilst some children will need minimal or manualised CBT approaches, other children will need more individualised and specialised CBT, and a minority of children will require highly specialist and narrowly focused interventions. He argues that all but the last of these levels of intervention could be provided in school, either by EPs or by other staff working under the guidance of an EP. Similarly, Buckley et al. (2013) state that CBT techniques can be incorporated into existing core curriculum for whole school populations, with the exception of CBT techniques which aim to modify 'core beliefs'<sup>1</sup> as these are suitable for one to one interventions involving appropriately trained professionals. They found that teachers, in particular, support an interactive approach

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<sup>1</sup> Sanders and Wills (2011) define core beliefs as: "...long-standing, enduring beliefs about the self, others and the world, often formed from early experience, and often unhelpful"



to facilitating learning; something which appears to facilitate effective intervention implementation.

Further support for school staff implementation of CBIs is documented. Gregory et al. (2007) argue that it may be more likely that interventions are embedded when teachers are implementers and that intervention effectiveness has been shown to be higher when interventions have been integrated into classroom routines and practices. Several researchers report on involvement of school-staff as implementers, with the intention of improving intervention sustainability or generalisability (e.g. Goodkind, et al., 2010; Ruttledge & Petrides, 2011; Stallard & Buck, 2013). Other benefits of school staff delivering CBT based interventions over clinicians include: school staff being more available; reduced threat/stigmatisation for children; and further dissemination of interventions, as they reach larger cohorts of children. Finally, it has been argued that teachers automatically make use of CBT based strategies. For example, Beck (in Mennuti, et al., 2006) states that:

“...all good teachers instinctively use cognitive behavioural strategies in the classroom (and with parents) without ever having received formal training in their modality. For example, they help students set goals, monitor their behaviour, and evaluate progress” (p. xv)

Despite the potential for, and benefits of, school staff delivering CBI's, it is highlighted here that without school staff having sufficient and relevant skills and competences, delivery of CBI's is less effective and, potentially, less ethical. Mychailyszyn et al. (2012) carried out a meta-analysis of studies involving school-based CBI's and found no significant difference between the outcomes of interventions implemented by school staff and interventions implemented by members of the research teams. However, they point out that the overall research offers mixed findings regarding the effectiveness of interventions implemented by non-research staff. A lack of CB competencies in non-research staff might explain why some CBI's are less effective. Indeed Stallard and Buck (2013) state that CBT interventions for depression tend to be more effective when delivered by mental health practitioners rather than trained school staff. They argue that teachers may not feel sufficiently knowledgeable or skilled about CBT.

Sanetti, Kratochwill and Long (2013) report that in contrast to other areas of psychology, the majority of school-based interventions are not implemented directly by the psychologist but rather by a mediator, such as a teacher. However, they argue that such mediators do not always implement interventions adequately, thus limiting their effectiveness. Consideration needs to be taken that school practitioners have a variety of training and professional backgrounds and vary in the degree of allegiance they feel towards psychological interventions. Indeed, Graham (2005) states that when procedures are delivered by less trained or motivated professionals, evidence for efficacy is less impressive. These findings highlight implications for CBIs which are available for school staff implementation without additional training or support (such as 'FRIENDS' (Shortt, 2001); and 'Cool Connections with Cognitive Behavioural Therapy' (Seiler, 2008)).

The need for teachers to be supported and trained to deliver emotional wellbeing interventions effectively is well documented (Buchanan, et al., 2009; Jennings & Greenberg, 2009; Lendrum, Humphrey, Kalambouka, & Wigelsworth, 2009; Marulanda, 2010; NICE, 2008; Weare & Gray, 2003; Yeo & Choi, 2013). Mennuti et al. (2006) argue that teachers can benefit from using CBT based strategies that go beyond standard strategies, but that require specific training:

“Cognitive therapy has a great deal to offer teachers...in dealing with students who suffer from psychological problems...school-based professionals must be well trained and prepared with knowledge and skills to offer prevention and treatment services built on evidence-based practices” (p. xv and 4)

Similarly, Cole et al. (2012) state:

“When planning a school-based, CBT intervention, consideration should thus be given to whether teachers and support staff have the capacity to take on board the theories and concepts which underpin it...” (p. 94)

Whilst school staff are not specifically trained in CBIs, they may have relevant experience and skills from other programmes that the DCSF have initiated (e.g. SEAL, 2005) or through delivering curriculum areas such as PSHE. However, it is argued here that effective implementation of CBIs requires understanding of theory and development of specific

competences related to CBT. At the time of this thesis, the BPS (Division of Educational and Child Psychology) was producing professional practice guidance around the skills and competencies necessary for delivery of EBIs (such as CBT) in school (2013). This includes reviewing the training standards, skills, qualifications and experience required for ethical and competent practice. Meanwhile, IAPT provide guidance and a CBT competency framework (University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014) describing the various activities which need to be brought together in order to carry out CBT effectively, and in line with best practice. This guidance formed the basis of the intervention, training and supervision provided for school staff in this study, as discussed further in Chapters 3 and 6. In particular, the key competences felt necessary for school staff to apply CBT theory to their practice are set out in Appendix H.

The findings provide support for the implementation of CBIs by school staff, at least at some levels of support and when adequate training and support are provided.

### Chapter 3: Intervention Implementation

The school context is complex and dynamic, making delivery of CBI's difficult. This chapter explores some of the issues related to implementation that will help to understand how school staff implement competencies related to CBIs and the barriers and facilitators surrounding successful CBI in school settings.

Allicock et al. (2012) state that implementation refers to the quantity and quality of delivery of the intervention components. Similarly, Durlak (1998) describe implementation as: how well the active ingredients that are believed to be responsible for the interventions effects are put into practice. They state that it can alternatively be referred to as treatment fidelity. However, the focus of implementation in this study is not around measuring treatment fidelity but rather around exploring the *process* of implementation, such as exploration of the range of factors impacting on implementation in a particular organisation. As such, implementation is defined here as the incorporating of a new practice or intervention in the functioning of an organization, group, and/or individual. Similarly, Moseley and Hastings (2005) define implementation as: "the process of communicating, piloting, launching, monitoring and modifying interventions" (p. 8).

In support of this study, Hawe, Shiell, Riley and Gold (2004) report that whilst it is sensible to investigate implementation fidelity:

"... it is also prudent to explore more naturalistically how the intervention might vary according to the different community contexts into which it is placed. This would allow one to delve deeper into the intervention" (p. 789)

As such, they focus on methods developed to describe the context (defined by them as the social, political, and organisational setting) in which an intervention was implemented. They define context evaluation as the "...naturally occurring events and influences in the setting or environment of the intervention that might act to contribute to or impede intervention success" (p. 789). They point out that without evaluation of the processes around implementation, researchers have inadequate data to account for what the intervention actually was or why it had its effects when they find that an intervention works or doesn't work. Similarly, Robert et al. (2006) argue that process evaluation studies (such as this study):

“... allows for salient indicators to be examined on the pathway through which an intervention is expected to work, and brings understanding to outcome results... Implementation data are critical to understand what, how and why an intervention works or does not work.” (p. 318)

Corboy and McDonald (2007) and Greenberg, Domitrivitch, Graczyk and Zins (2005) point out that the implementation of any intervention does not occur in a vacuum; a number of factors inside and outside of the programme affect its implementation. As such, Corboy and McDonald (2007) argue that even with the most effective interventions, there are constraints in implementing interventions. It is argued here that such constraints are often overlooked. For example, DuPaul (2009) argues that in most cases it is assumed that intervention integrity will be high simply on the basis of providing the necessary information to deliver treatment, whereas the track record of relatively low integrity rates in most treatment contexts suggests that this approach is not usually successful. Briesch et al. (2013) argue that, historically, a “publish and hope” approach has been used to disseminate information about EBIs. For example, researchers have provided best practice within the literature with the expectation that consumers could replicate those interventions. Similarly, Pas and Bradshaw (2012) argued that a common approach to developing educational programmes has been to create a programme, test it through a randomised trial, and then offer it to community institutions with the expectation that schools will successfully implement those programmes. Clegg (2005) argues that built into this evidence-based movement, therefore, is a separation between research and practice-based contexts with a simple one-way linear model of the relationship between the two. These approaches have meant that many effective interventions have gone underutilised, and benefits only partially gained or not at all gained, as the factors hypothesised to influence and predict implementation have been ignored (Demiris, Parker Oliver, Capurro, & Wittenberg-Lyles, 2014).

All above researchers argue for the need to better understand factors that impact on implementation, something which Briesch et al. call ‘the goal of implementation science’. Understanding the facilitators and barriers to implementation can lead to improved implementation (Lee, Hanrahan, Aiken, & Blank, 2006) which can, in turn, improve outcomes. Clegg (2005) argues the need for: “...a more sophisticated understanding of context...To understand the dynamics of the ways in which evidence comes to be used,

therefore, involves an analysis of the social and political relations at play” (p. 424). Durlak and DuPre (2008) argue that studies often neglect to consider the moderation of variables, other than fidelity, that may influence implementation. As indicated above, this is particularly important when studying implementation of EBI in real-world setting. Pas and Bradshaw (2012) argue that whilst there is established literature supporting research through clinical trials and studies around effectiveness of interventions, there is less literature around the processes of translating efficacious practices into real-world settings. The latter, they argue, is often characterised as being “messy”, as it is difficult to implement carefully controlled designs when examining the real-world process of programme implementation. Similarly, Briesch, Chafouleas, Neugabauer and Riley-Tillman (2013) state that limited work has been conducted in order to understand the extent to which EBIs are used in local settings, and Ginsburg et al. (2008) argue that the challenges which continue to confront psychology are around the successful dissemination of EBIs to community settings. Willis, Small and Brown (2012) state: “...there is ongoing debate about how we can study implementation...how research findings can be transferred into practice” (p. 1222). Such a knowledge gap is important to fill because sustained high quality EBI implementation is essential to public health impact (Spoth, Guyll, Redmond, Greenberg, & Feinberg, 2011). Similarly, Ferrari and Durlak (1998) argue that implementation should be a fundamental issue for those interested in community research and action, especially given the link between implementation success and outcomes of community-based interventions. Ferrari and Durlak (1998) state:

“ there can be quite a difference between what is planned and what actually happens in community-based programs. Monitoring implementation procedures in field research is the equivalent of manipulation checks in laboratory studies.” (p. 1-2)

Pas and Bradshaw (2012) describe the process by which programmes move from research settings into real-world settings as “translational research” whilst Mychailyszyn et al. (2012) refer to this challenge as ‘bridging the gap’ or ‘translating science into practice’. Similarly, Demiris et al. (2014) describe the process of translating innovations from research findings into broad application as ‘implementation and dissemination’. Durlak (1998) concludes that research on implementation is in its infancy but as systematic data on implementation increase, we will become better informed about factors that enhance programme

implementation, thus resulting in closer correspondence between the prevention programmes that are planned and those that are implemented in real world settings.

School change literature has long recognised the importance of, and need for, studying intervention implementation. Allen (2011) states that the field of school psychology, in particular, is “steadfastly attempting to address the gap between research and practice”, partly as a result of the implementation realities involved in translating programmes from research to school settings. Briesch et al. (2013) suggest that poor student outcomes have often been blamed on the gap between the dissemination of interventions by researchers and their adoption in local classrooms. Rather than blaming the ‘research-to-practice’ gap on either side of the divide, they suggest a shift of focus towards analysis of the activities that constitute the “to” in the translation of research to practice. This involves focusing on the variables that influence implementation. However, research into school-based intervention implementation has been limited. For example, Greenberg et al. (2005) report that the majority of published school preventative intervention trials in the 1980s and 1990s were conducted with little or no reported implementation information. Of particular relevance to school-staff implementation of CBI’s, Gregory et al. (2007) identify that: “...knowledge about the school conditions that facilitate teacher-led implementation of psychosocial programs in the classroom has lagged behind” (p. 251). As empirically based interventions move away from university personnel, they argue that the science of implementation needs substantial strengthening. Kalafat et al. (2007), Beidas et al. (2012) and Greenberg et al. (2005) all argue the need for more research into the factors influencing implementation in the school context. Cole et al. (2012) argue that there is a particular need “...in evaluating school-based interventions, to consider characteristics of the context in which change is sought (i.e. the school)...” (p. 94), and Goldberg Lillehoj et al. (2004) refer to several researchers who have documented the significance of evaluating programme implementation at the classroom level. The need for further research is especially important given the argument that schools are becoming one of the most important settings in which wellness promotion interventions are conducted (Greenberg, et al., 2005). As Christner et al. (2007) state: “...though there is considerable documentation to suggest a need for providing mental health services in schools, there are a number of factors that make fitting these services into the culture of the school difficult” (p. 175). Schools are complex organisations which raises challenges for intervention implementation (see, for example, Cantrell, Almasi, Carter, & Rintamaa, 2012). Corboy and McDonald (2007) argue that identification and examination of factors impacting on

implementation assist in ensuring quality outcomes for school-based interventions in the future.

To summarise, a number of authors have identified that whilst there has been a focus on the evidence base for programmes, there is an increasing need for evaluations that identify programme processes or mediators (e.g. Corboy & McDonald, 2007; Evans, 2004; Greenberg, et al., 2005; Kalafat, et al., 2007; Lendrum & Humphrey, 2012). In other words, more research is needed around the process by which programmes are implemented and the factors that influence implementation. This is particularly true for EBI implementation in real-world settings such as schools. Pas and Bradshaw (2012) state: “There is considerable need for more research on factors that enhance or relate to the adoption and adequate implementation of programs and lead to effective practice and outcomes, particularly in school settings” (p. 418).

Gregory, Henry and Schoeny (2007) call for an ecological perspective to help understand school contextual conditions that support school-based implementation. The next section will consider an ecological based framework.

## **Models of Implementation**

Bond (2008) describes three predominant models of programme evaluation (based on Virtanen & Uusikylä, 2004): *Goal-bound* which tend to emphasise mapping causal inter-linkages between interventions and outputs, *goal-free* which tend to emphasise the views of stakeholders distinct to the intervention being evaluated and a combination of *goal-free and goal-bound* which tends to focus on contexts, mechanisms and outputs. Durlak and DuPre (2008) reviewed both the impact of implementation on intervention outcomes and the factors that influence implementation, thus providing an example of *goal-free and goal-bound* programme evaluation. They researched the findings of over 542 studies and found evidence to suggest that the outcome of interventions (including school-based interventions) was influenced by implementation factors. Such factors included: fidelity of the intervention and level of intervention dosage. In sum they argue that levels of implementation are a significant determinant of intervention outcomes and, consequently, they highlight the importance of identifying facilitator/barrier to effective intervention implementation. They propose a ‘Framework for Effective Implementation’ which is used in this study and described below.



Durlak and DuPre's (2008) multi-level ecological perspective to understanding implementation, involves understanding variables present in five categories: innovations, providers, communities, the prevention delivery system and the prevention support system. They argue that when all variables are working effectively, this facilitates conducting the intervention as planned. In particular, they view the key elements of the Prevention Delivery System (related to organizational capacity) and two key elements of the Prevention Support System (training and technical assistance) to lie at the centre of effective implementation: they argue that some type of organizational structure is necessary for guiding the implementation of a new programme. Meanwhile organizations need support in conducting new interventions successfully, and they argue that this support comes primarily through training and technical assistance that is provided by outside parties. Finally, they argue that Community Factors (e.g. politics, funding and policy), Provider Characteristics (e.g. skill proficiency and self-efficacy) and Innovation Characteristics (e.g. the interventions adaptability and compatibility with the organisation) are also important factors in determining intervention implementation. Durlak and DuPre present at least 23 factors in total, which they argue merit attention in future research. See Figure 2 below for an illustration of Durlak and DuPre's framework, and Appendix J for a description of each factor identified within the five framework categories.

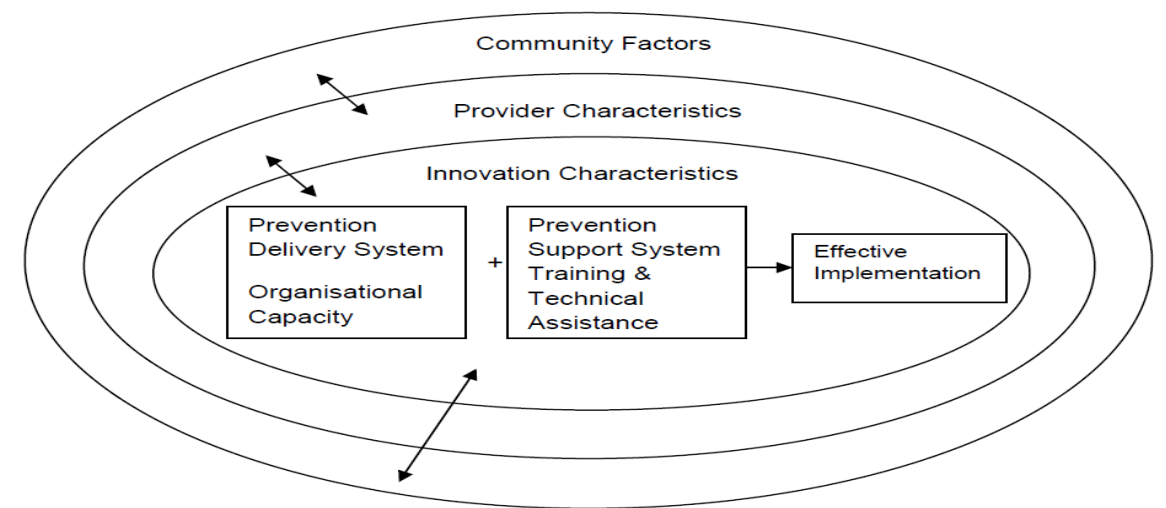


Figure 2: Framework for Effective Implementation (Durlak and DuPre, 2008)

The rationale for selecting this framework for utilisation in this study will now be considered.

Firstly, evidence is available to validate Durlak and DuPre's (2008) framework. Durlak and DuPre (2008) reviewed 81 studies containing data on factors affecting the implementation process; this data supported their ecological framework and highlighted implementation factors within each category. Durlak and DuPre (2008) report on three other systematic narrative reviews: each of these confirms the necessity of a multi-level ecological framework for understanding implementation and confirms that such a framework should consider variables related to the characteristics of innovations, communities, and individuals, as well as those associated with the prevention delivery and support systems. Moreover, there was substantial overlap regarding specific factors that affect implementation e.g. 11 factors featured in all four reviews. Whilst Greenberg et al. (2005) offer an alternative comprehensive model of implementation, they do not provide the same level of research analysis to validate their model as Durlak and DuPre.

A number of school-based studies, independent of Durlak and DuPre, have identified individual implementation factors that validate those identified in Durlak and DuPre's (2008) framework. For example: Bisset, Potvin and Daniel (2013) identify 'implementer factors'; Bolton, Snowdon, Kremer, Gibbs, Waters, Swinburn and Silva-Sanigorski (2012) highlight 'staff capacity building' and 'embedding activities into existing infrastructure'; Pas and Bradshaw (2012) highlight 'school contextual factors'; Acosta et al. (2013) identify 'factors at the individual and organisational level'; and Beidas et al. (2012) identify factors related to 'administrator support', 'teacher support', 'financial resources', 'high quality training', and 'alignment of intervention with school philosophy'. Briesch et al. (2013) identify variables most relevant to school-based intervention implementation to include: treatment acceptability (linked to implementer motivation and knowledge); intervention compatibility with existing practices (linked to resources required for implementation); and environmental and contextual factors (such as administrative support). These factors all feature in Durlak and DuPre's framework.

The following implementation factors were identified through recent healthcare studies, but are argued here to be relevant to the school context and to validate factors identified in Durlak and DuPre's framework:

**Table 1: Implementation factors identified through healthcare studies**

Researchers	Implementation Factors Identified
Allicock, Campbell, Valle, Carr, Resnicow and Gizlice (2012)	Time; space; resources; technical assistance; programme adaptability; and materials.
Amaral, Ronzani and Souza-Formigoni (2010)	Expectations about the project; collaborativeness of project planning; political environment; institutional support; and organisational culture.
Beune, Haafkens and Bindels (2011)	Political context; organisational factors; and implementer factors.

Finally, Durlak and DuPre’s framework incorporates categories of factors which are commonly identified by other researchers, namely: (1) Intervention, (2) Implementer, (3) Organisation and (4) Social-political context (see, for example: Acosta, et al., 2013; Briesch, et al., 2013; Forman & Barakat, 2011; Helmink, et al., 2012; Shapiro, Prinz, & Sanders, 2012).

The second reason for using Durlak and DuPre’s framework in this study relates to it being a comprehensive framework. Briesch et al. (2013) and Shapiro et al. (2012) argue that a wide range of variables have been identified across literature, acting alone and in combination, that serve as facilitators or barriers to implementation. Given this, Shapiro et al. (2012) argue that a conceptual framework that captures this complexity is required. Similarly, Briesch et al. (2013) argue that researchers have generally endorsed ecological models of treatment usage that acknowledge multiple levels of influence. They conclude that there exists: “a complex interplay among a number of different factors that simultaneously consider the individual implementer, the intervention components, and the environment in which the intervention is to be utilised” (p. 83). Durlak and DuPre’s (2008) framework addresses this level of complexity. In particular, it allows for in depth exploration of the wide range of factors that affect implementation within the naturally occurring constraints of a school setting.

It has been argued above that dissemination of information alone regarding interventions does not guarantee implementation of those interventions; a number of factors impact on implementation. The researcher considered Durlak and DuPre’s (2008) implementation

framework to be a comprehensive base from which to explore, at a deeper level, the facilitators and barriers impacting on implementation. This framework was used, primarily, to address RQ 3 of this study: what are the perceived barriers and facilitators to school staff implementing CBI? As will be discussed in Chapter 6, the framework was used to:

- 1/ Design pre and post intervention interviews
- 2/ Identify a-priory codes for thematic analysis
- 3/ Structure findings related to RQ3

### ***Adaptability and Fidelity***

Adaptation of an intervention is defined here as the process by which an intervention can be tailored or modified to make it more suitable to a particular context or community. Fidelity refers to the extent to which interventions are implemented as planned or intended by the developer (see Cantrell, et al., 2012; Spoth, et al., 2011). According to Greenberg et al. (2005) the definition of fidelity is based on the discrepancy between intervention implementation as *planned*, and intervention implementation as *delivered*: the greater the discrepancy, the lower the fidelity. Hence some argue that adaptation contradicts fidelity in that adapting an intervention is a failure to reach fidelity. There is some debate about the value of programme adherence versus adapting programmes to meet local need (see, for example, Dane & Schneider, 1998; Durlak & DuPre, 2008).

Despite adaptability and fidelity being considered in opposition by some, research suggests that fidelity and adaptation frequently co-occur and each can be important to positive outcomes. For example, a number of studies have demonstrated the positive impact of fidelity on various interventions, including school-based interventions (Durlak, 1998; Durlak & DuPre, 2008; Dusenbury, Brannigan, Falco, & Hansen, 2003; Gregory, et al., 2007; Pas & Bradshaw, 2012; Poirier, et al., 2013; Spoth, et al., 2011). Meanwhile other studies have demonstrated the positive impact of adaptability on various interventions, including school-based interventions (Blakely, et al., 1987; Cantrell, et al., 2012; Kerr, Kent, & Lam, 1985; McGraw, et al., 1996). Cantrell et al. (2012) argues that when teachers are well prepared to teach the content and have the belief in their own potential, then they can successfully adapt programmes to best meet the needs of their children. Berman and McLaughlin (1976) argued

that the more flexibility allowed for the modification of a programme to meet those needs, the greater the likelihood that the programme will be adopted, implemented and have positive results. This is especially relevant to school-based interventions as a number of researchers have documented that teachers, in particular, have demonstrated low levels of intervention fidelity (see, for example, Cantrell, et al., 2012; Gilbertson, Witt, Singletary, & VanDerHeyden, 2007; Gottfredson, et al., 2002; Gregory, et al., 2007; Sanetti, et al., 2013). Pettigrew et al. (2012) found that teachers seem to adapt material to accommodate their delivery pattern. They suggest that interventions can be designed to present alternative curriculum choices in order to provide teachers with practices consistent with their own styles.

Studies by Telzrow, McNamara and Hollinger (2000) and Stevens, Van Oost and Bourdeaudhuij (2001) indicate that the positive outcome of programmes are only significantly related to particular parts of programmes, hence leaving room for interventions to be modified without negative impact on outcomes. Indeed, fidelity ratings typically do not reach 100%; providers replicate some parts of programmes but modify others. This is especially true for less structured interventions, such as the intervention used in this study. Studies have demonstrated that interventions still achieve positive outcomes when implementation fidelity is relatively low (Durlak & DuPre, 2008; Gottfredson, et al., 2002; Robert, et al., 2006). Durlak and DuPre (2008) suggest that it is possible that once a certain level of fidelity is attained, higher levels may not lead to better outcomes, particularly if the intervention's core components have already been effectively delivered. Likewise, Hall and Loucks (1978, cited in Kay, 2012) argue that adaptation is acceptable up to a point, beyond which further adaptation may compromise the effectiveness of the programme. As a middle ground, many argue that whilst some adaptation is beneficial, at least the critical features of an intervention should be delivered as planned to constitute an acceptable level of implementation fidelity (e.g. Dane & Schneider, 1998).

So far it has been argued that adaptation should not be seen as opposing fidelity and that both are important to implementation. However, it remains unclear as to exactly what mix of fidelity and adaptation will lead to optimal results, particularly as this is likely to alter depending upon the programme and the context. Durlak and DuPre (2008) argue that it is unclear in most studies of implementation exactly which components are reproduced faithfully, or exactly how the intervention is being altered. They argue for the need to define core components in interventions that require implementation as planned, and to research

both adaptation and fidelity of interventions, particularly in real world settings. Similarly, Greenberg et al. (2005) argue research is needed to identify the specific elements of EBIs that are essential to intervention success and those elements that may be modified while remaining true to the intended purpose or concept underlying the model. Goodkind, Lanoue and Milford (2010) report on their study which demonstrated a modified school-based CBI. They outline the adaptations made to each intervention session, thus providing the clarity that Durlak and DuPre and Greenberg et al. argue is needed in implementation research.

Unlike manualised CBI's, the CBI implemented in this study was designed to be used flexibly and adaptively. The aim of the researcher was for school staff to develop a sound understanding of theory and competences so that they could develop their own CBI's to responsively match the needs of their children and school context. The intervention training comprised of: CBT based competences (listed in Appendix H); an understanding of the CBT model; and a loose framework for delivering these competences. For example, trainees who planned to deliver a structured intervention were expected to use: general competences relating to setting up and running an effective intervention (e.g. consent, confidentiality, rapport building and adjusting the level of sessions), and competences relating to the psycho-educational elements of CBI (e.g. identifying thoughts, feelings and behaviours and linking these), before using any other competences. School staff were expected to implement their interventions flexibly, with fidelity to the underlying theory and competences. Training and supervision were key methods used to ensure that participants implemented the competences as planned.

### ***Supervision***

Supervision is important to this study for two reasons. Firstly, as discussed above, supervision was a key method used to ensure that participants implemented CB competences with fidelity. That is, supervision was used to: identify specific competences implemented/planned for implementation; monitor appropriate implementation of these; and support staff continued development of such competences. In this sense, supervision was seen as a potential facilitator to staff development of CB competences, thus relating to RQ1&2. Secondly, Durlak and DuPre (2008) argue that two key elements of the 'Prevention Support System', namely training and technical assistance, lie at the centre of effective implementation (as can be seen in figure 2). As supervision is considered a form of technical assistance, it follows that supervision can be considered as a key facilitator or barrier to intervention implementation. Thus, supervision

and training were evaluated as part of this study and the findings explored under RQ3. This is particularly pertinent given that: Greenberg et al. (2005) indicate the need for increased research attention regarding the importance of ongoing supervision; and IAPT (Turpin, 2011) argue that research evidence to support the added value of supervision is modest and in its infancy.

The IAPT guidance (Turpin, 2011) identify five purposes of supervision, which are: to ensure that supervisee's deliver the same intervention and to the same level of competence as those who have delivered the intervention with positive outcomes; to optimize collaborative care of clients and effective case management; to deal with individual cases that might be more difficult (ensuring practice is ethical and safe); for skill development and training purposes; and to support staff wellbeing. They state that, ultimately, the purpose of all forms of supervision should be to safeguard the wellbeing of the 'client' and assist development of the supervisee. Squires and Williams (2003) describe four similar aims of supervision:

- Educative – to provide opportunities to explore and learn from practical, experiential and theoretical elements of practice.
- Supportive and Managerial – to provide opportunities to discuss potentially controversial or ethical issues.
- Managerial – to enhance the quality of service delivery.
- Supportive – to maintain and improve emotional health of supervisee.

Scaife (1993) describe a framework of supervision which involves three dimensions: the supervisor role (i.e. to inform-assess, listen-reflect or enquire), the supervisory focus (i.e. actions and events, knowledge, thinking and planning or feelings and personal qualities) and supervisory medium (i.e. live, recorded sessions, role play or reporting). Scaife argues that having such a framework aids discussion between supervisor and supervisee in order that a mutually satisfactory training experience is enhanced; together the supervisor and supervisee should find styles that suit them and review these regularly.

In terms of supervisor qualities, IAPT (Turpin, 2011) state that supervisors should have a working knowledge and experience of the interventions for which they are providing supervision. Squires and Williams (2003) identify core and desirable supervisory skills, many of which reflect those identified by Osborne (1993, cited in Nolan, 1999). Core skills include

active listening, confidentiality, self-reflection and refraining from judgment. Carrington (2004) points out that the supervisor needs to be able to apply a range of styles and approaches to suit the supervisee's needs and stage of development. Similarly, Nolan (1999) states that supervision is a: "...complex multi-functional concept, and that supervisors may need to carry out several different, and possibly conflicting tasks" (p. 98).

IAPT state that, amongst other things, effective supervision requires consideration of: the quality of relationship between supervisee and supervisor and the fostering of an atmosphere of trust and openness. Similarly, Greenberg et al. (2005) state that it is helpful for the trainee to perceive the trainer as one who respects their individual needs and that implementation can be improved by creating a supportive, cooperative partnership between trainers and implementers. It is argued here that the same conditions apply between a supervisor and supervisee partnership.

The models and principles highlighted above were used to inform supervision in this study. For example, descriptions provided by Squires and Williams (2003), Scaife (1993) and Osborne (1993, cited in Nolan, 1999) were used to inform the: aims of supervision; styles of supervision; and supervisor core skills (respectively). See Appendix N for a copy of the supervision statement and contract.



## Chapter 4: Role of the Educational Psychologist (EP)

The potential role for school-based practitioners in implementing CBI was highlighted in Chapter 2. This section focuses on the EP role in relation to CBT, particularly with regards to supporting school-staff to develop CB competences.

### **EP Use of CBT**

Caddick (2009) carried out a systematic literature review in relation to the use of CBT by EPs in the UK. Five relevant studies were identified: Squires and Dunsmuir (2011) Toland and Boyle (2008); Gregor (2005); Greig and MacKay (2005); and Squires (2001). The review findings are in line with Dunsmuir and Hardy (2013) who argue that research around EPs contribution to school-based mental health services is limited in the UK compared to USA. Since the review, other studies involving EP use of CBT in the UK have been published (e.g. Cole, et al., 2012; Squires & Caddick, 2012).

Whilst Caddick's (2009) review provided relatively limited research evidence to support the existing use of CBT by EPs in the UK, it produced a wealth of discussion around the *potential* uses of CBT by EPs in the UK. For example, five papers were identified (Boyle, 2007; Dunsmuir, 2007; Greig, 2007; Majors, 2008; McNamara, 1998) each discussing the use of CBT by EPs. The review also argued that CBT may be used by EPs more than the research evidence would imply; EPs may be using CBT but failing to report this in shared literature, possibly as a result of time constraints to conduct research or due to use of CBT informally, as part of their day to day practice.

Assuming that EPs use CBT in practice more than research evidence would imply, it remains a concern that there is little research evidence to support this. In its absence, the role of the EP in relation to CBT is less recognised by colleagues. Allen (2011) argues that lack of focus on implementation issues partly explains why EPs have not used CBIs more frequently in schools.

## Potential EP Use of CBT

A recent review of the contribution of EPs in England and Wales recommended that EPs should expand into areas such as therapy (Farrell, 2006). The data suggests that those we support would welcome further therapeutic input (Farrell, 2006) and that EPs themselves believe that therapeutic intervention should be core areas of their work (Greig and MacKay, 2005). Indeed, recent changes in the fields of education and health have highlighted opportunities for the EP role in relation to therapeutic work, specifically around CBT. It was estimated that in order to provide CBT intervention as recommended by 'NICE' for 12 – 18 year olds with depression, 760 full time trained therapists were required (Stallard, et al., 2007). Stallard et al. reported that this is well beyond the capacity of CAMHS or the availability of therapists accredited by the BABCP (the leading UK organization for CBT), thus highlighting potential for involvement from others with relevant skills. It is argued here that EPs are one such profession. In support of this, it is argued that the roles of the EP and Clinical Psychologist are becoming less distinct, thus removing some barriers in relation to EPs and therapeutic work. Indeed, a review of EP services (Farrell, 2006) recommends consideration of merging clinical and educational psychology.

Hoagwood and Erwin (1997) highlight concerns with the existing use of school interventions which lack evidence bases. They argue that, with schools remaining 'the de facto mental health system for children' they need to build on a scientific knowledge base. It follows that EPs can support schools to achieve this by introducing EBIs, such as CBT. MacKay (2007) argues that CBT has substantial evidence to support its use and that: "Educational Psychology in seeking to be an evidence-based profession can appropriately embrace therapeutic interventions and apply them where they have known effectiveness" (p. 15). Similarly, Zyromski and Joseph (2008) state: "School counsellors should utilise research supported, empirically based theoretical intervention strategies, such as CBT" (p. 17).

Ollendick and King (2004) argue that as psychologists, the identification, promulgation, and use of empirically supported treatments is in accord with ethical standards. Greig and MacKay (2005) argue intervention programmes used by EPs need to be: simple, flexible, sustainable, economical, ethical, generalisable, positive and effective. If CBT is (as it has been argued) a therapeutic intervention which meets the above criteria, then it follows that CBT should form

part of EPs work. Dunsmuir and Iyadurai (2007) conclude that CBT can have an exciting and worthwhile aspect of EP practice.

A number of the discussion papers referred to by Caddick (2009) discuss the role of the EP in incorporating CBT strategies at multiple levels, ranging from direct work with individual children and groups of children, to work at a whole school strategic level. Of the five studies identified by Caddick (2009), three involved EPs delivering group interventions (Gregor, 2005; Squires, 2001; Toland, 2008) and one involved an EP delivering individual intervention (Greig, 2005). Squires (2001) and Yeo and Choi (2013) highlight EP use of CB group interventions as a potential solution to the issue around EPs limited time for intervention. Indeed, in Squires and Caddick's (2012) study, a CBT group intervention was identified by school as having been good use of EP time. Findings of studies such as Liddle and Macmillan (2010), Squires (2001) and Ruttledge and Petrides (2011) provide evidence for professionals, such as EPs, using CB approaches in a group modality. Yeo and Choi (2013) conclude: "The findings lend support to group CBT for use by school psychologists to address behavioural difficulties".

Finally, and most relevant to this study, it is argued that EPs are well placed to support implementation of CBI's indirectly, through capacity building school-staff to deliver CBI's. Yeo and Choi (2013) state that school psychologists are uniquely placed to effect desired changes in children through opportunities for working collaboratively with teachers, counsellors and parents. It is argued that the positioning of the EP enables them to engage the wider social network of a school, and makes the way that psychologists can go about therapeutic work distinctive from counsellors or therapists (Squires, 2010). Training and supervision offer one type of support that EPs can provide in schools. The need for adequate training and support to deliver CBI's by school staff was highlighted in Chapter 2. Rait et al. (2010) argue that EPs are in an ideal and unique position to support school staff directly involved in the delivery of CBT programmes. For example, they suggest that EPs can use the CBT model and techniques to help school staff devise and formulate case profiles or formulations, and in highlighting the various influencing on cognition and behaviour, in individual casework. Rait et al. (2010) conclude:

"EPs are in an ideal position to support school staff to understand the theoretical model and core principles that underpin [CBT] programmes, so that

when required a programme can be adapted in a coherent and theoretically robust way. A distinct supervision role for EPs could be evolved here” (p. 117).

Squires and Williams (2003) argue that the skills needed to fulfill effective supervision are those typically practiced by EPs on a daily basis. It is argued here that EPs can use their skills in supervision and training to develop staff knowledge and competences around CBT.

There are several references in the reviewed literature to the benefits and challenges of EPs using CBT indirectly with adults to support children (e.g. Majors and Sykes, 2008, Squires and Dunsmuir, paper in progress and Greig and MacKay, 2005). Kay (2012) reports on studies that have found favourable results from EPs training school staff over a period of time, including positive results for pupils, and positive results for the adult participants (teachers and teaching assistants) who claimed that they had developed their knowledge, skills and confidence as a result of training. Dunsmuir and Iyadurai (2007) discuss the implication of EPs needing time to prepare and deliver interventions on services which operate time allocation systems. However, EPs offering training and supervision to teachers has the potential to reach a larger cohort of children than delivering individual intervention, thus providing some resolution to time management. Indeed, EPs have increasingly adopted a systems approach to service delivery, through offering training and consultation. This has involved filtering their expertise to adults who have close involvement with children. As Yeo and Choi (2013) state:

“Involving and equipping teachers and counsellors is one avenue whereby the skills of school psychologists can filter down to larger pupil populations. Teachers have the most direct access to children and many opportunities during a normal school day to reinforce good self-management habits” (p. 628).

Kay (2012) argues that it does not appear essential for EPs to deliver intervention programmes, but that they are able to facilitate training and supervision of staff to understand

the underpinning philosophy of the programme and successfully embed the programme within their school systems.

There are several barriers noted in relation to EP involvement in school-based CBI's. For example, several of the reviewed papers refer to teacher's lack of commitment to working with the EP on CBI's, either due to their difficulties with being released to participate with the intervention or their not taking ownership for the intervention (see, for example, Majors and Sykes, 2008 and Gregor, 2005). Squires and Dunsmuir (2011) discuss several barriers related to Trainee EPs use of CBT, many of which could apply to qualified EPs, including lack of training and confidence to deliver interventions. This finding is in line with Dunsmuir and Iyadurai (2007) who argue the need for EPs to have formal training and supervision by accredited CBT practitioners in order to practice CBT within the boundaries and competence set out by the BPS Code of Ethics and Conduct (2009). However, they also point out difficulties around becoming, and accessing, accredited CBT users, arguing that training is intense and costly for EPs. Squires and Dunsmuir (2011) also report on the increased amount of therapeutic content in the doctorate training programmes for EPs; newer EPs are more equipped to use therapeutic techniques. It seems timely that the BPS (Division of Educational and Child Psychology) are currently producing professional practice guidance and clarification of the skills and competencies necessary for delivery of EBIs in school (2013).

Overall, the literature emphasises that CBT can be considered a broadly-based flexible approach and that there is a crucial role for EPs with regards to CBT at a number of levels within the educational system. In particular, EPs are well placed to carry out CBT work indirectly, through supporting school-staff to deliver CBI's. The thesis has demonstrated that research into EP use of CBT is lacking. There is a need for further research to help redefine the EP role in relation to therapeutic interventions such as CBT, especially in light of recent developments around children's emotional wellbeing (e.g. IAPT and CAMHS initiatives), and given the rise in mental health issues, increased evidence for therapies and changing perspectives of applied psychology (MacKay, 2007).

## Chapter 5: Summary of the literature

### **Summary, Aims and RQ's**

The present study aims to address research gaps identified in the literature by exploring the process of school staff implementing CBI in their school settings, supported by EPs providing training and supervision. The RQ's, and a rationale for identifying the RQs, are presented below:

Chapter 2 presented a sound theoretical and evidence base for using CBT with children, and for using CBIs in schools, whilst acknowledging the need for further research into school-based CBIs. The research identified the potential implementation of CBT at multi-levels within the school system, including at an individual, group and whole school level. School-staff were argued to be well placed to implement CBI's, when appropriate training and support are provided. The possibility of school-staff developing particular CB competences, that are in line with best practice, was highlighted. This has led to the following RQs:

**RQ1. What CB competences do school staff believe they implement with training and support?**

**RQ2. How do school staff implement CB competences with training and support?**

Chapter 3 identified that further research is needed into the process of intervention implementation, particularly in real world settings such as schools where factors impacting on implementation are complex. Durlak and DuPre's (2008) multi-level ecological framework of intervention implementation identifies facilitators and barriers to implementation and this was presented as an effective framework to explore intervention implementation in this study. This has led to the following RQ:

**RQ3. What are the perceived barriers and facilitators to school staff implementing CBI?**

Durlak and DuPre's (2008) framework identified 'Technical Support' as being at the centre of effective intervention implementation. Supervision was discussed as one form of technical

support: this has relevance to RQ3 as supervision can be considered a key implementation facilitator or barrier, and relevant to RQ1 & 2 as supervision and training were used to support staff development of CB competences in this study.

Chapter 4 identified limited published research around EPs use of CBT in the UK, whilst highlighting potential for EP use of CBT. In particular, it was argued that EPs are well placed to support school-staff to develop CB competences through training and supervision. This has relevance to RQ3 as EPs can provide supervision as a potential facilitator to implementation, and relevant to RQ1 & 2 as EP can provide supervision and training to support staff development of CB competences.

These research areas are explored primarily via school staff perceptions. This is in line with Evans et al. (2004) who recommend that process evaluations be undertaken to ascertain the views of participants (e.g. teachers) about the strategies used.

## Chapter 6: Methodology

### **Epistemological Stance**

This exploratory study employed a mixed methodology: using mainly qualitative methods, but with some quantitative methods. The researcher's epistemological stance in relation to mixed methodology will now be considered.

Quantitative approaches that incorporate numerical data and techniques are usually associated with a positivist paradigm. This paradigm is typically based on “the philosophy that our preconceptions need to be set aside in order to identify objective facts based on empirical observations” (McEvoy & Richards, 2006 (p. 67)). Positivists believe that the goal of science is to uncover the ‘truth’. In contrast, qualitative approaches based on non-numerical narratives are usually associated with the interpretivist paradigm. Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.

Whilst purists argue that quantitative and qualitative approaches are so different that they should not be combined or reconciled, methodological pragmatists accept the same set of paradigmatic assumptions as the purists but argue that researchers should use whatever methods are needed to obtain the optimum results, even if this involves ‘switching between’ alternative paradigms. That is: “The logic of the pragmatist position is that neither quantitative or qualitative methods alone are sufficient to develop a complete analysis. As a consequence, they need to be used in combination” (McEvoy & Richards, 2006 (p. 68)). McEvoy and Richards (2006) describe some of the benefits of using this combination, for example arguing that it can make analysis more complete: “Quantitative and qualitative data may be triangulated for the purpose of completeness in order to obtain complementary perspectives, and a greater level of detail than could be obtained from using either data source” (p. 72). They provide a case study example to demonstrate how using both the quantitative and qualitative approaches gave an inquiry a greater sense of balance and perspective. Mingers (2004) provides an alternative description of pragmatism: “Pragmatism is a view about the purpose of science—that it is essentially a practical activity aimed at producing useful knowledge rather than understanding the true nature of the world” (Mingers, 2004 (p. 90)). The researcher in this study took a pragmatic methodological stance in that the study



utilised mainly qualitative methods, with some quantitative methods utilised to enhance exploration and understanding.

It is ‘critical realism’ that best describes the researchers epistemological stance with respect to the paradigms of positivism and interpretivism typically associated with quantitative and qualitative approaches (described above). In short, critical realism embraces both elements of positivism and an openness for interpretation of data. A critical realist (CR) believes that there is a reality independent of our thinking about it that science can study. They recognise that all observation has error and that all theory is revisable. In other words, the CR is *critical* of our ability to know reality with certainty. Where the positivist believes that the goal of science is to uncover the truth, the CR believes that this goal is not achievable, but that science can help understand as close to reality as possible (Trochim, 2006). Clegg (2005) explains that positivism involves an ontology of a regular universe of facts in which regularity is taken as evidence of cause and effect, and where the real is reducible to experience. However, CRs argue that such regularities rarely occur in the natural and social worlds of experience; the world has depth and the real cannot be reduced simply to experience (Clegg, 2005). CRs argue that the real world operates as a multi-dimensional open system. Instead of following a set order, effects arise due to the complex interactions between the many systems and mechanisms within it. A critical realist argues that positivists fail to adequately acknowledge external influences and contextual factors, but they are critical of interpretivists for failing to relate discourses to underlying social structures. As McEvoy and Richards (2006) state:

“For critical realists, the ultimate goal of research is not to identify generalisable laws (positivism) or to identify the lived experience or beliefs of social actors (interpretivism); it is to develop deeper levels of explanation and understanding”  
(McEvoy & Richards, 2006 (p. 69))

Similarly, Mingers (2004) describes how CR wants to get beneath the surface to understand and explain why things are as they are, to hypothesise the structures and mechanisms that shape observable events. The critical realist stance is especially suitable for the study presented in this paper, as the researcher was interested in exploring deeper levels of explanation and understanding around the complexities, and realities, of school-based intervention implementation. CR is particularly suitable in the field of EP as the EP role calls for a balance between an appreciation for scientific rigour and EBP, and an appreciation for real world

research and practical applications of psychology within multi-dimensional systems. This is in line with Lane and Corrie's (2006) conceptualisation of the EP role, as a scientist-practitioner.

Like pragmatics, critical realists argue that the choice of methods should be dictated by the nature of the research problem:

“CR does not have a commitment to a single form of research; rather it involves particular attitudes towards its purpose and practice....CR recognizes the existence of a variety of objects of knowledge—material, conceptual, social, and psychological—each of which requires different research methods to come to understand them” (Mingers, 2004 (p. 99-100))

In CR, it is to be expected that gaining knowledge in any particular situation will require a mixture of methods (Mingers, 2004). As CR argues that different methods will possess different types of error, CR would also argue for the need to use ‘triangulation’ across multiple methods to try to get a better grasp on what's happening in reality. Triangulation refers to the collection of data from different sources but aimed at corroborating the *same fact* or phenomena (convergence of evidence). This is different to using multiple sources in a study to address *different* questions (non-convergence of evidence). Table 2 (below) demonstrates how each RQ in this study is addressed through using at least four data sources and two data providers. This allowed for triangulation of data for each RQ and ensured that data was rich and varied. From any research point of view, triangulation of data can be considered as helping to counter threats to validity (Robson, 2002) and enhance reliability: “In social and evaluation research, data is triangulated for the purpose of confirmation in order to enhance the reliability and validity of the findings” (McEvoy & Richards, 2006 (p. 72)).

Critical realists view the key strength of qualitative methods as being that they are open ended thus allowing themes to emerge during the course of an inquiry that could not have been anticipated in advance: “Qualitative methods can help to illuminate complex concepts and relationships that are unlikely to be captured by predetermined response categories or standardised quantitative measures” (McEvoy & Richards, 2006 (p. 71)). McEvoy and Richards (2006) point out that whilst critical realists have tended to devote more attention to the development of qualitative research methods than quantitative approaches, the potential contribution of descriptive statistics in the search for retroductive explanations should not be

underestimated. Examples of this in this study are as follows: whilst quantitative data gathered (from training evaluation forms and IDs) under RQ 2 provided information around the frequency of use of various CBI methods, qualitative data (from interviews) confirmed some of these findings and provided richer information e.g. around the reasons behind methods of CBI used. Whilst RQ 3 relied heavily on qualitative data (from interviews) to explore facilitator/barrier to implementation, quantitative data (from supervision records and training evaluations) provided supportive data to demonstrate supervision and training as facilitators.

Robson (2002) provides a helpful overview of CR, as follows:

- “1. There is no unquestionable foundation for science, no ‘facts’ that are beyond dispute. Knowledge is a social and historical product. ‘Facts’ are theory-laden.
2. The task of science is to invent theories to explain the real world, and to test these theories by rational criteria.
3. Explanation is concerned with how mechanisms produce events. The guiding metaphors are of structures and mechanisms in reality rather than phenomena and events.
4. A law is the characteristic pattern of activity or tendency of a mechanism. Laws are statements about things that are ‘really’ happening, the ongoing ways of acting of independently existing things, which may not be expressed on the level of events.
5. The real world is not only very complex but also stratified into different layers. Social reality incorporates individual, group and institutional, and societal levels.
6. The conception of causation is one in which entities act as a function of their basic structure.
7. Explanation is showing how some event has occurred in a particular case. Events are to be explained even when they cannot be predicted.”

(Robson, 2002 (p. 62))

## **Methodological Design**

Table 2 below presents an overview of the data sources, and methods of data collection and analysis, used to address each RQ:

RQ1. What CB competences do school staff believe they implement with training and support?

RQ2. How do school staff implement these CB competences with training and support?

RQ3. What are the perceived barriers and facilitators to school staff implementing CBI?

The table demonstrates where qualitative and quantitative methods were applied. Individual data sources are discussed later in this chapter.


Table 2: Methodological Overview

RQ	Data Source and Data Collection Method	Data Analysis Method (relating to each data source)
RQ1. What CB competences do school staff believe they implement with training and support?	<p>Training Evaluations (Appendix I) – Trainees select competences from list</p> <p>Pre-Intervention Interview (Appendix K) – Participants answer semi-structured interview</p> <p>Post- Intervention Interview (Appendix L) - Participants answer semi-structured interview</p> <p>Supervision Records (Appendix N) – Participants and researcher select competences from list</p> <p>Intervention Diaries (Appendix O &amp; P) – Participants select competences from list</p>	<p>Quantitative: Descriptive statistics</p> <p>} Qualitative: Thematic analysis (TA)</p> <p>} Qualitative: Descriptive analysis</p>

*Continued overleaf*

<b>RQ</b>	<b>Data Source and Data Collection Method</b>	<b>Data Analysis Method</b> <b>(relating to each data source)</b>
RQ2. How do school staff implement these CB competences with training and support?	<p>Training Evaluations (Appendix I) – Trainees identify implementation methods</p> <p>Pre-Intervention Interview (Appendix K) - Participants answer semi-structured interview</p> <p>Post- Intervention Interview (Appendix L) - Participants answer semi-structured interview</p> <p>Supervision Reflections (Appendix R) – Researcher identifies implementation methods</p> <p>Intervention Diaries (Appendix O &amp; P) – Participants identify implementation methods</p>	<p>Quantitative: Descriptive statistics</p> <p>} Qualitative: TA</p> <p>Qualitative: TA (with some descriptive statistics)</p> <p>Quantitative: Descriptive statistics</p>

*Continued overleaf*

RQ	Data Source and Data Collection Method	Data Analysis Method (relating to each data source)
RQ3. What are the perceived barriers and facilitators to school staff implementing CBI?	Training Evaluations (Appendix I) – Trainees identify facilitators/barriers and rated training using ordinal categories	Quantitative and Qualitative: TA and descriptive statistics
	Pre-Intervention Interview (Appendix K) - Participants answer semi-structured interview	 Qualitative: TA
	Post- Intervention Interview (Appendix L) - Participants answer semi-structured interview	
	Supervision Reflections (Appendix R) – Researcher identifies facilitators and barriers	
	Intervention Diaries (Appendix O & P) – Participants identify facilitators and barriers	
	Supervision Evaluations (Appendix N) – Participants rate supervision sessions and identify supervision methods	Qualitative: Descriptive analysis (with some descriptive statistics)

Teddlie and Tashakkori (2009) argue that mixed-methods research involves: “...both qualitative and quantitative approaches to *data gathering, analysis, interpretation, and presentation*” (p. 7). Examples of how this definition applies to this study are given below:

*Qualitative data: collection; analysis; and presentation*

- The data sources involved open-ended and semi-structured questions designed to capture richer data e.g. interviews and open-ended requests for information about implementer facilitator/barrier.
- The interviews provided qualitative data.
- TA was the primary qualitative method of data analysis used.
- Interview findings were presented in thematic networks.

*Quantitative data: collection; analysis; and presentation*

- The data sources involved closed-ended questions (e.g. requesting scale ratings for training and supervision) or predetermined response categories (e.g. requesting selection of CB competences from a list).
- Ordinal data obtained from the training evaluation forms and supervision records was expressed as a number i.e. ratings of sessions from a five-point scale.
- Some qualitative data was converted into quantitative data e.g. counting the frequency by which specific implementation methods were reported.
- Some qualitative data was analysed quantitatively i.e. to analyse the frequency by which participants expressed key themes from the interview data.
- Descriptive statistics were used (i.e. frequency distribution graphs and tables) to meaningfully summarise and present the frequency that each: individual CB competences; and method of implementation were used.

Mixed-methods research has been defined by Creswell and Plano Clark (2007) as a research design based on assumptions that guide the collection and analysis of data and the mixture of qualitative and quantitative approaches. Similarly, Creswell, Klassen, Plano Clark and Smith (2011) describe mixed methodologies as involving the intentional collection of both



quantitative and qualitative data and the combination of the strengths of each to answer RQs. This integration leads to maximizing the strengths of the quantitative and qualitative data and minimizing their weaknesses. In line with this, integration of qualitative and quantitative methods in this study was used with the intention of developing a more complete understanding in response to the RQs and to triangulate findings. Integration was achieved through using two out of three possible methods described by Creswell et al. (2011):

a/ Merging: this integration consists of combining the qualitative data in the form of texts or images (e.g. TA network for RQ2) with the quantitative data in the form of numeric information (e.g. frequency distributions of data from ‘intervention diary records’ for RQ2).

b/ Embedding: This integration involves a dataset of secondary priority (e.g. supervision and training evaluation data: RQ3) being embedded within a larger, primary design (e.g. all other data in RQ3).

## **Methodological Procedure**

As part of an LA initiative, two EPs developed a programme of training and supervision based on CBT. Two clusters of schools in the LA were selected to access the training and supervision, based on: their limited access to previous training provided by the LA (other school clusters had received further training opportunities by the LA); and/or their need for SEBD interventions (evidence within the LA suggested that some schools would benefit from such intervention). Each school was offered training and supervision for two members of staff. The rationale for offering two places over one per school was to increase the potential for: sustainability of the intervention; and ‘in-house’ peer support for staff following training. Following invitations to head teachers (detailing aims of the training, who it was suitable for and expectations of the EPs and school staff) 16 schools opted into the training and supervision. The training was delivered to the two clusters of schools separately: firstly to seven schools and secondly to nine schools.

## ***Participants***

For the purpose of this study: 10 members of education staff, from five schools who had opted into the training and supervision, were selected as participants.

Morrow (2005) argues that qualitative research reports should describe participant demographics, including the rationale for the sample size; sampling strategies; recruitment; and researcher roles and relationships. These factors, in relation to this study, will now be described.

Sampling in this study was purposive in that the five participating schools were selected to produce the most information-rich data possible (see 'Credibility Checks' for further information). Five of the 16 schools that received the training and supervision were selected, based on the following rationale:

- Together they catered for a range of economic status (from affluent to deprived)
- Together they catered for varying prevalence's of SEBD (from high to low percentages of children identified with SEBD)
- Together they catered for a range of pupil ages (one was a high school and four were primary schools)
- The schools were of varying sizes (numbers of children on role ranged from around 200 to 950)
- Five schools provided adequate richness and quantity of data, whilst ensuring that the delivery of supervision remained manageable.

Selecting schools to represent a range of size, need, age and catchment was believed to contribute to the richness of data gathered. Table 3 below demonstrates basic demographics regarding each school. To enable the schools to remain anonymous in this research, they will be referred to as 'S1', 'S2', 'S3', 'S4' or 'S5'.

Pairs of education staff from the five schools took part in the research (10 participants in total). Sampling was criterion based in that participants needed to meet the following criteria:

- They had received the researchers training in CB competences (see summary of training design below)
- They had identified at least one child in their school for whom the use of CBI was deemed beneficial, based on the criteria set out in Appendix M
- They had given informed consent to take part in the research (see participant consent below)

Table 3, below, demonstrates key demographics regarding the five schools and 10 participants. In this study, participant ‘1’ refers to those that were individually *and* group supervised and participant ‘2’ refers to those that were group supervise. Each school’s socio-economic status was defined by the researcher as ‘deprived’, ‘average’ or affluent’ using the school’s ‘free school meals’ (FSM) status as a proxy indicator.

**Table 3: Participant and School Demographics**

<b>School Reference and Phase</b>	<b>Description of Schools Economic Status</b>	<b>Description of Schools SEBD Prevalence</b>	<b>Participant Reference /Supervision Received</b>	<b>Participant Gender</b>	<b>Participant Title within School</b>	<b>Participant Time Spent in Current Post (years)</b>	<b>Participant Age (years)</b>	<b>Participant Ethnic group</b>
S1 Primary	Deprived	High	1	Female	Teaching Assistant	4	50 - 60	White British
			2	Female	Teacher and SENCo	8	40 - 50	White British
S2 Secondary	Average	Average/high	1	Female	Learning Support Assistant	4	40 - 50	White British
			2	Female	Learning Support Assistant	3	40 - 50	White British
S3 Primary	Deprived	High	1	Female	Resource Provision Manager	2	40 - 50	White British
			2	Female	Pastoral Mentor	1	20 - 30	White British
S4 Primary	Average	Average	1	Male	Teaching Assistant	1	30 - 40	White British
			2	Female	Teacher and SENCo	2	20 - 30	White British
S5 Primary	Affluent	Low	1	Female	Teaching Assistant	5	40 - 50	White British
			2	Female	Teacher	18	40 – 50	White British

### ***Participant Consent***

Prior to training completion, the researcher approached the Head Teachers from the five selected schools to request consent for their school to participate in the study, subject to the two potential participants from their school consenting. Head Teachers from all five schools gave provisional consent for their school to be involved in the study, subject to potential participants consenting.

Following training completion, 10 potential participants were approached by the researcher to be part of the study. They were provided with information sheets and consent forms and given at least two weeks to consider their potential participation (see appendix C, D and F). All 10 potential participants provided written consent.

### ***Parent Consent***

Once participants had been recruited, written consent was requested from parents of children identified as being suitable for intervention; consent was requested to allow participants to discuss children involved in the intervention for the purpose of supervision. The researcher provided participants with the parent research information sheet and consent form (see Appendices E and G), and offered to discuss the contents of these with parents on request. All parents approached by the participants provided written consent.

The training provided guidelines to participants around gaining assent from children regarding their involvement in the intervention. Guidance included: how to explain the intervention to children when inviting them to be involved; providing children with the option of ‘opting out’ at any stage; and knowing when to cease the intervention based on the child’s responses.

Key components of the study, and how they were utilised, will now be described.

### ***CBI***

The intervention that participants were trained to implement was not intended to be prescriptive. Training comprised of: CBT based competences (listed in Appendix H); an understanding of the CBT model; and a loose framework for delivering these competences (see training design below for further details). The aim of the researcher was for school staff

to develop a sound understanding of theory and competences so that they could develop their own CBI's to responsively match the needs of their children and school context.

However, as was argued earlier, both adaptation and fidelity are important to implementation. That is, whilst participants in this research were given flexibility in the methods they used to implement the CB competencies, it was important to ensure that they implemented them appropriately. Supervision was used to monitor and address appropriate use of CB competences. Intervention integrity was therefore promoted through all participants receiving intervention training and supervision: this reflects the treatment methodology described by Heyne et al. (2011).

The intervention training was primarily based on: 'Cool Connections with CBT' (Seiler, 2008) and 'Think Good, Feel Good' (Stallard, 2002); two well regarded CBT based interventions. The CB competences targeted through training and supervision mapped directly onto IAPT guidance around CBT: IAPT sets out best practice, based on what has been shown to be most effective from research trials. IAPT sets out the competences required to deliver CBT at its best through a competency framework (University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014) which can be used to inform training, supervision and research (Roth, 2007). The researcher selected 37 competencies from the IAPT competency framework, based on the researcher deeming them appropriate for implementation by trained school staff (see Appendix H). Other competencies were deemed to be more complex, requiring implementation by more experienced and qualified practitioners. The competences selected also mirrored those necessary to deliver the 'Cool Connections' and 'Think Good, Feel Good' interventions. The selected competences were used to:

1. Inform intervention training (see training design below)
2. Evaluate training (see Appendix I)
3. Supervise participants (see Appendix N)
4. Structure intervention diary records (see Appendix O)
5. Inform part of the pre and post interviews (see Appendix K and L)

In this sense, intervention integrity was enhanced as the same IAPT CB competencies were presented to participants throughout the research.

It should be noted that the intervention diary record (ID) and supervision record (Appendix O and N) includes six CB competences than are not included in the training evaluation forms: Items 5 and 6 had been combined on the training evaluation form and items 20, 27, 32, 33 and 36 were absent from the training evaluation form. Hence the ID and supervision record contained 37 CB competences and the training evaluation form contained 31 CB competences. This decision was made following evaluation of the training; on reflection, the additional six CB competences had been covered during training and hence could be implemented by participants.

Reynolds, Girling, Coker and Lynne (2006) argue that children require sufficient cognitive and emotional knowledge to reflect on their own feelings and thoughts and to understand the relationship between their thoughts, feelings and behaviours. At least some of such meta-cognitive skills have been shown to have developed by the age of around 7 or 8 years old. Similarly, Stallard (2002) suggests that, generally, children of the age of 7 and above can access CBT but he points out that it depends on the child's abilities and that adaptation of CBT may be required to improve children's access to CBT. This guidance is reflected in the criteria that school staff used to select children for intervention (see Appendix M).

### ***Training Design***

#### *Background Information*

The training which participants received took place over four half days, with a one or two week gap in between each session to enable trainees to practice strategies. The two trainers were EPs, one of whom was also the researcher.

The training was primarily based on: 'Cool Connections with CBT' (Seiler, 2008); 'Think Good, Feel Good' (Stallard, 2002). The 'Cool Connections' manual states that a background in the psychological therapies, or specific training in CBT, is a useful but not essential attribute for the implementers. The manual also argues that what makes CBT distinct from CBI is the involvement of a trained therapist who develops with the client a shared formulation of the client's problems, which will inform treatment to promote change. In contrast, CBI aims to increase children's awareness of thoughts, feelings, body signals and actions and it is suggested that through this awareness, change can be initiated. In line with this guidance, the training and supervision delivered for this research involved facilitating participants to understand the background of CBT but to use CBI, not CBT; participants were provided with clear guidance

around the limits of their role as intervention implementers. Below is a description of the training that was implemented.

### *Training Title and Aims*

‘Changing thinking to change behaviour; how school staff can use cognitive and behavioural strategies to support children experiencing emotional, social or behavioural difficulties.’

- To understand a basic model of CBT
- To learn strategies to support children to develop their understanding of thoughts, feelings and behaviours and how these are linked
- To learn strategies to support children to develop more helpful thinking styles
- To learn strategies to support children to develop more helpful behaviour patterns
- To learn strategies to support children to manage their feelings more successfully
- To practice the above strategies

### *Content*

Each training session is outlined below, with links made to the 37 IAPT competences referred to above and found in Appendix H. Appendix B provides samples of the training presentation that correspond to each training session below.

*Session 1 Content:* Background of CBT, ‘Health Warning’, setting up an intervention, understanding what thoughts, feelings and behaviours are and understanding the link between these. This session focussed on IAPT competences: 1 – 12 from Appendix H.

*Session 2 Content:* Homework reflections, thinking errors and ‘thinking strategies’. This session focussed on IAPT competences: 11 - 21 from Appendix H.

*Session 3 Content:* Homework reflections, ‘behavioural strategies’, ‘feeling strategies’ and ‘problem solving strategies’. This session focussed on IAPT competences: 20 and 22 - 32 from Appendix H.

*Session 4 Content:* Homework reflections, problem solving strategies, intervention structure/framework, session structure, ‘homework’ for children, good practice guidance. This session focussed on IAPT competences: 33 – 37 and 1 - 6 from Appendix H.



### *Trainees*

The training targeted people who considered themselves to have skills in empathy and active listening. Prior training in relation to behaviour and/or emotional wellbeing was felt helpful. Trainees who attended were: teachers; teaching assistants; Learning Support Assistants; a Resource Provision Manager; Mentors; SENCos; and a Head Teacher. Table 4 below demonstrates how many trainees attended each training session.

### *Follow up Support*

- The schools' EPs observed the training delivered. This enabled EPs to support with intervention implementation following training e.g. through their consultations with school staff.
- Five trainees received regular individual supervision sessions.
- All trainees were offered two group supervision sessions. Table 4 below demonstrates how many trainees attended each training and group supervision session.

**Table 4: Trainee Attendance at each Training and Group Supervision Session**

	<b>Training Session 1</b>	<b>Training Session 2</b>	<b>Training Session 3</b>	<b>Training Session 4</b>	<b>Group Supervision Session 1</b>	<b>Group Supervision Session 2</b>
<b>No. trainees who attended</b>	30	30	26	25	25	11

### *Training Evaluation Forms*

Trainees completed an evaluation form following each training session (see Appendix I). The initial eight questions of the training evaluation forms were designed with the purpose of evaluating training effectiveness. These questions had been used to effectively evaluate previous training delivered by the EPS. Questions nine onwards were designed to capture trainees predicted facilitators and barriers of intervention implementation, and the predicted implementation of each competency covered by the training. Competences relevant to each training session, taken from the IAPT CBT competency framework described above, were presented within each training evaluation form. Information gained was used by the researcher to identify areas to address in supervision sessions.

## *Supervision*

All participants were offered 2 x sessions of group supervision. One participant from each school was also offered regular individual supervision. The participant who received individual supervision was selected by the head teacher through discussion with both participants from each school. Table 5 below presents the number of group and individual supervision sessions attended by each of the 10 participants:

**Table 5: Number of Supervision Sessions Attended by Participants**

	Individually Supervised Participants					Group Supervised Participants				
	S1	S2	S3	S4	S5	S1	S2	S3	S4	S5
<b>No. individual supervision sessions attended</b>	6	4	3	3	2	NA	NA	NA	NA	NA
<b>No. group supervision sessions attended</b>	2	1	1	2	2	2	1	2	2	1

As discussed in Chapter 3, the role of supervision was two-fold. Firstly, it provided a form of technical assistance, which Durlak and DuPre (2008) argue is at the centre of effective implementation. Secondly, it provided a method by which the researcher could address any fidelity issues relating to participants implementation of CB competences.

### *Group Supervision*

All participants took part in a group supervision session at the end of the final training session. Trainees requested a second group supervision session which took place around a month later; not all participants attended this session.

Group supervision sessions were at least an hour long and entailed supervisees identifying intervention based issues or observations that they wished to share or gain support around. The trainers facilitated the group discussion, initially by helping to place all discussion themes in order of priority, and subsequently helping to address each theme in priority order. Members of the group took their own records from the session.

### *Individual Supervision*

Five participants received regular individual supervision sessions, delivered by the researcher, with each session lasting at least an hour and offered four weeks apart. This was felt to be appropriate given that IAPT suggest the need for each 'client' (under a CBT practitioner) to be reviewed at least once every four weeks. It states that minimum standards might need to be adjusted to take into account smaller caseloads (Turpin, 2011).

The supervision contract and supervision record (Appendix N) incorporated Scaife (1993) and Squires and Williams' (2003) models, and the IAPT CBT competency framework (University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014), all described earlier. Hence there was a rationale and research base to the design of the supervision record. The record was also successfully piloted with the first participants.

Participants were shown the 'Supervision Contract' prior to supervision commencing, and during each session the supervisee and supervisor completed the supervision record together, and took a signed copy. Completion of supervision records involved: identification of agenda items discussed and actions agreed; styles of supervision used; evaluation of supervision session; and identification of competences covered. Supervision records were used by the supervisor to plan and monitor supervisee development of CB competences. Whilst a particular effort was made to develop supervisee CB competences as identified by the supervisor, it was also necessary for supervision to meet the supervisees self-identified needs and the pupil's identified needs. That is, the pace and content of supervision sessions was partly determined by the participant and the pupil's reported responses to intervention. In this sense, it was necessary for the focus of supervision sessions to remain flexible.

The supervisor used a basic CBT session structure. The rationale for this was to facilitate supportive and productive sessions and to model a structure for supervisees to implement in their CBIs. Sessions used the following structure:

1. Review of situation and actions agreed from last supervision
2. Set agenda together
3. Tackle agenda together
4. Agree actions to carry out before next supervision
5. Evaluate session and feedback

### ***Supervision Reflections***

Following each individual supervision session, the researcher made notes to reflect the barriers and facilitators to implementation, and the methods of implementation used, as identified through the supervision discussions. See Appendix R for notes made following each supervision session. The researcher identified when a facilitators or barriers mapped onto a category presented in Durlak and DuPre's (2008) model of intervention implementation. Anecdotal examples provided by supervisees were noted in order to capture richer data and to help justify the correspondence of a facilitator/barrier with Durlak and DuPre's model. Following initial analysis of data, the researcher re-checked each corresponding category identified against Durlak and DuPre's (2008) model description.

### ***Intervention Diary Records***

The intervention diary record (ID) template (Appendix O) was designed to monitor ongoing participant implementation of CB competences. These had been piloted with success by the first participants. Participants were encouraged to complete a record at least once a week and whenever they noticed themselves using a CB competency. Participants noted the date of diary completion together with: the competency they had implemented (by selecting from a list based on the CBT competency framework: University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014); the method of implementation used; and any facilitators or barriers to implementation. Examples of activities that related to each competency were given to facilitate ID completion. The records used in this study are comparable to the 'implementation logs' described by Gottfredson et al. (2002) in their school-based CBI study.

### ***Interview Design***

The pre-intervention and post-intervention interviews (Appendices K and L respectively) are split into two parts: 'Part 1' consists of six questions related to RQs 1&2. 'Part 2' consists of questions related to RQ3, which are based on Durlak and DuPre's (2008) framework of intervention implementation (see Appendix J).

The pre-intervention interview was piloted on two participants to determine the appropriateness of the questions and interview length. As a result, no changes were made. Following all pre-intervention interviews, the post-intervention interview was adapted to reflect the intention for richer data collection. For example, where participants had raised

particularly interesting or vague points during the pre-intervention interview, this was explored further during the post-intervention interview. As the aim of the post-intervention interview was to gather more tailored and richer data (with a focus on data quality rather than quantity), the post-intervention interview was less structured and consisted of three fewer questions than the pre-intervention interview.

### ***Research Procedure***

Table 6 summarises the steps that were taken during the training and data collection phases.

**Table 6: Research Procedure**

<b>Actions Taken</b>
Delivered training to 16 schools in total
Training evaluations collected
Recruited research participants x 10
Conducted pre-intervention interviews
CBI implemented by participants
2 x group supervision sessions implemented
Regular individual supervision sessions implemented and supervision records maintained
Collected participants intervention diaries
Conducted post-intervention interviews

### **Data Analysis**

Data was gathered from individual participants using all sources of data reported in Table 2. The data was then collated to consider a group response (all 10 participants). However, the methods used to collect and analyse the data allowed the researcher to consider each school and participant as individual units where this enhanced exploration and understanding in relation to the RQs. Likewise, whilst the impact of participants receiving individual or group supervision was not part of the RQs, the methods used to collect and analyse the data allowed the researcher to consider the impact of supervision where this enhanced exploration and understanding in relation to the RQs. For example, the ‘ATLAS’ tool (used to support analysis in this study) enabled the researcher to identify where each transcribed interview quote

originated from (in terms of: school; participant; type of supervision received; and pre or post-intervention).

## ***Qualitative Analysis***

### ***1. Thematic Analysis (TA)***

As Table 2 demonstrated, the main method of qualitative analysis used in this study was TA. TA is essentially a method for identifying and analysing patterns (themes) in qualitative data (Clarke & Braun, 2013). TA is a widely used qualitative analytic method within psychology. It entails searching *across* a data set to find recurring patterns of meaning. One of the key benefits of TA is its flexibility as a research tool, which can potentially yield: “...a rich and detailed, yet complex account of data” (Braun & Clarke, 2006). Theoretically it was felt that such an approach would be congruent with the aims of this study. TA is argued to be flexible because the search for, and analysis of, patterns across data does not require adherence to any particular theory of language or explanatory frameworks (Clarke & Braun, 2013). Clarke and Braun argue that TA is suitable to a wide range of research interests and theoretical perspectives because: a/ it works with a wide range of RQs; b/ it can be used to analyse different types of data; c/ it works with large or small data-sets; and d/ it can be applied to produce data-driven or theory-driven analysis. Braun and Clarke (2006) provide an outline guide of the six phases of TA which were used in this study.

**Table 7: TA Process (Braun and Clarke, 2006)**

Phase		Description of the process
1	Familiarizing yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas
2	Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic ‘map’ of the analysis.

5	Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6	Producing the report	Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the RQ and literature, producing a report of the analysis.

Durlak and DuPre's model (2008) was used to identify a priori codes for TA in relation to RQ3 of this study. Themes that emerged from the data were mapped onto this model where appropriate. The researcher was also open to identifying emerging themes, independent of Durlak and DuPre's model, which might address the RQs. Braun and Clarke (2006) distinguish between coding data for specific RQ's (a more theoretical approach) and coding data which leads to specific RQ's (an inductive approach). The researcher in this study used a theoretical approach to coding the data.

#### *Interview Data*

The greatest data set in this study came from the interviews. Each of the 20 interviews (10 pre-intervention and 10 post-intervention interviews) lasted approximately 1 hour long. Each interview was recorded via audio tape and then transcribed into electronic written format: this can be considered the first step in analysing qualitative data (Bailey, 2008).

TA was used to analyse the interview data. All 10 of the *pre*-intervention interviews were analysed using Braun and Clarke's (2006) entire TA process. Whilst all 10 of the *post*-intervention interviews were analysed using the first and second stage of Braun and Clarke's TA process, a select four were analysed further using Braun and Clarke's remaining TA stages. The rationale for this will now be explained.

The first stage of Braun and Clarke's (2006) process involved the researcher immersing in the data; that is, repeated reading of the data, in an active way, searching for meaning and patterns. This stage reflects the immersion and incubation phases of Moustakis's heuristic approach to inductive analysis (1990, cited in Moustakis, 1994). Moustakis argue that these phases allow for: total involvement in the data and intense concentration on knowledge expansion through becoming aware of nuances and meaning and capturing intuitive insights to achieve understanding. Following the immersion and incubation phase, and initial coding phase, of the

entire post-intervention interview data set in this study, it was clear that the same codes emerged as those from the pre-intervention data set, with exception to a small number of additional codes (listed in appendix V). That is, the codes appeared largely stable between pre and post-intervention interviews. As the post-intervention interviews were designed to enhance data obtained from pre-intervention interviews, but in practice they confirmed the same findings, it was not necessary or beneficial to analyse the entire data set further. In this sense, TA was used flexibly to reflect the research needs, which is in line with Braun and Clarke (2006): “...qualitative analysis guidelines are exactly that - they are not rules, and, following the basic precepts, will need to be applied flexibly to fit the RQs and data” (Braun and Clarke, 2006 (p. 86).

The four post-intervention interviews purposefully selected for ‘full analysis’ represented:

- Two group supervised and two individually supervised participants
- One high school and one primary school
- Schools with contrasting levels of need, in terms of proportions of children with SEBD.

It was felt that this range could enhance the richness of data obtained and allow for any potential differences in intervention implementation relating to supervision to be identified.

The ‘ATLAS.ti’ programme was used to support with TA of the interview data. This is software that can be used to analyse large amounts of unstructured data. The steps taken to analyse the data through ATLAS are described below. This ran alongside Braun and Clarke’s (2006) TA process:

1. Data was transcribed and prepared for use in ATLAS Ti (transcribed interviews are available on request)
2. Data segments were coded to produce Codes and Quotations, ensuring that all of the data was dealt with and accounted for (see Appendix T for samples)
3. Integrity of codes was checked by scanning quotations for each code
4. Data was re-coded or adjusted and then re-checked for coding integrity. This was repeated as necessary. See Appendix V for code changes and Appendix W and X for examples of final codes and final code families.
5. Conceptual networks were produced using the codes to explore how they related to each other in meaning (see results section for networks produced)



Further details of the ATLAS and coding process used in this study can be found in appendices U.

#### *Other Data Sources*

Whilst Braun and Clarke's (2006) TA process was used to analyse qualitative data from other sources in this study (training evaluations, IDs and supervision reflections), 'ATLAS' was not required to support this as the data was less in depth and was manageable manually. For example, appendix P and R demonstrate how most of the collated data gathered from the supervision reflections and IDs mapped directly onto Durlak and DuPre's (2008) framework (used as a-priori codes). Additional codes, and themes, were identified manually from the remaining data.

#### *2. Descriptive Analysis*

As Table 2 demonstrated, data relating to the supervision reflections and IDs (RQ1), and supervision evaluations (RQ3) were analysed descriptively. Nominal data was summarised using cross-case displays, thus allowing for comparisons across schools. Meaning, observations and conclusions were drawn through logical evaluation and systematic description.

#### ***Quantitative Analysis***

As Table 2 demonstrated, quantitative data gathered from the collated training evaluations (RQ1,2&3) and IDs (RQ2) were analysed using descriptive statistics, in the form of frequency distributions.

Descriptive statistics is the discipline of quantitatively describing the main features of a collection of information. "With descriptive statistics you are simply describing what is or what the data shows" (Trochim, 2006). Descriptive statistics are distinguished from inferential statistics in that they aim to summarize a sample, rather than use the data to learn about the population that the sample of data is thought to represent.

## Limitations of Methodology

The small number of school staff involved in this research limits the representativeness of their experiences in relation to other school staff and limits the generalisation of the conclusions that can be drawn from the data. In this sense, the study shares the same limitations of case study designs. As Yin (2009) argues, case studies are generalizable to theoretical prepositions and not to populations or universes. However, Bromley (1986) argues that the most important and interesting aspects of human nature are so context-dependent that generalisation is naturally severely limited.

This study used mainly self-report measures of implementation. The limitations of such measures have been recognised. For example, Goldberg Lillehoj et al. (2004) studied two different implementation measures of a school-based intervention: independent observer ratings and intervention provider self-ratings. They found that whilst independent observer ratings of implementation predicted intervention outcomes, intervention provider self-report ratings of implementation did not. They suggest a possible social desirability bias in provider self-report ratings of implementation and that caution must be used when interpreting self-report ratings. Other researchers have also questioned the accuracy of data gathered by self-reports, suggesting that self-report data is typically skewed in the positive direction, or information may be lost, forgotten or not raised because it is too sensitive (Durlak, 1998; Scaife, 1993; Shapiro, et al., 2012). However, Durlak and DuPre (2008) recognise that self-reports may be the only practical way to obtain implementation information in some situations.

In this study it was considered unethical to: a/ observe the CBI directly; or b/ to observe the intervention out of context (staff recording themselves and bringing to supervision), given the potential negative impact of the researchers presence on the children or intervention (see, for example, Finkelstein, et al., 2005) and due to staff feeling potentially threatened by this (Scaife, 1993). In this study, it was also felt that observation data was not essential given that the study focussed on staff perceptions around implementation rather than their actual practice or intervention outcomes. As Goldberg Lillehoj et al. (2004) report, self-report data gathered from programme providers is useful as those implementing an intervention have a unique perspective on how and why they are delivering the programme in a particular manner. Similarly, Shapiro (2012) conclude that provider self-reports are: “an important source of information in implementation research, as factors operating at the provider level, as well as at

the organisational and systems level, have an impact on program use” (p. 92). Other studies have used teacher reports to measure the process of intervention implementation, including Salmivalli et al. (2005).

An additional challenge which Goldberg Lillehoj (2004) report in the research assessing implementation is presented by limited variability in the measure assessing implementation. One method of addressing this limitation is to include implementation information collected from multiple sources, a method which Goldberg Lillehoj et al. argue is rarely used. Indeed, Keller-Margulis (2012) state that use of a blend of both direct and indirect methods can strengthen the conclusions that can be made regarding implementation by addressing the limitations inherent in both approaches. Whilst in the study presented in this paper several sources of data were used (e.g. supervision, interview and intervention diaries), all sources were based on implementer reports.

There are a number of criticisms of the CR paradigm. For example, Klein (2004) states that it is: “almost impossible to pin down a concrete concept of CR without writing a book” (p. 130) and that preferred positions in CR are rapidly changing. He raises a number of key issues around the ontological and epistemological position of CR and calls for further clarification around CR. For example, Klein states that CR lacks definition around its epistemological stance on truth and knowledge and that it remains ambivalence with regard to social norms and values. He concludes that CR does not offer any new conceptual developments in the philosophy of science beyond those of post-positivists and does not go much further than simply meeting the criticism of earlier versions of positivism. In contrast to Kline, Mingers (2004) proposes that critical realism resolves or dissolves most of the issues associated with extreme positivism.

## **Ethical Considerations**

Ethical clearance was obtained through the university ethical procedures (see Appendix A for authorisation response).

There was potential in the study for participants to experience emotional discomfort as a result of being involved in the study e.g. due to their competences being indirectly measured. Steps taken to address this risk included:

- Participants received training to build their confidence around intervention delivery.
- Participants were encouraged to regularly self-assess their use of CB competences as part of good practice.
- During the consent phase, participants were made aware of the researchers data collection methods, and of their right to withdraw from the research at any point.
- Participant reports were gathered in a sensitive, respectful and constructive manner.
- Participant CB competences were not observed directly through observation.
- The supervision model facilitated opportunities for participants to express any issues they had, and to provide emotional support, in relation to the intervention and research.

There was potential in this study for children's situation to deteriorate as a result of being involved in the study e.g. if the intervention was not delivered effectively. Steps taken to address this risk included:

- It was a requirement that key adults involved with each children taking part in the intervention (including the SENCo, teacher, parent/s and any other professionals involved) had identified the children as having SEBD and agreed that they were likely to benefit from the intervention.
- The intervention was selected on the basis of it having an effective evidence base.
- Participants received training and supervision around monitoring the effectiveness and suitability of the intervention, and around adapting or aborting the intervention if necessary.
- Participants implemented the intervention at a relatively low level, mainly through using psycho-educational CB techniques.

## **Validity**

An important component in the validity of a positivist study is its measures (as discussed earlier, for positivists reality is 'knowable' and can be measured). Hence, validity in positivist studies asks: does the test or instrument measure the phenomenon that it claims to measure? However, as mixed methods involve qualitative methods, which typically view social reality as being socially constructed, the meaning of validity and validity checks are slightly different. Hesse-Biber (2010) argues that validity in mixed methods asks:

- How well do the researcher's findings fit the problem or capture the issue at hand?
- How well does the researcher answer his/her research questions?
- Did the research capture an understanding of the issue?

Hesse-Biber (2010) argues that one of the key criteria that validity in mixed methods research should address is validity as a quality of craftsmanship – this refers to the extent that the research has credibility. Indeed, credibility and trustworthiness are criteria's often used to critique the 'validity' or quality of qualitative research, where as 'validity and reliability' are often used for quantitative research (Cope, 2014; Farrelly, 2013; Rolfe, 2006). Credibility can be considered as a form of internal validity (Hansen, 2006; Morrow, 2005; Rolfe, 2006). For example: "the credibility of a study is assessed by examining the findings and interpretations. If the reader considers that they represent some type of 'truth', they are deemed to be credible" (Hensen, p. 49).

The use of credibility checks in this study will now be considered.

### ***Credibility Checks***

Credibility checks aim to enhance rigour and validity in a study. Cope (2014) promotes methods of enhancing credibility which include: triangulation, thorough data collection, reflexivity, audit trails, member checking and providing evidence. Morrow and Williams (2009) categorise checks under three headings: 1. Integrity of data (replicability, quality and quantity of sample, fit of data) 2. Balance between participant meaning and researcher interpretation (reflexivity through journals, member checks, triangulation and multiple researchers) and 3. Clear communication and application of findings (communicating what is found and why it matters). Roberts and Priest (2006), McLeod (1999) and Marrow (2005) describe similar methods.

Key credibility checks considered in this study are described below:

#### ***Thorough Data Collection***

By engaging with the participants over a period of training sessions, prior to data collection, the researcher built trust and rapport with participants: Cope (2014) argues that 'prolonged engagement' fosters rich and detailed responses. To promote quantity and depth of data in this study, data sources were triangulated and included 20 in-depth interviews. The researcher

ensured every participant was heard and that schools were selected purposefully to reflect diversity and equality. Thorough data collection meant that interpretations made from the data were supported with evidence. For example, detailed quotes were presented to support interpretations that resulted from TA.

### *Triangulation*

Through triangulation, the researcher is looking for a convergence of data collected by all methods in the study to enhance the credibility of the research findings. This study involved triangulation of data methods (qualitative and quantitative) and data sources (e.g. supervision reflections and interviews). Patton (1999) argues that triangulation attempts to “guard against the accusation that a study's findings are simply an artifact of a single method, a single source, or a single investigator's biases” (Patton, 1999, p. 1197).

### *Purposive sampling*

The researcher should provide evidence that sufficient quality and quantity of data has been gathered (Morrow & Williams, 2009): this can be achieved partly through purposive sampling. Purposive sampling can be defined as: “A collection of specific informants whom a researcher deems likely to exemplify patterns that he or she seeks to pursue in an in-depth qualitative study.” (Hesse-Biber, 2010, p. 216). That is, purposive sampling aims at including in the study those information-rich cases that will provide a full understanding of the phenomena being studied: careful consideration is given to the desired range, characteristics and numbers of participants. Earlier in this chapter, the purposive sampling strategy employed in this study was reported: this allowed for adequate quality and quantity of data to be gathered.

‘Redundancy of data’ is often cited as a hallmark of adequate data. Redundancy refers to the point at which no new information is gained with the introduction of additional data. In this study, full TA of all post-intervention interviews was not necessary as the interview data had reached redundancy.

### *Clear Articulation of Methods*

Clear articulation of methods allowing for replication of the study by others. Roberts and Priest (2006) argues that using computerised data analysis packages (such as ATLAS) can enhance reliability by applying the rules built into the programme. This study used a clear and

transparent TA method, involving the use of ATLAS. This study also used thick descriptions, quotations, subheadings, tables and figures, which Morrow (2005) argues assists the reader in replicating the interpretation.

The study will now focus, in depth, on an important element of credibility, namely reflexivity.

### *Reflexivity*

Etherington (2004) describes how academic research has traditionally been seen as an impersonal activity, aiming to be as objective as possible and viewing subjectivity as a contaminant. Parker (1994) describes the view that a subjective interest can only prejudice the neutrality of social psychology. In line with this, the positivist approach is typically associated with the collection of quantitative data, designed to be used objectively to find some ‘truth’. In contrast, non-positivist stances accept a subjective element to research. In non-positivist research the researcher is never completely objective. Indeed he or she is:

“...considered part of the research process, which takes a holistic view of the subject under examination. This means that many important variables are included in the study and people cannot be considered outside the context of their ongoing relationships with others.” (Farrelly, 2013, p. 149).

Similarly McLeod (1999) argues that the qualitative research intentionally personal nature of is one of the characteristics that separate it from positivist research and that the experience and identity of the researcher always influence the ‘findings’ that are produced.

Reflexivity requires recognition of the subjective nature of research described above.

Reflexivity can be defined as: “... the awareness that the researcher’s values, background, and previous experience with the phenomenon can affect the research process” (Cope, 2014, p. 90). Morrow and Williams (2009) offers a different but complementary definition: “... an awareness of self...wherein the researcher remains self-reflective and able to identify, as clearly as possible, what comes from the participant and what comes from the researcher” (Morrow and Williams, 2009, p.579). Wren (2004) argued that reflexive researchers are researchers who – whatever else they may be exploring or measuring – are also prepared to make their project itself an object of study.

It is argued here that subjectivity can be managed, or indeed embraced, through reflexivity, thus improving the rigour and credibility of a study:

“If we can be aware of how our own thoughts, feelings, culture, environment and social and personal history inform us as we dialogue with participants, transcribe their conversations with us, and write our representations of the work, then perhaps we can come close to the rigour that is required of good qualitative research” (Etherington, 2004, p. 31-32)

McLeod (1999) argues that promoting and communicating reflexivity contributes to the meaningfulness of a research report. Hansen (2006) argues that reflexivity helps a researcher:

1. consider honestly their role in their project which can help improve the study design and how they conduct themselves, and
2. question their own assumptions and interpretations.

Ethingsson (2004) and Morawski (2005) argue that academic researchers and positivist scientists have commonly disregarded reflexivity, associating it with dangerous elements of subjectivity which contaminates good research. However, it is widely argued that reflexivity is important in any research as no research is completely objective (Alvesson & Skoldberg, 2000; Morawski, 2005; Morrow & Williams, 2009; Morrow, 2005; Wren, 2004). As Banister (2011) argues:

“...inevitably any researcher will have biases, interests, predilections, values, experiences and characteristics .... you should always be questioning in a disciplined manner what it is that you have done, asking yourself whether your choice of methods was appropriate, what alternatives could have been utilised, what your impact on the setting, situation, participants, results etc. was, what alternative interpretations might be put forward” (Banister 2011, p. 198).

Hansen (2006), McLeod (1999) and Banister (2011) argue that reflexivity should be carried into the written reports of the project. There are many ways of reporting on reflexivity. Whilst examples of reflexive practice used in this study are described below, reflexive practice can also be found elsewhere in the thesis e.g. under the ‘limitations of methodology’, ‘ethical considerations’ and ‘further research’ sections. For the purposes of this reflexive section, the researcher will now write in first person.



### *Theoretical / Epistemological Beliefs*

Throughout the research, I reflected on the assumptions that I made about the world and the implications of this for my findings. In particular, I reflected on how my identity as a Scientist Practitioner may have partly determined the epistemological stance of the research: a critical realist perspective might naturally follow from the Scientist Practitioner model. This, in turn, might lead to the mixed methodology used. In sum, I have been mindful of how my perceptions as a researcher and Psychologist might bias my choice of methodology.

Cope(2014) and Morrow (2005) argue that one way the researcher can avoid or minimise researcher bias is to maintain a reflexive journal that reflects and notes thoughts and feelings in an effort to examine and set aside assumptions, perceptions and subjectivity. The research diary that I completed contained information which is in line with suggestions made by Banister (2011). That is, it included reflections around: issues experienced and decisions made regarding the design and methodology; what it felt like to be the researcher doing the study; and what other ways it could have been done.

My journey as a researcher has confirmed that I consider myself to be a Scientist Practitioner – I have sought to carry out rigorous research involving EBP, whilst also seeking to inform real world practice. I have an appreciation for both quantitative and qualitative research and believe that these approaches can each contribute to the search for knowledge.

### *Personal and Professional Beliefs*

As indicated above, I have made my implicit assumptions and biases overt to myself in an attempt to manage subjectivity in this research. For example, I have been mindful that I had predicted the outcome of my RQs prior to data collection: I suspected that my data would support Durlak and DuPre's (2008) model of intervention implementation to some extent, and I expected that education staff would use CB competences in a variety of ways. Consequently I actively challenged these predictions when collecting and analysing the data (see 'testing rival explanations' for further information).

As a Psychologist, I consider myself to be reflexive in nature: I am mindful of the subjective impact that I have on consultations, direct work with children and observations that I carry out. This extends to my role as researcher: I appreciate that who I am impacts on how I

design, conduct and interpret research. Indeed, Wren (2004) describes how the need for reflexivity in qualitative research mirrors the need for reflexivity in clinical work: “Good clinical work is a reflexive business” (Wren, 2004, p. 475).

### *Relationship to Participants*

I have been mindful of the impact of me being the: researcher; trainer; supervisor; and author in this study. For example, as researcher I collected training and supervision evaluations off participants; as such participants may have been positively biased towards providing responses that would please me. To alleviate this, I challenged participants about their responses to supervision evaluations, and training evaluations were completed anonymously.

Whilst I was not considered an ‘insider researcher’ in this study, I was familiar to the experiences of the participants (having been a teacher and being a school practitioner) and familiar to them following the training and supervision. Roberts and Priest (2006) and Berger (2013) describes such familiarity with participants as being both advantageous and potentially problematic: “Such insights can be useful in authenticating responses and findings, but familiarity may also obscure any ambiguous issues that others, from outside the field, might question.” (Roberts and Priest, 2006, p. 44). Whilst such familiarity may enable more in-depth understanding of participants’ perception and interpretation of their lived experience, the researcher must remain constantly alert to avoid projecting own experiences (Berger, 2013). Advantages to my familiarity in this study included me holding some shared: language; empathy; expectations of them; and credibility to them. Consequently: I was better able to understand implied content, I was sensitive to their challenges and I believe that participants felt comfortable with me. However, I was aware that I compared how they responded to intervention implementation with how I would have in my previous role as a teacher. I managed this by paying attention and staying sensitive to my own perspectives, and ‘bracketing’ those perspectives, a process whereby researchers attempt to suspend their experience, judgement and beliefs (Roberts and Priest, 2006). I adopting what Patton (1999) calls ‘emphatic neutrality’: “a stance in which the researcher or evaluator is perceived as caring about and being interested in the people under study, but as being neutral about the findings.” (Patton, 1999, p. 1204). Berger (2013) describes how, as reflexivity is a conscious process, it allows the researcher to critically consider how their personal experiences might influence the research which, in itself, helps to explicate potential biases.

### *Testing rival Explanations*

I have challenged my interpretations of data, by actively looking for contradictory evidence or alternative interpretations. Failure to find strong supporting evidence for alternative explanations enhances credibility to the final research findings. Patton (1999) describes considering achieving this in two ways: Inductively through looking at other ways of organising the data that might produce different findings, and logically through thinking of other possibilities and seeing if data can be found to fit these. For example, once I had finished mapping data onto Durlak and DuPre's (2008) implementation model, I re-checked my decisions through: revisiting the detailed description of Durlak and DuPre's model and considering if other codes might fit better, and searching for anecdotal evidence to disprove my decisions. Through searching for negative cases that contradicted my other findings, I found that the training evaluation forms provided alternative interpretations to all other data sources – this brought further light and offered deeper explanation to the findings.

### *Reflexivity Limitations*

I am reflective of not having used 'member checks' to enhance rigour in my study. 'Member checks' can be considered:

“An important step in qualitative research that substantially enhances credibility... At completion of data analysis, the researcher communicates a summary of the themes that emerged and requests feedback or member-check from the participants.” (Cope, 2014, p. 90).

Morrow (2005), Cope (2014) and McLeod (1999) also promote the importance of member checks. From a reflexivity and credibility point of view, this is a weakness as “the purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes, the participants are the only ones who can legitimately judge the credibility of the results.” (Farrelly, 2013, p. 150).

I am mindful that whilst I used regular supervision sessions to critically discuss my study and my data interpretation, I did not use a 'peer reviewer' to independently interpret a sample of data that I had interpreted; this process could have helped to validate my findings.

## Chapter 7: Findings and Discussion

The findings and discussion are presented under the three RQs:

1. What CB competencies do school staff believe they implement with training and support?
2. How do school staff implement CB competences with training and support?
3. What are the barriers and facilitators to school staff implementing CBI?

The researcher was also interested in the impact of supervision on the above. Findings around this are explored where the data sources facilitate this.

Findings from interview data, found under section 4 of each RQ below, are presented using a 'network view' of codes obtained through TA. As the codes remained, largely, stable between pre-intervention and post-intervention interview analysis, the networks represent pre-intervention and post-intervention interview data combined.

## RQ 1

**What CB competencies do school staff believe they implement with training and support?**

### *1. Training Evaluation Responses*

Trainees were asked to indicate:

1. If they felt able to use each CB competency covered within the training
2. If they thought they would make use of each CB competency covered within the training

Table 8 demonstrates the percentage of trainees who: felt able to use, and planned to use, each CB competency. The table represents the responses of the 25 trainees who attended training session 4, which included ratings for the entire set of CB competences covered by the training.

**Table 8: Training Evaluations - CBT Competencies Predicted for Use**

<b>CB Competency</b>	<b>Feel Able %</b>	<b>Will Use %</b>
Obtain informed consent for interventions from pupil/s	100	56
Maintain confidentiality, and know the conditions under which confidentiality can be breached	100	60
An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need	100	56
Develop rapport	100	60
Adjust the level of session activity and structuring of the session to the children needs	100	56
Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem	100	52
Knowledge of the cognitive component in CBI – the way children think about their lives	92	44
Knowledge of the link between thoughts, feelings and behaviours	100	60
Help pupil identify what a behaviour, thought and feeling is	100	100
Help pupil identify automatic thoughts which arise for them in specific situations by a detailed focus on these events	100	92
Help pupil specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings	100	92
Help pupil identify specific situations associated with specific automatic thoughts and feelings	100	92
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	100	92

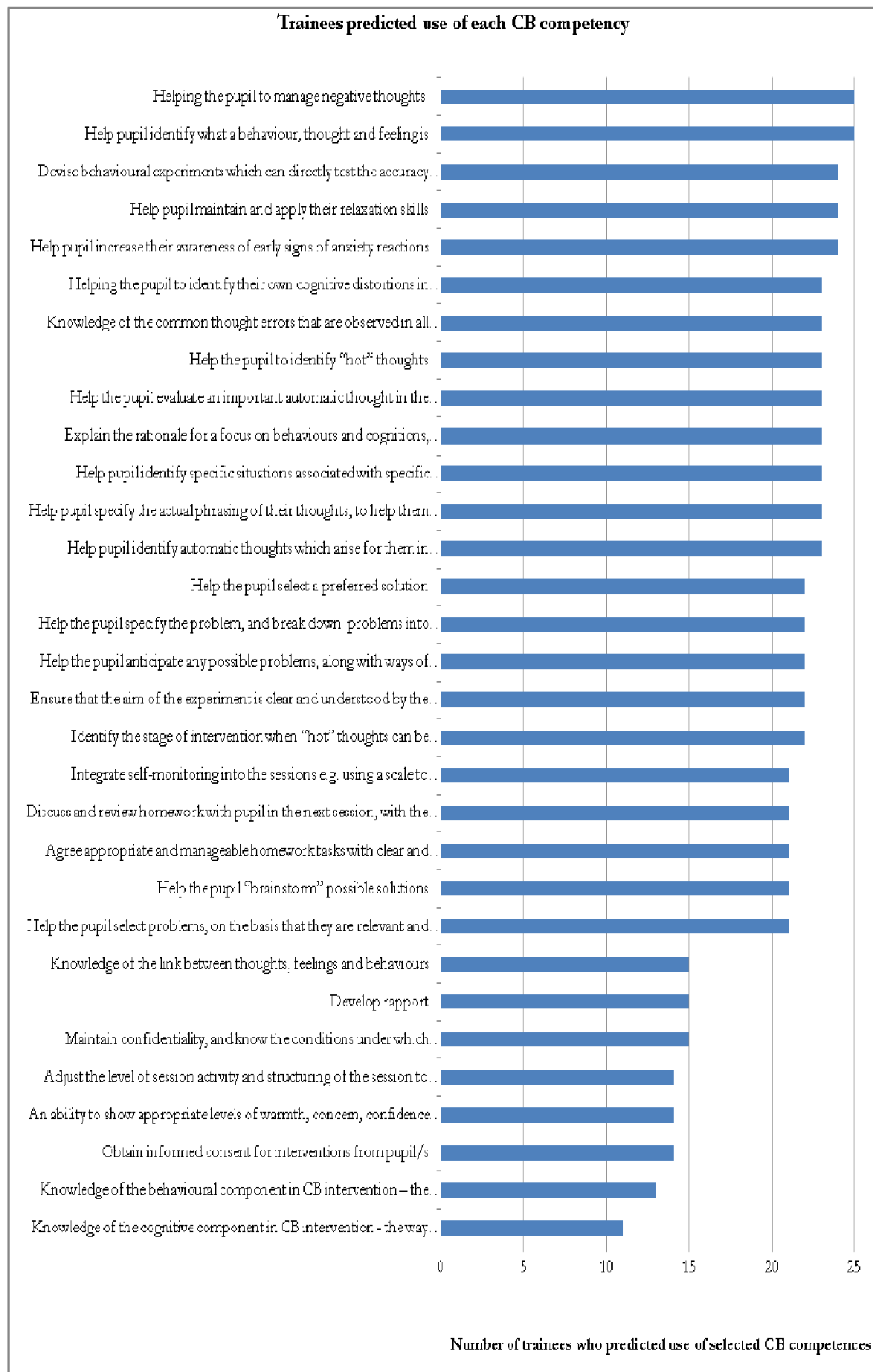
Help the pupil evaluate an important automatic thought in the session, prior to their completing the full thought record	100	92
Identify the stage of intervention when “hot” thoughts can be focused on	100	88
Help the pupil to identify “hot” thoughts	100	92
Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals	100	92
Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts	100	92
Helping the pupil to manage negative thoughts	100	100
Help pupil increase their awareness of early signs of anxiety reactions	100	96
Help pupil maintain and apply their relaxation skills	100	96
Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework	96	96
Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment	100	88
Help the pupil anticipate any possible problems, along with ways of overcoming these	100	88
Help the pupil select problems, on the basis that they are relevant and are ones with achievable	100	84
Help the pupil specify the problem, and break down problems into manageable parts	100	88
Help the pupil “brainstorm” possible solutions	100	84
Help the pupil select a preferred solution	100	88
Agree appropriate and manageable homework tasks with clear and specific precise goals	100	84
Discuss and review homework with pupil in the next session, with the aim of helping them identify what they have learned from their experiences	100	84
Integrate self-monitoring into the sessions e.g. using a scale to monitor extent of problem	96	84

Table 8 demonstrates that 100% trainees reported feeling able to implement 28 out of the 31 CB competences covered in the training. Each of the remaining three competences was *not* identified as ‘felt able’ by one or two trainees. This indicates that the training was successful in empowering trainees to feel able to implement most of the CB competences.

Two trainees did not report feeling able to implement the following competency: ‘Knowledge of the cognitive component in CBI – the way children think about their lives’. This may reflect the fact that the training did not focus on the ability to explore children’s core beliefs and deeper thought processes (this would require further training). It may also reflect the possibility that some trainees perceived their role as relating to how children thought about school rather than their ‘lives’ more holistically.

Although 100% of trainees reported feeling able to implement most CB competences, considerably fewer trainees reported that they would actually implement them. For example, Table 8 demonstrates that between 44% and 60% trainees (11 – 15 trainees) reported that they would implement the first eight competences listed. Indeed, data from other sources (supervision sessions and interviews) suggests that some trainees felt a discrepancy between what they were able and motivated to implement, and what they would be supported to actually implement, or could practically implement. Some trainees did not believe that they would be given adequate opportunity to implement the intervention as a result of time constraints placed upon them. This is disappointing given that trainees felt that they had the skills to implement most of the competences covered by the training.

Despite ‘predicted use’ being less for some CB competences (e.g. ‘Knowledge of the cognitive component in CBI’), between 84% and 96% trainees (21 – 24 trainees) predicted that they would use the majority of the competences covered. Figure 3 below demonstrates trainees predicted use of each competency in rank order.



**Figure 3: Training Evaluations - CBT Competences in Rank Order**



Figure 3 demonstrates that the eight competences predicted for use the least are in relation to more general/less specific CB competences such as rapport building, gaining consent and adjusting sessions to suit the child's needs. Whilst these can be considered essential elements of an effective intervention, it may be that trainees did not feel that they had the time to implement such elements. Indeed several trainees reported feeling that they had a lack of time to deliver the intervention as desired. Trainees may have felt more likely to implement more structured elements of the intervention, possibly as a result of these elements being more prescriptive/easier to follow. Another explanation for this finding is that the first eight CB competences appeared on all four training evaluation forms as they were covered in all four training sessions; trainees may have declined rating these in session 4 due to repetition.

100% trainees reported that they would use the following: 'Help pupil identify what a behaviour, thought and feeling is' and 'Helping the pupil to manage negative thoughts'. This is reassuring given that these can be considered key components of CBI.

## ***2. Intervention Diary Responses***

Table 9 and 10 below shows the CB competences that participants reported using through their IDs. The 'ID' numbers represent the sequence in which the records were completed, and the number of records that were completed, by each participant. For example, S1 individually supervised participant completed 19 records in total, in the sequence that they are presented in the table. Two keys are provided overleaf to describe each competency and school referred to in Table 9 and 10.

Records were not completed at equal intervals across participants. However, participants who implemented a structured intervention tended to complete the records on a weekly basis. That is, individually supervised participants from S1, S2, S4 and S5 and group supervised participants from S2 all completed: structured interventions and IDs at equal intervals. Those who did not complete IDs at regular intervals (dates on IDs were not equally spaced apart) were individually supervised participant from S3 and group supervised participants from S3, S1 and S4; these participants did not deliver structured interventions but rather implemented CB competences opportunistically (as revealed through interviews). Therefore, participants were more likely to use CB competences regularly, or at least record using them regularly, if they are involved in a structured intervention.

*Key 1 to Table 9 and 10:*

School 1 – S1

School 2 – S2

School 3 – S3

School 4 – S4

School 5 – S5

*Key 2 to Table 9 and 10: Description of each competency referred to*

1. Obtain informed consent for interventions from pupil/s
2. Maintain confidentiality, and know the conditions under which confidentiality can be breached
3. An ability to show appropriate levels of warmth, concern, confidence and genuineness
4. Develop rapport
5. Adjust the level of session activity and structuring of the session to the children needs
6. An ability to structure sessions
7. Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem
8. Knowledge of the cognitive component in CBI – the way children think about their lives
9. Knowledge of the link between thoughts, feelings and behaviours
10. Help the pupil to identify what a behaviour, thought and feeling is
11. Help the pupil to identify automatic thoughts which arise for them in specific situations
12. Help the pupil to specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings, and to identify the thoughts which are most closely associated with distress
13. Help the pupil to identify specific situations associated with specific automatic thoughts and feelings
14. Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours
15. Help the pupil to evaluate an important automatic thought in the session, prior to their completing the full thought record
16. Identify the stage of intervention when “hot” thoughts can be focused on
17. Help the pupil to identify “hot” thoughts
18. Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals.
19. Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts
20. Help the pupil to use and complete relevant written records
21. Helping the pupil to manage negative thoughts
22. Help the pupil to increase their awareness of early signs of anxiety reactions
23. Help the pupil to maintain and apply their relaxation skills
24. Devise behavioural experiments which can test the accuracy of the pupils thoughts, which help them construct new, more helpful thoughts, and which can be carried out in the session or as homework
25. Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment
26. Help the pupil to anticipate any possible problems, along with ways of overcoming these
27. Review the outcome of experiments with the pupil in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them
28. Help the pupil to specify the problem, and break down problems into manageable parts
29. Help the pupil to “brainstorm” possible solutions
30. Help the pupil to select a preferred solution
31. An ability to help the pupil to plan and implement preferred solutions
32. An ability to help the pupil to evaluate the outcome of implementation, whether positive or negative
33. Agree appropriate and manageable homework tasks with clear and specific goals
34. Discuss and review homework with the pupil: help them identify what they have learned
35. Help the pupil to appraise the outcomes of homework: when outcomes are in line with the prior expectations and when there is a different outcome from that which has been predicted
36. Integrate self-monitoring into the sessions (e.g. using a scale to monitor extent of problem), ensuring that the agenda for the session includes regular and consistent review of self-monitoring records

Table 9: Intervention Diary Responses – CBT Competences Implemented by Individually Supervised Participants (Participants 1)

CB competency	ID 1	ID 2	ID 3	ID 4	ID 5	ID 6	ID 7	ID 8	ID 9	ID 10	ID 11	ID 12	ID 13	ID 14	ID 15	ID 16	ID 17	ID 18	ID 19
1.	S2 S5 S4	S1 S2	S2	S1 S5				S5	S5	S5							S1		
2.	S5 S4	S1 S2 S5	S2 S5	S5	S5	S5	S1 S5	S2 S5	S2 S5	S2 S5							S1		
3.	S1 S2 S5	S1 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2	S1 S2	S1	S1	S1	S1	S1	S1	S1
4.	S3 S5	S1 S3 S5 S4	S1 S2 S5	S1 S2 S5	S2 S5	S2 S5	S1 S2 S5	S1 S2 S5	S1 S2 S5	S1 S2	S1 S2	S2	S1	S1	S1	S1	S1	S1	S1
5.	S5	S1 S5	S1 S2 S5	S1 S2 S5	S2 S5	S2 S5	S1 S2 S4 S5	S1 S2 S4 S5	S1 S4 S2 S5	S1 S4 S2	S1 S4 S2	S1 S4 S2	S1 S4	S1	S1	S1	S1	S1	S1
6.	S5	S5	S5	S1 S2 S5	S2 S5	S2 S5	S5	S2 S5	S2 S5	S2		S2		S1	S1		S1	S1	S1
7.	S5	S5	S5 S4	S1 S2 S5	S2 S5	S2 S5	S5	S2 S5	S2 S5	S2		S2		S1	S1		S1	S1	S1
8.	S5	S5	S5	S1 S5 S4	S5	S2 S5	S2 S5	S2 S5	S2 S5	S2	S2	S2		S1	S1	S1	S1		S1
9.	S5	S5	S5	S1 S5	S4 S5	S5	S5	S1 S2 S5	S2 S5	S1 S2	S1 S2	S1 S2		S1	S1	S1	S1	S1	S1
10.	S5	S5	S5	S5	S5	S4 S5	S2 S5	S2 S5	S2 S5	S2	S1 S2				S1		S1	S1	S1
11.				S1	S5		S5	S4 S5	S2 S5	S2 S5	S1 S4	S4		S1	S1	S1	S1	S1	S1
12.	S5	S5	S5	S5	S5	S2 S5	S2 S5	S2 S5	S2 S5	S2	S1 S2		S4		S1	S1	S1	S1	S1
13.		S5	S5	S5	S5	S5	S2 S5	S2 S5	S4 S2 S5	S1 S2 S5	S1 S2	S2		S1	S1	S1	S1	S1	S1
14.	S5	S5	S5	S5	S5	S5	S5	S2 S5	S2 S5	S4 S2 S5	S4	S4 S2	S4 S2		S1		S1	S1	S1
15.							S5	S5	S2 S5	S2	S2	S2					S1		
16.									S5	S2					S1				
17.							S4	S4	S4 S5	S4 S2	S4	S4	S4						
18.				S5		S5		S5	S5	S2									
19.								S5	S5	S2									
20.								S5	S5										

Continued Overleaf...

	ID 1	ID 2	ID 3	ID 4	ID 5	ID 6	ID 7	ID 8	ID 9	ID 10	ID 11	ID 12	ID 13	ID 14	ID 15	ID 16	ID 17	ID 18	ID 19
21.			S5	S5	S5		S5	S5	S5	S5				S1	S1	S1			S1
22.			S5	S5	S5	S5	S5	S1 S5	S5	S5				S1	S1		S1		
23.								S5	S5	S5				S1	S1				
24.											S2	S2			S1				
25.												S2		S1	S1				
26.												S2		S1	S1				
27.												S2			S1				
28.	S3	S3							S5			S2		S1	S1				
29.	S3	S3							S5					S1	S1	S1			
30.	S3	S3							S5	S5				S1	S1	S1			
31.									S5										
32.									S5										
33.	S5	S5	S5	S5	S5	S5	S5	S5	S1 S5							S1	S1		S1
34.		S5	S5	S5	S5	S5	S5	S5	S1 S5	S5					S1	S1	S1		S1
35.		S5	S5	S5	S5	S5	S5	S5	S5										
36.	S5	S3 S5	S5	S5	S5	S5	S5	S5	S5	S5				S1	S1	S1			S1

Table 9 highlights potential for individually supervised school staff to use a range of CB competences.

Individually supervised participants used the former competences in the list more than the latter competences in the list. For example, whilst many of the competences between 1 and 14 were reported over 20 times, none of the competences between 15 and 36 were reported over 20 times. The competences most reported were those in relation to: setting up and running an intervention; and identifying thoughts, feelings and behaviours, and how these are linked.

Table 9 demonstrates that individually supervised participants from S1 (black font) and S5 (green font) appear to have used a fuller range of competences than other participants. That is, participant from S1 reported using 29 of the 36 competences and participant from S5 reported using 32 of the 36 competences. This is in comparison to the other three participants who reported using between 5 and 24 of the competences. S5, in particular, used a relatively full range of CB competences from early on in the intervention (a considerable number of competences were reported in S5's first IDs). This may reflect the fact that S5 participant had previous counselling experience, and hence was more able/confident to make use of a range of competences sooner in the intervention. S5 was also one of the few participants who made most use of the homework related CB competences (competences 33 -35); this partly reflects the high level of parent and child engagement achieved through S5's intervention. Whilst S1

also used a wide range of competences, many competences were not reported until later in the IDs and hence later in the intervention. S1 participant may have used a wider range of competences compared to other participants as a result of her having delivered the most intervention sessions during the research (S1 was the first participant to commence intervention). Indeed, this participant completed more IDs to reflect this (19 in total). It follows that other schools may have reported using a fuller range after further intervention opportunity.

Data from S3 participant (brown font) suggests minimal use of CB competences: five competences were reported over two IDs. Three of these competences were related to 'problem solving'. This is in line with advice provided during training; it was emphasised that problem solving techniques were one of the more accessible CB competences to implement should other strategies prove difficult to implement.

S2 participant (red font) reported re-using certain competences throughout their intervention, namely those around: rapport building; knowledge about thoughts and behaviours; and adjusting session activities. This reflects discussions that took place with S2 participant during supervision sessions: the participant explained that there had been a need to focus on improving group dynamics and that some members of the group struggled to grasp earlier parts of the intervention, such as understanding what a thought, feeling and behaviour is. These factors seemed to delay the use of other competences.

The use of competences reported by S4 participant (purple font) was somewhat limited in range and sporadic in nature, indicating that the intervention implemented may not have been progressive in nature. Competency five was reported frequently ('adjust the level of session activity'). Indeed, individual supervision with S4 revealed that the child involved was difficult to engage and resistant to discussing feelings, thoughts and behaviours in relation to himself. This resulted in more focus on 'adjust the level of session activity' and 'structuring of the session to pupils needs' than other competences. It also limited progress made within the intervention. Although this is not reflected in the IDs, supervision data revealed that S4 repeatedly used 'building rapport' with the child; this indicates that the IDs may not be a true representation of competences used.

Table 10 below presents the ID responses for group supervised participants.

*Key 1 to Table 10:*

School 1 – S1

School 2 – S2

School 3 – S3

School 4 – S4

School 5 – S5

*Key 2 to Table 10: Description of each competency referred to*

1. Obtain informed consent for interventions from pupil/s
2. Maintain confidentiality, and know the conditions under which confidentiality can be breached
3. An ability to show appropriate levels of warmth, concern, confidence and genuineness
4. Develop rapport
5. Adjust the level of session activity and structuring of the session to the children needs
6. An ability to structure sessions
7. Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem
8. Knowledge of the cognitive component in CBI – the way children think about their lives
9. Knowledge of the link between thoughts, feelings and behaviours
10. Help the pupil to identify what a behaviour, thought and feeling is
11. Help the pupil to identify automatic thoughts which arise for them in specific situations
12. Help the pupil to specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings, and to identify the thoughts which are most closely associated with distress
13. Help the pupil to identify specific situations associated with specific automatic thoughts and feelings
14. Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours
15. Help the pupil to evaluate an important automatic thought in the session, prior to their completing the full thought record
16. Identify the stage of intervention when “hot” thoughts can be focused on
17. Help the pupil to identify “hot” thoughts
18. Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals.
19. Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts
20. Help the pupil to use and complete relevant written records
21. Helping the pupil to manage negative thoughts
22. Help the pupil to increase their awareness of early signs of anxiety reactions
23. Help the pupil to maintain and apply their relaxation skills
24. Devise behavioural experiments which can test the accuracy of the pupils thoughts, which help them construct new, more helpful thoughts, and which can be carried out in the session or as homework
25. Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment
26. Help the pupil to anticipate any possible problems, along with ways of overcoming these
27. Review the outcome of experiments with the pupil in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them
28. Help the pupil to specify the problem, and break down problems into manageable parts
29. Help the pupil to “brainstorm” possible solutions
30. Help the pupil to select a preferred solution
31. An ability to help the pupil to plan and implement preferred solutions
32. An ability to help the pupil to evaluate the outcome of implementation, whether positive or negative
33. Agree appropriate and manageable homework tasks with clear and specific goals
34. Discuss and review homework with the pupil: help them identify what they have learned
35. Help the pupil to appraise the outcomes of homework: when outcomes are in line with the prior expectations and when there is a different outcome from that which has been predicted
36. Integrate self-monitoring into the sessions (e.g. using a scale to monitor extent of problem), ensuring that the agenda for the session includes regular and consistent review of self-monitoring records

Table 10: Intervention Diary Responses – CBT Competences Implemented by Group Supervised Participants (Participants 2)

CB Comp.	ID 1	ID 2	ID 3	ID 4	ID 5	ID 5	ID 7	ID 8	ID 9	ID 10	ID 11	ID 12	ID 13
1.	S2 S4	S2 S4	S2 S3	S3					S4		S4		
2.	S3 S4	S1 S2 S4	S2	S3					S4 S2	S4 S2	S4		
3.	S2 S4	S3 S4	S2 S4	S1 S2 S3 S4	S2 S4	S2	S2	S2	S4 S2	S4 S2	S2	S2	
4.	S4	S3 S4	S2 S3 S4	S2 S4	S2 S4	S2 S4	S2	S2	S4 S2	S4 S2	S2	S2	
5.		S3 S4	S2 S3 S4	S2 S3 S4	S2 S4	S2	S2	S2	S2	S2	S4 S2	S2	
6.					S2	S2	S2	S2	S2	S2		S2	
7.			S1 S4	S4	S2 S4	S2 S4	S4	S2 S4	S4 S2	S2	S4	S2	
8.			S1		S4 S1	S2 S4	S2 S4	S2 S4	S2	S2	S4 S2	S4 S2	
9.		S1	S1	S1	S4 S1	S1		S2	S2	S2	S4 S2	S4 S2	
10.	S3		S1		S4 S1	S4	S2	S2 S4	S4 S2	S4 S2	S4 S2		
11.	S1	S1	S3			S1	S4	S4	S2	S2		S4	
12.						S2	S2	S2	S4 S2	S4 S2	S2	S4	
13.								S2	S2	S4 S2		S4 S2	
14.									S4 S2	S2	S2	S2	
15.										S2		S2	
16.		S3								S2			
17.									S4	S2			
18.									S4	S2		S4	
19.													
20.		S3		S1	S1	S1							
21.													
22.		S3	S3	S1	S1					S4	S4		
23.										S4	S2	S2	
24.												S2	
25.				S3								S2	
26.												S2	
27.				S3								S2	
28.										S4		S2	
29.													
30.													
31.													
32.													
33.													
34.													
35.													
36.													



Table 10 demonstrates that none of the group supervised participants used the later eight of the CB competences from the list, whereas some individually supervised participants reported using the full range (see Table 9). This might reflect group supervised participants having delivered less structured interventions and thus having less opportunity to use the full range. Alternatively it might reflect that one of the individual supervision aims was to support supervisees to develop their range of competences; consequently participants may have been more likely to demonstrate a wider range of competences as a result of individual supervision.

Table 10 implies that group supervised participants are more likely to use CB competences found earlier in the competency list (those in relation to rapport building and the basic psycho educational elements of CBI including identifying thoughts, feelings and behaviours and how they are liked) than specific behavioural, feeling or thought strategies found in the latter part of the competency list. It may be that more specific strategies (e.g. behavioural experiments) are likely to require ongoing involvement with a child: as group supervised participants were less likely to implement structured interventions, they may not have had enough ongoing involvement with a child to implement such strategies. Participants S2 (red font) and S4 (purple font) made repeated use of psycho educational competences.

Tables 9 and 10 demonstrate how ID completion for both participants at S2 (red font) were almost identical, despite participants being asked to complete IDs separately. This is likely to reflect them having planned and delivered a group intervention jointly: S2 participants are likely to have implemented similar competences. Table 10 indicates that S2 implemented competences in a progressive manner; according to how they are presented in the competency list. That is, they waited until later on in the intervention before implementing competences lower in the list. This is not surprising given that the list reflects the order in which many CB interventions are implemented.

Table 9 and 10 demonstrate that out of the five schools, S3 completed the fewest IDs. That is two IDs were completed by the individually supervised participant from S3 (see table 9) and four were completed by the group supervised participant from S3 (see table 10), suggesting minimal implementation of CB competences in S3. Indeed, other data gathered (e.g. through interview and supervision) indicates that this reflects strategic issues within the school (e.g. whole school/leadership factors) being a barrier to intervention implementation.

Although S3 participant (brown font) and S1 participant (black font) reported use of CB competences with limited frequency, they appeared to use a mixture of discrete strategies e.g. helping the pupil to identify specific situations associated with specific automatic thoughts and feelings, identifying hot thoughts, implementing relaxation techniques and helping the pupil to manage negative thoughts. This might reflect these participants using CB competences as part of their wider roles (i.e. SENCo and Mentor), possibly making use of selected strategies to enhance their existing work with children.

Comparison of Tables 9 and 10 demonstrates that more IDs were produced by individually supervised participants than by group supervised participants. For example, four individually supervised participants completed more than nine IDs whereas only two group supervised participants completed more than nine IDs. This might have reflected individually supervised participants being more likely to engage in structured interventions, and more likely to make regular use of CB competences. However, it might also reflect individually supervised participants being more motivated to complete the IDs as a result of them feeling a stronger sense of alliance to the supervisor/researcher. These factors might explain why S5 group supervised participant did not complete any IDs, despite repeated reminders. Her interview responses indicated that she used more CB competences than her lack of IDs would suggest.

Overall, Tables 9 and 10 demonstrate that different CB competences were reported to be used by different participants, although the former ones in the list were more likely to be reported than the latter. The CB competences reported may depend on a number of factors including: participant experience, pupil engagement, nature of intervention (e.g. structured/non-structured) and whether participants are individually supervised.

### 3. Supervision Reflections

Table 11 shows the CB competences that individually supervised participants reported using, or developed use of, during each supervision session.

Key to Table 11 below: School 1 – S1      School 2 – S2      School 3 – S3      School 4 – S4      School 5 – S5

**Table 11: Supervision Reflections – CBT Competences Developed/Reported**

<i>CB Competency Developed/Reported</i>	<b>Supervision Session Number</b>					
	1	2	3	4	5	6
<i>Obtain informed consent for interventions from pupil/s</i>	S1 S2 S5	S2				
<i>Maintain confidentiality, and know the conditions under which confidentiality can be breached</i>	S1 S2		S2	S2		
<i>An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need</i>	S2					
<i>Develop rapport</i>	S1 S2 S4 S5	S1 S4				
<i>Adjust the level of session activity and structuring of the session to the children needs</i>	S1 S2 S4 S5	S1 S2 S3 S5 S4	S1 S2	S1	S1	S1
<i>An ability to structure sessions</i>		S2 S4		S1	S1	S1
<i>Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem</i>	S1					
<i>Knowledge of the cognitive component in CBI – the way children think about their lives</i>			S3	S2		
<i>Knowledge of the link between thoughts, feelings and behaviours</i>	S4 S5	S1 S5 S4	S1 S2 S3	S1	S1	S1

*Continued overleaf*

Help the pupil to identify what a behaviour, thought and feeling is	S1 S4 S3 S5	S1 S2 S3 S5 S4	S1 S2 S3	S2		S1
Help the pupil to identify automatic thoughts which arise for them in specific situations by a detailed focus on these events	S5					
Help the pupil to specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings, and to identify the thoughts which are most closely associated with distress						S1
Help the pupil to identify specific situations associated with specific automatic thoughts and feelings		S1 S2 S3 S5	S1 S3	S1 S2	S1	
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	S5		S3			
Help the pupil to evaluate an important automatic thought in the session, prior to their completing the full thought record			S3			
Identify the stage of intervention when "hot" thoughts can be focused on		S5	S2	S2		
Help the pupil to identify "hot" thoughts	S3 S5	S5	S2	S2		S1
Knowledge of the common thought errors ("cognitive distortions") that are observed in all individuals.		S2	S2 S3			
Helping the pupil to identify their own cognitive distortions in relation to specific events/ thoughts		S5	S3	S2		
Help the pupil to use and complete relevant written records			S3			
Helping the pupil to manage negative thoughts		S5	S2 S3			S1
Help the pupil to increase their awareness of early signs of anxiety reactions	S4		S3			
Help the pupil to maintain and apply their relaxation skills	S3 S5	S3 S5				
Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework			S2 S3	S2		
Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment						

Continued overleaf

Help the pupil to anticipate any possible problems, along with ways of overcoming these				S1	S1	
Review the outcome of experiments (whether positive or negative ) with the pupil in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them						
Help the pupil to select problems, on the basis that they are relevant and are ones with achievable		S5	S2	S1	S1	
Help the pupil to specify the problem, and break down problems into manageable parts			S2	S2		
Help the pupil to “brainstorm” possible solutions		S4	S2	S1 S2	S1	S1
Help the pupil to select a preferred solution		S4	S2	S1 S2	S1	S1
An ability to help the pupil to plan and implement preferred solutions		S4	S2	S1	S1	S1
An ability to help the pupil to evaluate the outcome of implementation, whether positive or negative						
Agree appropriate and manageable homework tasks with clear and specific precise goals	S4 S5	S2 S5 S4	S2 S3	S2		
Discuss and review homework with the pupil in the next session, with the aim of helping them identify what they have learned from their experiences		S5 S4	S3			
Help the pupil to appraise the outcomes of homework: when outcomes are in line with the prior expectations of the therapist and pupil when there is a different outcome from that which has been predicted			S3			
Integrate self-monitoring into the sessions (e.g. using a scale to monitor extent of problem), ensuring that the agenda for the session includes regular and consistent review of self-monitoring records	S4 S5	S2 S5 S4		S1	S1	S1

Table 11 demonstrates that for at least some schools (S1 and S2, black and red font respectively), they tended to use more CB competences from the beginning of the list in earlier supervision sessions, and they covered more CB competences from the end of the list in later supervision sessions. This implies that development of CB competences were loosely following the order presented in the list. Indeed, the order of CB competences presented in the list was roughly in line with the order in which they were covered during training and the order in which many ‘manualised’ CBIs are delivered. That is, starting with setting up the intervention and rapport building, moving onto psycho education about thoughts, feelings and behaviours, and then working on specific strategies around thoughts, feelings and behaviours. S2 and S1 were those who had implemented the most intervention sessions, and participated in the most supervision sessions; it may be that the other schools would have demonstrated a similar pattern of implementation had supervision sessions continued for longer. Indeed, all schools focussed on ‘rapport building’ and ‘identifying what a thought, feeling and behaviour is’ during their first supervision sessions. As S3, S4 and S5 only participated in two or three supervision sessions, a pattern could not be established.

S5 (green font) and S3 (brown font) appeared to cover a varied range of CB competences over just two or three supervision sessions. This is likely to reflect additional information known about these participants: participant S5 had prior experience in implementing such techniques and therefore had increased capacity to explore them early on in the intervention. On the other hand, participant S3 struggled to find opportunities to implement the intervention, which resulted in supervision sessions exploring a wider range of competences.

Most individually supervised participants made some use of, or were supported in developing, a wide range of CB competences across the supervision sessions. To some extent, this is likely to reflect the supervisor’s intention to facilitate supervisee’s development of CB competences.

#### 4. Interview Responses

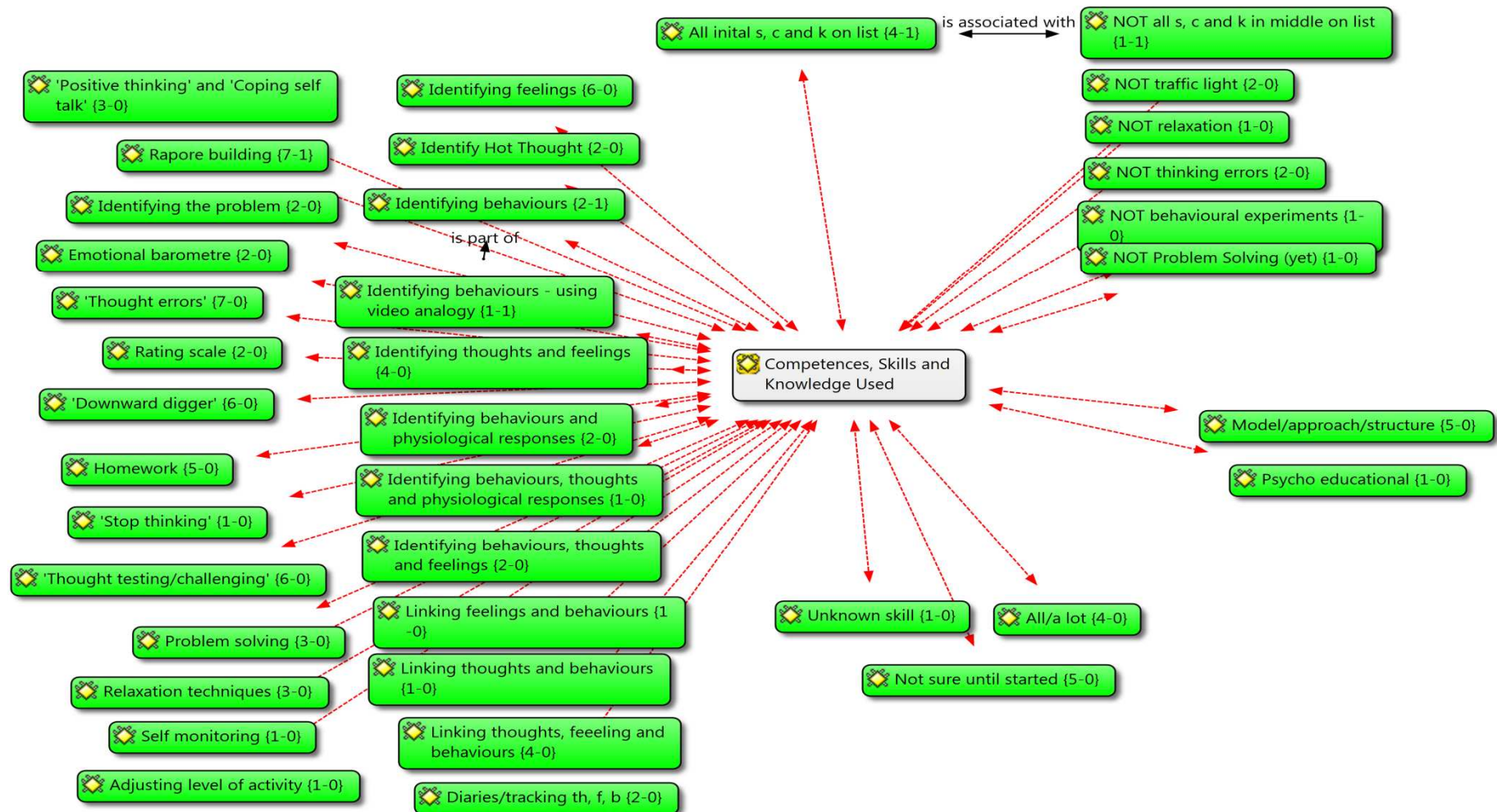


Figure 4: TA Network - CBT Competences Implemented

Figure 4 shows a TA network view of the competences reportedly used by all participants, according to interview data. All network codes presented to the middle left are clustered together as they refer to fundamental aspects of CBI and the CBT model, namely the identification of thoughts, feelings, behaviours and physiological responses and how these are linked. All network codes presented to the far left are clustered together as they refer to specific strategies or tools implemented within CBI. All network codes presented to the top right refer to competences that participants reported NOT using. Finally, all network codes presented to the bottom right hand corner refer to non-specific competences or interesting comments made.

Five references were made to participants being unsure of which skills they would use until they had started intervention implementation, and five references were made to participants planning use of the CB approach/model/structure. There were four references made around plans to use 'all/a lot' of what they had learnt. Examples of such responses are given below:

"I'd rather be open minded at the minute....I'd just rather wait and see." (theme: not sure until started)

"I'm able to advise teachers on their dealings with children in their class...It's backed up the idea that a lot of children have got these serious thoughts and feelings going on inside them that end up resulting in certain behaviour patterns and I think it's just that for me. It was more of an overview..." (theme: model/structure/approach)

"I would think I'd use all of it; it gives the opportunity to work and take the child through all of it and I'd like to use all of it because then we can try to see which was best ..." (theme: use all/a lot)

These general responses (absence of referring to specific competences) were gained from the pre-intervention interviews and thus might reflect participants being unsure of which competency they would use until they started intervention implementation. References to use of the CB approach may also reflect that many participants did not plan to deliver a structured intervention, but rather use the CB competences in their day to day interactions.



More specific references to what they would use tended to be either around identifying and linking thoughts, feelings, behaviours and physiological responses (28 references in total) or around specific activities/tools related to this (49 references). The former references are reassuring given that these can be considered essential components of CBIs. Examples of such references are:

“When you did the feeling and thoughts and physiological in the beginning; definitely most of that ... because we’ve listened to it and really thought about it...”  
(theme: identifying feelings, thoughts and physiological responses)

“I’d give them a ticket with a feeling on it and they had to role-play it, and then the group had to guess what feeling they were expressing.” (theme: identifying feelings)

“I picked out the first section that we did about feelings because it’s just such a clear structure of what happens ...” (theme: identifying feelings)

“We were looking at different emotions and discussing different emotions...it was really good. [We] literally talked about ‘frustrated’...” (theme: identifying feelings)

Specific activities or tools frequently reported were: rapport building (seven references), thought errors (seven references), downward digger (six references) and thought testing/challenging (six references). Examples are given below:

“The kits that you gave us [about] the ways of approaching children, I found very useful. The way you said how to start the intervention off was good...I’ll use a lot of different sort of ways of getting them to know why I’m doing it for them ... and getting their trust” (theme: rapport building)

“It seems to be generally an all or nothing thinking that you come across quite a lot and you can just help them to think a bit more flexibly and maybe recognise some of the ways that they have done it before, and give them a bit of evidence against what they’re saying, and put a bit more positive spin on things...” (themes: thought errors and thought testing/challenging)

“...if they say ‘I’ll never be able to do that’ get them to think about that word never: ‘well let’s have a think about when you’ve done it before’, and just little gentle challenges” (themes: thought errors and thought testing/challenging)

Use of other specific activities were referred to across interviews, such as use of: the emotional barometer; homework; problem solving; thought stopping; relaxation techniques; positive thinking and coping self talk; and thought tracking/diaries. This indicates that a range of CB activities were used and that different CB competences were used by different participants.

‘Rapport building’ was one of the most frequently referred to strategy: this is not surprising given that the training emphasised the importance of developing an effective relationship with the children, as research indicates that the effectiveness of a therapeutic intervention is impacted by the therapeutic relationship (see, for example, Lambert, 1992). ‘Thought errors’ was a frequently referred to strategy: this is not surprising given the enthusiasm presented by participants during training when identifying their own thought errors. Trainees appeared to find this tool useful. More surprisingly, the ‘downward digger’ activity was another strategy frequently referred to; participants reported their view of this being useful, although some participants tended to use an adjusted version of the activity in order to help children gain perspective on their concerns (i.e. in essence to help the child ‘de-catastrophise’) rather than use it to identify deeper thought processes. For example:

“In the playground I’ve been using the downward digger so much. It’s incredible when the child comes to me and says: ‘such and such has done this’ ... I’ll say ‘if this is happening what’s the worst thing that could happen?’. Most of the time they stand there and on that first question alone the thought of: ‘it’s not going to be a big issue’. Then within another two or three questions they’ve sorted it out themselves” (theme: Downward Digger)

This may reflect some participants having misunderstood the activity, potentially a symptom of the trainers having avoided training around deeper thought processes (e.g. core beliefs) elsewhere in the training. Indeed the trainers were mindful around whether to include this activity in the training as a result of it focussing on deeper thought processes.

A small number of participants reported NOT using one of the following competences: relaxation strategies; thinking errors; behavioural experiments; problem solving techniques; or traffic light system. All but one of these (i.e. 'traffic light system') were reported at post-intervention interviews; this indicates that participants were more able to identify what they had NOT used once they had implemented the intervention and that they were not able to predict this prior to implementation. Lack of use of the identified competences is in line with participants reporting more use of competences presented in the initial part of the competency list. That is, participants may have been more likely to use basic and general components of CBI (such as identifying and linking thoughts, feelings and behaviours) than specific tools presented later in the list.

## RQ 1 - Summary Discussion

### What CB competencies do school staff believe they implement with training and support?

The training evaluation forms indicate that, following training, all trainees *felt able* to implement most or all of the CB competences covered in the training. This implies that the training had empowered trainees to feel able to implement CBI. This somewhat counteracts Stallard and Buck (2013) who argued that teachers may not feel knowledgeable or skilled about CBT. Whilst the majority of trainees also predicted that they *would use* most of the CB competences, some trainees indicated that they would *not* make use of some CB competences from the training. These CB competences focussed on setting up an intervention and on basic components of a CBI e.g. rapport building, gaining consent, adjusting sessions to suit the child's needs and knowledge of cognitive and behavioural components. Reasons for this were explored. For example, trainees may have felt that they did not have adequate time to implement a full intervention or they may have planned to use more prescriptive strategies. Some trainees did not predict that they would use some CB competences, despite them feeling able to do so; the potential barriers to trainees implementing CBI are explored further under RQ 3.

Predicted use of the CB competences as measured by the training evaluation forms were not fully in line with predicted and actual use of the CB competences as measured by the other data sources (interviews, intervention diaries and supervision records). That is, the latter data sources indicated that participants were most likely to use competences in relation to setting up an intervention, structuring the intervention and psycho education around thoughts, feelings and behaviours (in the first half of the competences list given to participants), whereas the training evaluations forms highlighted less predicted use of these competences. This is important given that these competences can be viewed as fundamental to an effective CBI. It is possible that the few trainees who reported in the training evaluation forms that they would not use such competences were not part of the 10 research participants represented in the other data sources. Alternatively, trainees may have planned to use these CB competences at a later date (e.g. after supervision), despite not having planned to immediately after training. It may be that trainees are more likely to deliver an intervention effectively, or at least cover fundamental elements of an intervention, once they have received individual or group

supervision (all trainees received supervision immediately after completing the training evaluation forms).

In terms of more specific strategies predicted for use, interview data indicated the following to be the most used: 'rapport building', 'downward digger' and 'thought challenges/thought errors'. A range of other specific strategies were referred to, as well as plans to use the general CB approach/model/structure. The latter may reflect that some participants did not plan to deliver a structured intervention, but rather use the model/approach to inform their day to day interactions. This is explored further under RQ 2.

IDs indicate that individually supervised participants were likely to report on more frequent use of CB competences than group supervised participants. This might reflect that individually supervised participants were more likely to make use of structured intervention rather than opportunistic implementation and hence more likely to report regular use of the competences. It might also reflect individually supervised participants being more motivated to complete the IDs. Individually supervised participants were also more likely to make use of the full range of CB competences than group supervised participants. That is, group supervised participants were less likely to use specific strategies such as behavioural experiments and homework, and more likely to limit their use of CB competences to rapport building and the basic psycho educational elements of CBI (around identifying thoughts, feelings and behaviours and how they are liked). This may reflect the supervisor aiming to develop the supervisee's range of competences during individual supervision. It might also reflect that group supervised participants were less likely to be involved with regular and structured interventions; structured interventions may facilitate use of a greater range of competencies. These findings highlight the benefits of teachers having adequate support (perhaps individually) to deliver CBI: this is in line with the views of Buchanan et al. (2009), Jennings and Greenberg (2009), Marulanda (2010), Weare and Gray (2003), Yeo and Choi (2013) and Lendrum et al. (2009) presented earlier.

Individually supervised participants from S5 and S1 used a fuller range of CB competences; information gained from interview data suggests that this may reflect S5 participant having more experience and training around therapeutic interventions and S1 participant having had longer to implement the intervention. Both participants from S2 tended to re-visit certain skills throughout their intervention; information gained from interview data suggests that this

is likely to have reflected participants needing to 're-teach' certain skills to children e.g. teaching them what a thought, feeling and behaviour is.

According to supervision records, individually supervised participants from S1 and S2 tended to make use of/develop CB competences in the loose order in which they were presented during training (in line with how many 'manualised' interventions are implemented). Supervision data also highlights that most individually supervised participants developed a wide range of competences across supervision sessions.

The data sources indicated that participants used different CB competences, with some using a wider range than others and some using a wider range earlier in the intervention than others. Some of the most commonly used CB competences were those related to psycho education around thoughts, feelings and behaviours. Factors which impacted on participant use of competences included: participant experience/proficiency, pupil engagement, use of structured/non-structured intervention, length of intervention and type of supervision. This indicates that CB competences would be implemented in a variety of ways across schools and participants.

The findings of this study demonstrate potential for school staff to use a range of CB competences. This is in line with the views and findings expressed earlier by Squires (2010), Buckley et al. (2013), Mychailyszyn et al. (2012), Mennuti et al. (2006). The findings also suggest that individually supervised school staff may use a wider range, and more frequent use, of CB competences compared to group supervised staff.

## RQ 2

### How do school staff implement the CB competences with training and support?

#### 1. *Training Evaluation Responses*

Following each of the four training sessions, trainees were asked to indicate in which context they planned to implement the CB competences covered. Responses from training ‘session 4’ can be considered most representative of trainees’ plans since the training was progressive and cumulative in nature; trainees were in a better position to consider how they planned to implement the CB competences once they had received the entire training.

Figure 5 represents the responses of the 25 trainees who attended training session 4.

Figure 5 Key: All – all methods listed below

I – Individual pupil

G – Group of children

C – Whole class

DP – Discussion with parent

DS – Discussion with school staff

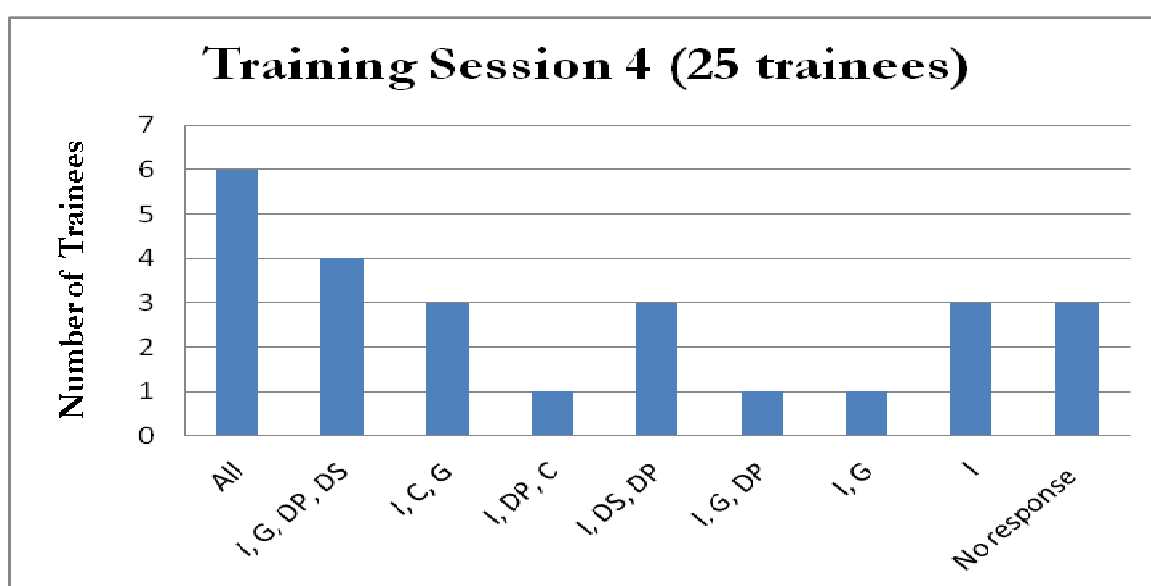


Figure 5: Training Evaluation Responses - Methods of CBI Implementation Predicted

Figure 5 demonstrates that the most frequently reported combination of methods following training session 4 was ‘All’ (reported by 6 trainees). That is, these trainees planned to implement CB competences with: individual children; group; whole class; parents; *and* school staff. Indeed, following training session 1 (not represented in Figure 5), the number of trainees who reported that they would use all five methods of implementation was the highest compared to any other combination of methods reported across sessions (12 trainees). This is not surprising given that session 1 focussed on the CBT model and psycho-educational elements of CBI; trainees may have felt that such competences could be more easily applied across contexts than some specific CB competences covered in later sessions. Despite the proportion of trainees who reported ‘All’ methods being lower in training sessions 4 compared to training session 1, ‘All’ methods was the most commonly reported combination overall.

It is not surprising that the number of trainees who reported plans to use ‘All’ methods reduced by training session 4 as each training session included supplementary competences for trainees to consider using (trainees responded to a cumulative list of competences); trainees may have felt that use of all competences, across all methods, would be ambitious.

Three trainees planned to use only one implementation method. All other 19 trainees who responded planned implementation of CB competences through at least two methods. This, together with the findings presented above regarding the number of trainees who planned to use ‘All’ methods of implementation, is promising as it is argued here to be more likely that an intervention is embedded, and implemented on a sustained basis, when it is used across systems within an organisation (e.g. at individual child, whole class and staff levels).

The only single implementation method reported was at the individual child level (three trainees). All trainees who responded (22 trainees) planned to implement CB competences at an individual child level. Hence all trainees who responded either planned to implement CB competences with individual children as an isolated method, or in combination with other methods.

Four trainees reported plans to use CB competences at a whole class level; this implies potential for the wider impact of CBI as it suggests its use with larger cohorts, perhaps at a preventative level.



Figure 5 demonstrates that none of the trainees reported plans to implement CB competences solely through discussions with parents (DP) or school staff (DS); these two methods were always reported in combination with methods involving whole class (C), groups (G) and/or individual children (I). In other words, trainees were not likely to implement CB competences through their discussions with adults, unless they were also implementing CB competences directly with children. This might be because trainee discussions with school staff and parents would be based on their interventions with children e.g. feeding back on work done or around homework tasks. The second most frequently reported combination of methods was: individual children, group, discussion with parent and discussion with school staff (I, G, DP, DS): these four trainees may have planned to involve school staff and parents in their intervention with children.

The combination of methods by which trainees planned to use the intervention varied across trainees (8 different combinations were reported); suggesting that implementation methods are influenced by factors associated with the trainee and school. Overall, Figure 5 demonstrates creative use of CB competences, in contrast to the traditional individual method most often used in clinical settings.

## ***2. Intervention Diary Responses***

Table 12 presents the frequency by which participants reported using CB competencies across each implementation method. The table represents participant reports gathered over differing amounts of time (some participants implemented intervention for longer) and from different numbers of IDs (some participants completed more IDs). Caution should therefore be taken when comparing school's data. To aid with interpreting the data, the following categories will represent frequencies of reported use (raw data is provided in brackets within the table):

Few – 1 – 20 reports of use

Minimum – 21 – 40 reports of use

Moderate – 41 – 60 reports of use

Frequent – 61 – 80 reports of use

Very Frequent – Over 80 reports of use

Red font – Individually Supervised

Green font – Group supervised

Table 12: Intervention Diary Responses - Implementation Methods Reported

Method Used	S1	S2	S3	S4	S5
Individual	Very Frequent (138) Few (15)	Few (1) Few (2)	Few (7) Minimum (23)	Few (13) Moderate (58)	Very Frequent (174)
Group	Few (6)	Very Frequent (93) Frequent (78)	Few (1)		
Discussion with Parent	Few (4) Few (7)				Few (12)
Discussion with Teacher	Few (1)			Few (4) Minimum (34)	
Whole Class	Few (2)				

Table 12 demonstrates that the most frequently used method of implementation was at an individual child level; all five schools reported using this method and it had the highest frequency of reported use (431 reports in total). Two participants reported using this method ‘very frequently’ and five reported using it ‘few’ times. The second most frequently used method was at a group level; three schools reported this method of use and it had the second highest frequency of reported use (178 reports in total). Two schools reported using this method on ‘few’ occasions, one ‘frequently’ and one ‘very frequently’.

Three schools (S1, S4 and S5) reported using the intervention when talking to parents and teachers. None of the participants reported use of these methods in isolation (without reporting use with individual or groups of children). In other words, participants did not use CB competences through their discussions with adults unless they were also implementing the intervention directly with children. This might be because participant discussions with teachers

and parents were based on their interventions with children e.g. feeding back on work done or around homework tasks. The total frequency of reports for implementation through discussion with teachers and parents was 62; this is relatively low when compared against the frequency of reports for implementation through individual and groups of children (431 and 178 reports respectively).

Only one participant reported implementation of competences at a whole class level. This, together with the above findings which suggest limited implementation at a staff/parent level, indicates less opportunity for embedding of CBI across systems within the schools, and less opportunity for CBI with larger cohorts. Nevertheless, all schools reported using more than one method of implementation which implies more varied use of CBI than solely at an individual or group level. S1 reported using all five methods of intervention, despite four out of the five only being reported on a few occasions. This highlights potential for CBI to become embedded in S1 as it was being implemented across systems within the school.

The most frequently reported implementation method was reported by individually supervised participants from S5 and S1; they reported implementation at an individual level 178 times and 134 times, respectively. This may reflect the frequency by which individually supervised participants completed the IDs: they may have been more motivated to complete IDs as a result of a stronger alliance with the supervisor/researcher. However, this may also reflect their increased use of CBI. Indeed, interview data suggest that individually supervised participants were more likely to implement a structured intervention, and hence more likely to use CBI regularly. Participant from S1 had also used the intervention for longer and participant S5 had prior experience with therapeutic interventions.

S2 *group* supervised participant provided one of the most frequent reports of CB implementation. It is known that this participant co-delivered a structured intervention with the *individually* supervised participant from the same school (hence why their reports are similar): had the intervention not been indirectly supported via individual supervision of the co-deliverer, such frequencies of use may not have been reported.

### ***3. Supervision Reflections***

The researcher completed reflection notes following each individual supervision session; see Appendix R for a record of reflections. Below is a summary of the findings from this data in relation to the methods of intervention implementation reported by individually supervised participants:

- Participants implemented competences through a variety of methods. This suggests more creative use of CBI compared to the traditional one:one method traditionally used in clinical settings. It also suggests that methods of implementation depend on factors associated with the participant and/or school.
- Each school used at least two methods of intervention. This is promising as it is argued here to be more likely that an intervention is embedded, and implemented on a sustained basis, when it is used across systems within an organisation (e.g. at individual, whole class and staff levels).
- Only one participant reported implementation at a whole class level. This indicates less opportunity for CBI to reach larger cohorts of children.
- Only one participant used all five methods of implementation. This seemed to reflect barriers relating to participants' roles in school e.g. many didn't manage a whole class thus limiting opportunity for implementation at a class level, and many were not given adequate resources to implement at individual and group levels.
- The most frequently used implementation method reported was at an individual level, most often through structured interventions (used by three out of five participants). One school used a group intervention and one school used CBI opportunistically.
- None of the participants implemented the intervention through discussions with parents and teachers in the absence of implementation at an individual or group level (i.e. directly with children). Indeed, responses indicated that their discussions with teachers and parents were based solely on their interventions with children (e.g. feeding back on work done or around homework tasks).

Table 13 demonstrates data gathered through supervision regarding methods of implementation reported by each supervisee.

**Table 13: Supervision Reflections - Implementation Methods Reported**

School	Summary of Implementation	No. Methods Used
S1	Structured individual intervention, involving discussions with teachers and parents and use of strategies in social skills group. Incidents of whole class use (e.g. circle time).	5
S2	Structured group intervention, involving some individual intervention and discussions with teachers and parents.	4
S3	Opportunistically implemented through group and individual work.	2
S4	Structured individual intervention, involved discussions with class teacher.	2
S5	Structured individual intervention, involving discussions with parents and teacher.	3

According to Table 13, data from the IDs (presented earlier) underestimate the use of competences through discussions with parents and teachers. For example, the ID responses indicated that S2 and S5 had not used these methods at all. Similarly, some supervisees reported implicitly using competences through their interactions with adults and children e.g. they explained the CBI to teachers and used competences to resolve conflict on the playground. This was not adequately captured through the IDs.

#### 4. Interview Responses

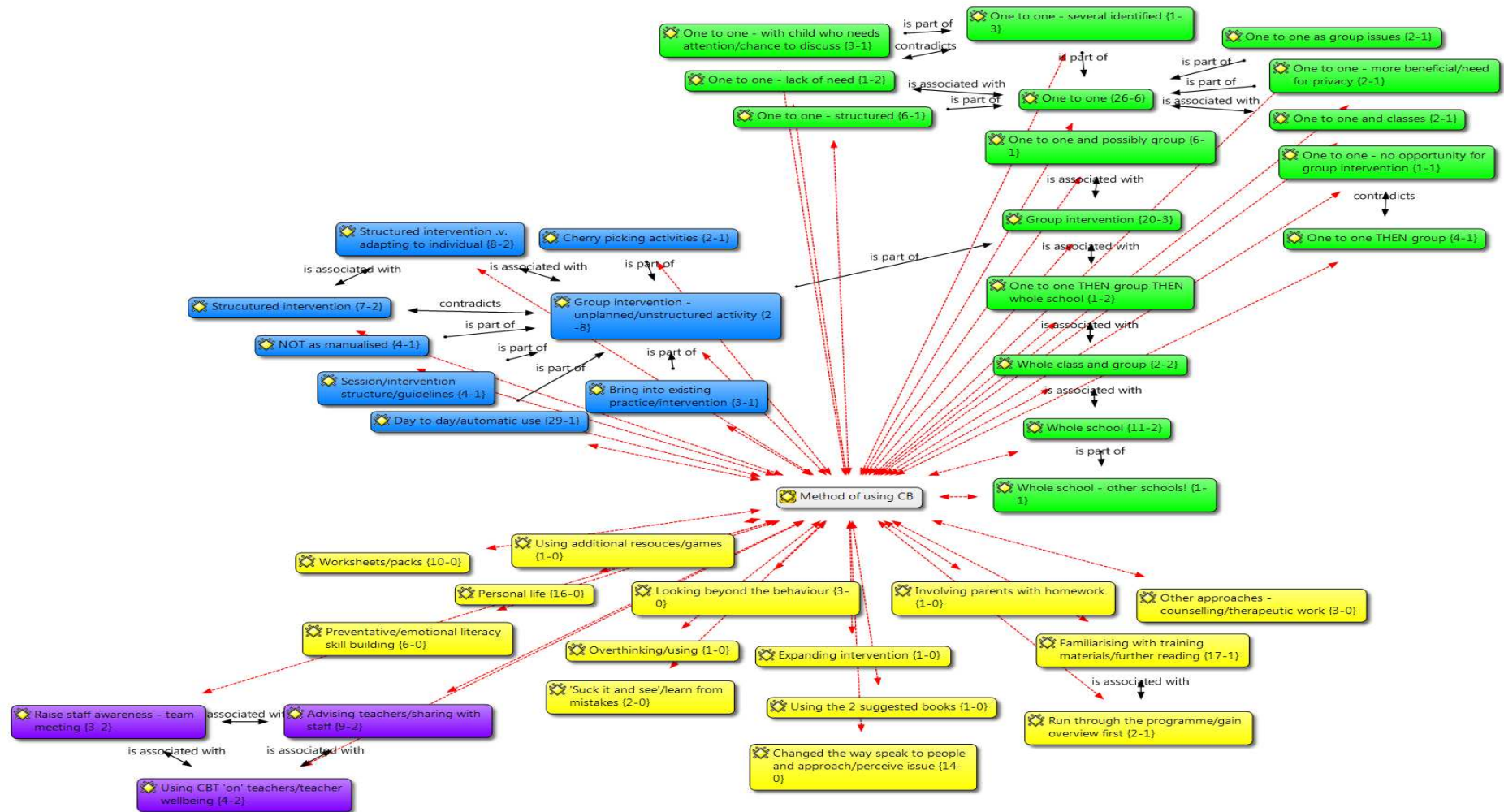


Figure 6: TA Network - Methods of Implementation

Figure 6 shows a network view of the implementation methods reported by all participants, as identified through interviews.

Codes in green refer to implementation of CBI at different systems levels within a school: individual; group; whole class; or whole school level. Three codes in purple refer to implementation of CBI with other education staff. These 2 clusters of codes are discussed further under the theme ‘Methods of Implementation: Across School Systems’ below.

Codes in blue refer to implementation of CBI using structured or non-structured methods. These are discussed further under the theme ‘Methods of Implementation: Prescriptive versus Non-prescriptive’ below.

Codes in yellow refer to alternative methods of implementation or use of discrete intervention elements. These are discussed further under ‘Strong Themes around Methods of Implementation’ below.

#### *Methods of Implementation: Across School Systems*

The most commonly reported implementation method was at an individual level. Some participants had several individual children identified for intervention and some indicated that it would be used for children who were in need of individual attention/a chance to talk (refer to green codes in network):

“In terms of intervention I haven’t actually started with either of the children yet. There’s one child that we’d already identified ... and then there is another child that is a potential one” (theme: one to one)

“I’m thinking it’s not just one child it could work with. I think there’s a few if run properly....at the moment there’s one child for me that I have in mind that I think this could really work well if used properly.” (theme: one to one – several identified)

“One child from year 1...his teacher wants him to just have a bit of time for him” (theme: one to one – with children who need attention/chance to discuss)



There were references to this method being beneficial over other methods of implementation as it provided children with the privacy that participants deemed was needed, and avoided some of the group dynamic issues that they predicted would arise from group intervention. For example:

“...I’ve got a couple of children I’d probably work one to one, only because I know they wouldn’t work together very well” (theme: one to one as group issues)

“I think you can get more out of a child when you’re on a one-to-one basis ... a lot of people prefer to work with a group whereas I personally prefer to work with children on their own. I feel it’s more beneficial for them because it’s time alone ... the children I work with are children that need that privacy just for them so personally I think it fits well with what I think the children sometimes benefit from” (theme: one to one – more beneficial/need for privacy)

Some participants implied the possibility of implementation at a group level, or a whole class level, as well as at an individual level. Four references were made to the possibility of group interventions being implemented AFTER individual intervention. Some participants implied that they felt the need for experience and evidence of impact at the individual level prior to implementing a group intervention. Others implied that implementation would start at the smaller systems within the organisation prior to implementation at larger systems within the organisation (refer to green codes in network):

“I kind of see myself doing individual ones to get used to the material and working with them, and then I can definitely see it working as part of a group” (theme: One to one THEN group)

“...whether or not you start with a few children and then filter through to group and do it that way...start with the highest need” (theme: One to one THEN group)

One participant referred to the possibility of implementation at the individual, then group, then whole school level, thus implying that the intervention would work through multiple systems of increasing size within the school:

“...the little girl that I’m going to [be] working with first ... and then I would ask, for further down the line, if I can use it more in group situations and then pass some of the ideas on to the teachers. Will then have a wider effect on the school as well” (theme: One to one THEN group THEN whole school)

The second most commonly reported method of implementation was at a group level, sometimes as a structured intervention and sometimes through using CB competences as part of other interventions (refer to green codes in network):

“I do with another member of staff an ECM (Every Child Matters) club, like a nurture group, and some of it we might be able to bring into that because that’s going to be a full morning intervention so we might be able to work on the thought and feelings side” (theme: Bring into existing practice/intervention)

“Well I’m hoping once we’ve done a few groups that the word will get round about what we’re doing, and more children would actually want to be involved ... and want to know more about it.” (theme: Group intervention)

One participant referred to group interventions being more time efficient, implying that they reach more children at once:

“If we can get the group going, that will be even better in terms of time. So if you’re working as a group that would be great as well...” (theme: Group intervention)

The third most commonly reported method of implementation was at a whole school level. This is pleasing given that research suggests interventions are most effective when implemented at a whole school level as well as at targeted levels (see, for example, Weare & Gray, 2003). There were references to using the intervention at a preventative/emotional literacy building level across school (refer to green codes in network):

“... just help children to be more independent in their learning would be one thing, if it's emotional factors that are effecting their approach to the learning or their access to the learning and then I would ask for further down the line if I can use it more in group situations and then pass some of the ideas on to the teachers. [This] will then have a wider effect on the school as well just in terms of...the emotional skilling kind of thing” (theme: Whole school)

Similarly there were several references to participants raising staff awareness of CBI via team meetings and providing CBI advice or support to staff (refer to purple codes in network); this implies its wider use within school. For example:

“One of the head teacher's asked us if we could do/give some input at staff meetings...the basics of the approach and to make the staff aware of what we can use and maybe some of the kind of activities that you could translate into a classroom situation ...‘this is what's available and if there are any children that you feel in your class that could use it this is what you could do’. But also like your just saying ‘these are some of the good interventions you might use in Circle time’ and just give them some resources as well and pass those down the line” (theme: Whole school/Raise staff awareness – team meeting)

“...it's just given us an extra string to our bow in dealing with children ...I'm able to advise teachers on their dealings with children in their class and I just feel I can just given them...the idea that a lot of children have got these serious thoughts and feelings going on inside them that end up resulting in certain behaviour patterns” (theme: Advising teachers/sharing with staff)

“...I would like to think that they would be aware of what the training is or aware of what the programme is and...be able to flag up children themselves rather than me have to go and find you...they're aware of what's available and perhaps come and ask for it” (theme: Advising teachers/sharing with staff)

“It’s meant that I can give it to other members of staff and can say: ‘this is what you need to do and why’, and they understand it and they understand how to explain it to the children” (theme: Advising teachers/sharing with staff)

“...[implemented] not only with children to be fair...even with staff members. Just the way that you talk: if there’s a little bit of negativity going around the course it actually shows you how to be quite positive about situations, and if someone’s having a bit of a negative time and you are having your one-to-one time with your class teacher you can bring little tiny bits in.” (theme: Using CBT ‘on’ teachers/teacher wellbeing)

One school referred to extending implementation to other schools, thus providing opportunities for more widespread implementation:

“...would probably almost end up doing that [implementing within own school] and then showing other people how to do it ...other schools ... and then it gets shared. So they go ‘I’ve heard your doing this’, so then you end up sharing it out. So they’ll almost wait to see how it works here or I’ll say ‘well I’ve tried this’ and because I’ve had the time to do it and I’ll have the time to analyse it and then they’ll say ‘how’s it worked’ ...” (theme: Whole school – other schools!)

#### *Methods of Implementation: Prescriptive Versus Non-prescriptive*

Whilst several references described the planned use of structured interventions there were several references which debated the benefits of using the intervention as a prescriptive versus non-prescriptive/flexible intervention (refer to blue codes in network). For example:

“Initially I thought ‘oh I will have to prepare the whole series’ but then when I was looking at it I was thinking I don’t think so because it’s going to go in different directions depending on what the child needs” (theme: structured intervention .v. adapting to individual)

“I’m going to use it as a working document, as something I’m going to refer to” (theme: NOT as manualised)

“...you could actually take it from session to session as a makeshift intervention, but then I don’t think I would necessarily use it like that anyway” (theme: NOT as manualised)

“... we’ve sort of cherry-picked bits out of different sessions and see how that goes” (theme: Cherry picking strategies/activities)

“I like the fact that you can just pick them [activities] out, and just the odd activity to apply across school” (theme: Cherry picking strategies/activities)

“...we’ve split it into six sessions and we’ve actually gone through as we did it through the four [training] sessions. We’ve gone through each session and split it into those bits so we’re covering a bit of each within each session” (theme: Structured intervention)

This implies that whilst participants valued having guidance and a basic structure to follow, many also valued the ability to implement the intervention flexibly, to suit individual needs.

### *Strong Themes around Methods of Implementation*

The results will now turn to five of the strongest themes within the network:

#### *1. Theme: Day to day/ automatic*

Participants referred to their unplanned/opportunistic use of CB competences (29 references), for example, through their day to day interactions with children. This implies that the intervention was being used creatively, rather than solely through structured interventions. It also implies potential for CBI even in schools where time and resources do not allow for structured intervention. It could be argued that sustainability of an intervention is more likely when it is implemented implicitly and opportunistically, as this places less demands on time and resources. Examples of the theme ‘Day to day/automatic’ are given below (refer to blue code in network):

“I do find that I hear your voice and I hear some of the ideas that came up...quite a lot during the day. You think: ‘actually yeah I use that’ or ‘I have used that’.”

“I think from the training we realised that a lot of it we do...”

“I think it’s quite useful to [have] some of the insight, just on casual interaction with children, everyday interactions. I kind of pick up on things more now”

“...these things can be used by chance. It’s not planned, it’s not like: ‘right Ok Tuesday I’m going to sit down with such and such and we’re going to do this’ because things just kind of bounce off each other. You might just change it as you go. In the playground or even just in the classroom, because I could use it in the classroom as well, because the situation could happen and then you could think: ‘hold on I’ll use this with the child’ and talk to the child”

“...I could use some techniques when I’m in the class because it’s three of the children I work with are in our class so...I could perhaps use it in the classroom as a more casual intervention”

“I’ve come back here and I’m thinking: ‘what can I remember about that course?’ and I can’t actually tell you it’s so much, but when I actually start communicating with somebody the things that you were telling us start just coming into play...so it has happened, something has happened”

One participant referred to a great deal of the intervention being common sense and being used automatically by teachers. This highlights the possibility that school staff may subconsciously implement some basic CB competences, without specialist training:

“It’s quite new for a lot of people to talk about cognitive behavioural techniques, you think: ‘what!?’ But obviously I think a lot of it is makes sense anyway. Its common sense isn’t it? Some of it you know teachers use anyway without knowing what they are doing. I think that always helps if someone says: ‘I use that anyway’”

2. *Theme: Familiarise with training materials/further reading*

Participants referred to their need for further reading prior to implementation (17 references). This implies that the training may not have allowed enough time or reading material for trainees to fully familiarise themselves, or feel skilled, with the intervention; a factor to consider for further training. Examples of the theme 'Familiarise with training materials/further reading' are given below (refer to yellow code in network):

"I have read them several times since the course just so that, if I needed to, I can pull on particular things"

"I want to get the materials out and have a look and just sort of sift through...because when you're saying: 'what part are you going to use?' I need to go back to look at it all to decide."

"I feel that I need to do a lot more reading up on it"

"...if I didn't quite grasp in the session I read up on it. I read it again after and got it then...I just read the training materials. I was going to research a bit which I still need to do, I will research more"

"I've started it [the intervention] now but I'm finding myself having to go through all of it to remind myself which order to do it in... Rather than learning it as you were going you have to do it after"

3. *Theme: Changed the way speak to people and approach/perceive issue*

Participants indicated that the training/intervention had impacted on their methods of perceiving and addressing problems (14 references). For example, there were three references to participants 'looking beyond' the problem as a result of the training. This implies that the training/intervention had impacted on participants at a deeper level than merely enabling them to use competences with children. That is, participants were using the CB model/approach to guide their conversations and problem solving techniques. This also implies potential for CBI to be used in sustainable ways. That is, staff using CB approaches to problem solving can be ongoing regardless of the external barriers which commonly impact

on other methods of implementation. Examples of the theme 'Changed the way speak to people and approach/perceive issue' are as follows (refer to yellow code in network):

“...it also heightens awareness of it...We all know that people do things for a reason, but the course just brought it to the forefront of, certainly, my mind and made me start thinking about one or two characters that I knew in school”

“...it's made me stop and think when there is a situation again, maybe out in the yard or with a child in the classroom, instead of just maybe going and saying: 'come on why did you do that?' which I've now learnt doesn't get the answer you want....and when I feel myself saying that I actually stop...it's changed the way I think as well”

“...generally talking to children and actually change the way that I speak to children and correcting myself, just by some of the things that you were telling us about in there [training room]”

“...school have put me in for a lot of training and I think it's probably the best training, the most useful that I've been on, because it's made such a difference to how I look at problems and sorting out a problem or just general chit chat to a child in the playground. It's not cut and dried, as you would normally just say: 'go and sort it out'...you would take a step back and think: 'how would I have done that?'”

“... it really has given me food for thought how I communicate with people”

#### 4. *Theme: Personal life*

Participants indicated that they had used CB approach/strategies with friends, family and themselves (16 references). This implies that the training/intervention had impacted on participants on a personal and perhaps deeper level, thus indicating a genuine interest or belief in the intervention. Examples of the theme 'Personal life' are (refer to yellow code in network):



“I see this with my own child: being a single parent now and he has to go to after school club. I have to work to run a home and I have to do everything myself. Sometimes I think I’m not giving [boys name] enough time: I need to know how’s his day’s gone, what’s he’s thinking, what he’s feeling”

“I have an adult friend who has depression ... he’s not sleeping and he’s really worried about it [description of CB based conversations that took place] and he frequently had those situations so it came in very useful then”

“... when we were doing the training I tried it on my son and...the flow was much smoother because he was more aware”

“I’ve used it at home as well at a house party ...it was how someone was seeing herself, and how she was using certain negative thoughts and behaviours that she was using, and I could see it but she couldn’t, so it was quite good because it reminded me that I knew about it...so I helped her a little bit. She said: ‘come back to give me some more, that was great’”

“...I’ve used it on myself, I’m sat there thinking: ‘I didn’t realise I did that’ and it’s changed the way I think about things...if I find myself thinking in a certain way I can look at the negative behaviours”

5. *Theme: Worksheets/packs*

Participants indicated that they valued the worksheets/training packs (10 references). This may reflect busy school staff appreciating readily available and concrete resources. Examples of the theme ‘Worksheets/packs’ are (refer to yellow code in network):

“...guidelines in school at the moment very much steer away from worksheets but these are great worksheets and I think as a tool [for] children who have difficulty expressing themselves...to be able to maybe draw pictures or just write the odd thing down about their feelings and their thoughts is invaluable because that’s something they can’t talk about it...it’s a really good way of expressing themselves.”

“...the materials I’ll use and adapt”

## **RQ 2 - Summary Discussion**

### **How do school staff implement the CB competences with training and support?**

Data from all sources indicates that the intervention was used in a variety of ways across participants and schools. That is, some participants implemented a group intervention, whilst others implemented an individual intervention. Some participants implemented a structured intervention, whilst others implemented the intervention on an opportunistic basis. Some involved specific education staff in the intervention whilst others involved the whole school. Interview data highlighted that some participants implemented the intervention implicitly, in their day to day interactions with adults and children and when solving problems, including in their personal lives. Data from all sources indicated that all participants planned to implement, and went on to implement, CBI through at least two methods. The combination of methods used differed across participants.

The data sources demonstrated that one school (S1) used all five methods of implementation (i.e. individual, group, whole class, discussion with parents and discussion with teachers). This is despite many trainees having predicted to use all five methods immediately after training ('all five methods' was the most common combination of methods selected through training evaluation forms). Whilst participants had good intentions to implement the intervention across the school, there were barriers to this taking place in practice. Such barriers are explored under RQ 3.

All data sources revealed that the most common single method of implementation, planned and used in practice, was at an individual child level (e.g. all schools used this method and it was reported most frequently). Supervision reflections further indicated that this was most often through a structured (e.g. timetabled) intervention. IDs and interview data revealed the second most common single method of implementation to be at a group level. Finally, interview data indicated whole school use to be the third method of implementation most referred to. Examples were participants introducing the intervention/strategies through staff meetings and participants using CBI to advice staff on their practice. Interestingly, interview data revealed that some participants planned to implement CBI across systems in order of increasing size. That is, from individual child, to groups, to whole school; in other words,

using a 'bottom up' approach to implementation. This may reflect leadership styles within schools or the participants' role within the school. This is explored further under RQ 3.

Most data sources indicated that few participants planned to implement, or implemented in practice, at a whole class level. Many of the participants did not teach their own classes (they were teaching assistants) and therefore had limited opportunity to implement through this method. Indeed, one participant who implemented at a class level was a class teacher, and she revealed that this was the only method that she could use due to lack of 'non-contact' time for individual or group intervention. This indicates that methods of implementation, to some extent, are determined by the participants' role in school. Whilst the training evaluation forms revealed greater numbers of trainees who predicted use of CBI at a whole class level than other data sources, these trainees may not have been research participants and hence not part of subsequent data sources. Alternatively, participants may have adjusted their plans around methods of implementation subsequent to completing training evaluation forms.

The data revealed that participants usually only used the intervention through their discussions with teachers and parents when they also implemented the intervention directly with children. This was due to participants discussing the intervention with adults only when this was in relation to their interventions with children e.g. to feedback on their sessions or on homework activities. However, interview and supervision data indicated that IDs and training evaluation forms had underestimated implementation of CBI through discussions with parents and teachers, particularly in the day to day interactions that they had. This was not adequately captured through the IDs or evaluation forms, possibly as a result of participants forgetting to record this or not deeming this as significant to record. Participants may make more use of CBI through their interactions with others, and on an opportunistic basis, than their self-reports suggest.

The ID data indicated that group supervised participants were far less likely to report using the intervention as frequently as individually supervised participants. To some extent, this might reflect how motivated individually supervised participants were to complete the IDs; individually supervised participants may have felt an increased alliance with the supervisor, who was also the researcher. However, it is also known from interview data that individually supervised participants were more likely to implement a structured intervention, and hence more likely to use the intervention regularly. It is argued here to be likely that individually

supervised participants used CB competences more often than group supervised participants. Individually supervised participants from S1 and S5 reported most frequent implementation, when different methods of implementation are combined; this may reflect S1 participant having implemented the intervention for longer and S5 participant having greater experience and training around therapeutic interventions.

A number of strong themes emerged from the interview data. For example, participants reported using the intervention: implicitly through their day to day interactions; in their personal lives; and in the way that they approached people/issues. This could indicate that the training/intervention had impacted on participants at a deeper level. That is, those participants were not merely implementing the intervention through planned methods but perhaps embedding the intervention into their daily lives. It is argued here that this is more likely to have a sustaining impact than, for example, the use of a manualised intervention. Many participants referred to the benefits of using of the intervention in a flexible manner, rather than as a manualised/prescriptive intervention. One participant referred to school staff implementing CB competences automatically and subconsciously, without specialist training. This concurs with Mennuti (2006).

This data highlights several factors, including:

- CBI can be used at multi-levels within a school system, something which Maxwell et al. (2008), Burns et al. (1999), Weare and Gray (2003) and Marulanda (2010) argued is important for effectively addressing childhood emotional wellbeing.
- CBI can also be used creatively in schools, for example, through teachers' opportunistic and day to day interactions, and to help teachers problem solve around children's difficulties. This contrasts with the traditional CBT methods most often used in clinical settings and reinforces the view that CBT can fit well into school settings (Squires and Caddick, 2012; Buckley et al., 2013; Platts and Williamson, 2000; Christner et al., 2007; and Mennuti, 2006).
- Schools are likely to implement CBI through at least two levels of intervention. Further research could investigate whether implementing across systems within a school makes CBI more sustainable.
- The combination of implementation methods used by participants is likely to be dependent upon factors related to the participant and/or school.

### **RQ 3**

#### **What are the barriers and facilitators to school staff implementing CBI?**

Where possible, each facilitator/barrier identified through the data is mapped onto a factor from Durlak and DuPre's (2008) model of intervention implementation (*this is presented in italics*). For a description of this model, see Appendix J.

The symbol: \* indicates where a factor cannot be easily mapped onto the model. This is then discussed further under the 'Summary Discussion' for RQ 3.

## ***1. Training Evaluation Responses***

Following training, trainees were asked to identify, on the training evaluation forms, what they perceived as the main facilitators/barriers to them implementing CBI. TA was used to identify themes that emerged; these are presented below.

Time, Space, Resources *Factors relevant to the prevention support system and Factors relevant to the prevention delivery system \**

The majority of trainees identified that they would need time to prepare and deliver the intervention and a designated room in which to deliver the intervention. Many trainees identified the need for further resources, particularly CBT related books and websites.

The two strongest themes identified for facilitators and barriers were ‘time’ and ‘space’; most trainees indicated that these factors were both needed, and a potential barrier, to successful intervention implementation. Despite ‘time’ and ‘space’ being related to Durlak and DuPre’s: *‘factors relevant to the prevention delivery system’* and *‘factors relevant to the prevention support system’*, it is argued in this study that there is potential need for a discrete category around ‘logistical/practical resources’. This is discussed further under ‘Summary Discussion’.

Human Support - *Factors relevant to the prevention support system and Factors relevant to the prevention delivery system: Specific staffing considerations.*

Many trainees identified support from: their managers; ‘support networks’; and the trainers as being facilitators. With regards to support from the trainers, they referred to the need for follow up training. The need for ‘support networks’ was in reference to trainees from different schools coming together on a regular basis to problem-solve around their interventions (peer supervision).

Many trainees identified that lack of support from their colleagues would be a barrier to implementation. This may reflect them acknowledging the potential lack of awareness of other school staff around the intervention at the time, particularly as only one other colleague from their school attended the training. This theme maps onto *‘Factors relevant to the prevention delivery system’* in that it indicates the need for: general organisational factors; specific staffing

considerations; and specific practices and processes (all related to the prevention delivery system). That is, school staff being supportive of the intervention is somewhat reliant on factors such as positive work climate, staff welcoming change, shared vision, effective communication and effective leadership/management.

School staff on board - *Factors relevant to the prevention delivery system.*

This was a similar theme to that above but, more specifically, many trainees indicated the need for staff to share their visions around the intervention.

Pupil related factors - *Related to Innovation Characteristics and Provider Characteristics \**

Many trainees referred to pupil related factors as being a potential barrier to the intervention e.g. their engagement or ability levels. Whilst this theme is related to '*innovation characteristics*' and '*provider characteristics*', it could be argued that this is a distinct category. This is discussed further under 'Summary Discussion'.

Confidence/skill - *Provider Characteristics*

Trainees referred to their own confidence and skills (in relation to the intervention) as being a potential barrier to implementation. This could partly reflect the training evaluation forms having been completed immediately after training, before implementation had begun and before receiving any supervision support. This theme maps onto Durlak and DuPre's: '*provider characteristics*' in terms of it relating closely to trainees' self-efficacy and skill proficiency.

## ***2. Intervention Diary Responses***

Participants were asked to identify, on their IDs, any facilitators/barriers to their intervention implementation. See Appendix P for a table of ID responses provided by individually supervised and group supervised participants.

Below is a summary of key themes that emerged through TA of the data. P1 refers to individually supervised participants whilst P2 refers to group supervised participants.

Time, Space, Resources – *Factors relevant to the Prevention support system* and *Factors relevant to the Prevention delivery system* \*

All participants referred to at least one of the following factors as being a barrier/facilitator: ‘time’, ‘space’ or ‘resources’. Two participants reported all three of these factors whilst one participant referred to ‘space’ and ‘time’:

‘No suitable private space (quiet and private)’, ‘Didn’t feel session went that well – adult aware of inappropriate space and felt it was a rushed session’ and ‘Good environment to carry out relaxation techniques’ (P2, S3)

‘Use the library as a private/relaxed area’, ‘Being given the time’ and ‘Access to materials’ (P1, S1).

‘Resources from course and books very helpful’, ‘Limited time for preparation’ and ‘Rooming issues’ (P1, S5).

Six participants referred to ‘time’. Whilst for P1, S4 ‘time’ was reported to be a facilitator (he had daily timetabled sessions with a children), for P2, S4 ‘time’ was reported to be a barrier, seemingly because of her SENCo role limiting the amount of implementation time she had.

Whilst these themes can be considered related to Durlak and DuPre’s ‘*Factors relevant to the prevention support system*’ and ‘*Factors relevant to the prevention delivery system*’, it is argued in this study that there is a potential need for a discrete category around ‘logistical/practical resources’ (such as time and space). This is discussed further under the ‘Summary Discussion’.



Pupil Related Factors – *Provider characteristics* and *Innovation characteristics* \*

Seven participants referred to pupil related factors as being facilitators/barriers e.g. readiness of child to engage, complexity of problem presented by child and child's skills. For example:

'Pupil is taking a very active part in these sessions asking relevant questions –  
"Can you have more than one feeling?"' (P1, S1)

'With group, dynamics meant that they refused to engage with the strategies.' (P1, S3)

'The child was chatty, could provide enough input to work with' (P2, S3)

Some references to pupil factors relate to Durlak and DuPre's '*Provider characteristics*' as they refer to pupil difficulties in relation to accessing the intervention which may have reflected participant proficiency in delivering the intervention. For example:

'...pupil didn't understand what feelings were' and 'unable to determine feelings!' (S1)

'Pupils not remembering difference between thoughts and feelings' and 'Pupils very quiet, all reluctant to participate' (S2)

S2 participants implied that pupil/group characteristics slowed the pace of the intervention; again this may, at least partly, reflect the participants having miss-judged the pace at which the intervention should proceed. Indeed, one participant acknowledged the impact of her practice on the intervention implementation:

'Possibly wasn't planned well enough' and 'Possibly purpose wasn't clear between adult and pupil' (PS, S3)

Pupil factors also relate to Durlak and DuPre's '*innovation characteristics*' in that the pupil's engagement and understanding of the intervention is somewhat dependent on the intervention being adaptable to suit pupil needs.

Despite the above, it is argued here that some 'pupil related factors' are related but discrete from '*provider characteristics*' and '*innovation characteristics*'. To illustrate this point, P1, S2 reported:

'One pupil disengaged having reported issues [safeguarding]'.

That is, the pupil's capacity to engage during a personally traumatic period could be minimal despite provider or intervention characteristics. Also, P2, S3 reported:

'Pupil didn't seem bothered by the lack of private and quiet space available'

This is likely to reflect the pupil's individual traits; another pupil might have disengaged in response to the same situation. It is argued here that Durlak and DuPre's model does not adequately encompass such pupil based factors and that 'pupil related factors' is a discrete facilitator/barrier. This is discussed further under 'Summary Discussion'.

#### Relationship between participant and pupil – *Provider characteristics* \*

Reports by one participant referred to the relationship between them self and the child as being a potential facilitator. For example:

'Have a good rapport with the child as he expressed his views' and 'Child says feels relaxed with talking to me' (P1, S1)

Indeed, the relationship between a therapist and patient has been shown to be a very important factor in determining the success of a therapeutic intervention (see, for example, Lambert, 1992). Whilst this is related to Durlak and DuPre's '*provider characteristics*' in that the relationship between participant and child is partly dependent on the participants qualities/skills, it is argued here that their therapeutic relationship is also dependent on the unique combination of provider and child factors. This is discussed further under 'Summary Discussion'.

### Supervision and Training – *Factors relevant to the prevention support system*

Supervision and training are examples given by Durlak and DuPre of ‘support systems’, specifically ‘training’ and ‘technical assistance’. Three participants referred to the training and/or supervision as facilitators:

‘Very useful having had the training – able to draw on elements of the training at various times during the term’ (P2, S1)

‘After my conversation with the supervisor I feel better carrying on, following what we had decided to do...’ (P1, S1)

‘Session plan discussed at supervision session very helpful’ (P1, S5)

### Adapting use of intervention – *Innovative characteristics*

There were several references to adapting the intervention to the needs of the pupil or making use of the intervention through different methods (e.g. through using it opportunistically). For example:

‘Pupil, teacher and parent confirmed that pupil is handling issues more effectively and using a range of CBT strategies to help – we talked about applying model to other problems’ (P1, S5)

‘... chose specific areas to focus on which suited the child and the situation’ and ‘I am choosing different aspects of the intervention that are appropriate for this child’ (P2, S3)

‘Used with two children during a residential trip, with one child used twice e.g. when child was anxious about using the ‘Zip Wire’ (P2, S1)

This demonstrates the interventions adaptability and compatibility, known by Durlak and DuPre as ‘*innovative characteristics*’.

### Confidence – *Provider characteristics*

Two participants referred to their growing confidence as an intervention facilitator:

‘The more we do the better I feel, and more confident’ (P2, S2)

‘Our increasing confidence meant we could tease discussion from some of the children’ (P1, S2)

This is interesting given that ‘confidence’ was identified as a theme under ‘barriers’ from the training evaluation forms. It may be that whilst trainees were concerned about their levels of confidence immediately after training, their confidence grew following intervention implementation and/or supervision. This factor maps onto Durlak and DuPre’s ‘self efficacy’ under ‘*provider characteristic*’.

P1 from S1 provided additional notes to those provided in the IDs; these can be found in Appendix S.

### ***3. Supervision Reflections***

The researcher completed reflection notes following each individual supervision session; see Appendix R for the complete record. Below is a summary of the key themes that emerged from this data in relation to the facilitators/barriers identified to intervention implementation:

#### Time and Space – Factors relevant to the prevention support system and Factors related to the prevention delivery system \*

Having appropriate space to deliver the intervention was identified as a significant barrier for S1; she regularly complained about lack of privacy and quietness.

‘Time’ was discussed regularly by participants. All participants, apart from S3 participant, had a timetabled weekly or daily session to deliver their intervention. For S3 participant, lack of time to implement the intervention, and receive adequate supervision, partly reflected her having other responsibilities that took priority over the intervention (she was a ‘Resourced Provision Manager’). This related to leadership and support issues around her role and the intervention. For example, the intervention was not given priority by the head teacher and the participant felt unsupported in her wider role. Whilst the themes ‘time’ and ‘space’ relate to Durlak and DuPre’s ‘*prevention support systems*’ and ‘*prevention delivery systems*’, it is argued here that they are also discrete themes; this is discussed further under ‘Summary Discussion’.

On the whole, ‘time’ was not a major barrier to implementation for S1, S2, S4 and S5. In three of these cases, this reflected the head teacher supporting the intervention, at least at a basic level through providing the participant with dedicated time for implementation. However, for S1, S2 and S5 ‘time’ remained a barrier in terms of time to prepare and evaluate the intervention, or to provide additional sessions for children where this was needed.

#### Leadership, Communication and Shared Vision – Factors relevant to the prevention delivery system

Although S2 had a weekly timetabled slot to deliver the intervention, several references were made to a lack of: communication; shared vision; leadership; and support from within the school around the intervention. The participant was also unclear on her role and there was a lack of coordination between teachers and the participant around setting up the intervention.

In contrast, for S5 participant, a facilitator was the head teacher perceiving the intervention to have benefits and therefore fully supporting its implementation. The intervention also complimented this schools mission and ethos. Effective leadership and shared visions around the intervention meant that basic resources were allocated and the participant felt supported/empowered to champion the intervention within the school.

These factors map onto Durlak and DuPre's '*prevention delivery system*'; the data representing individual schools highlights the contrasting impact that the 'prevention delivery system' can have on implementation.

#### Supervision – *Provider characteristics and Factors relevant to the prevention support system*

All participants, apart from S5 participant, were noted by the supervisor as benefiting from receiving guidance around structuring the intervention and/or adapting intervention to suit the children's needs. In this sense, supervision can be considered a facilitator under the '*prevention support system*'. It was noted that three participants followed supervision guidance well and one participant was reported to grow in confidence following supervision. Participant in S3 needed a high level of mediation around using the intervention in creative ways, as there were barriers to her implementing a structured intervention. Participant from S5 did not require a high level of mediation: this seemed to reflect her having had prior training in therapeutic techniques; this maps onto Durlak and DuPre's '*provider characteristics*' as a facilitator.

#### Adapting use of intervention – *Innovative characteristics*

Participants from S1, S2 and S4 adapted their plans considerably following supervision in order to match pupil needs, thus demonstrating adaptability of the intervention as being a facilitator; this maps onto Durlak and DuPre's '*innovation characteristics*'.

#### Involving Carers and School Staff – *Factors relevant to the prevention delivery system*

There were references to participants involving school colleagues in the intervention e.g. class teachers and participants sharing observations around the pupil, or school staff being involved

in setting up the intervention. Participant from S2 planned, delivered and evaluated the intervention with a colleague which proved to be a valuable source of support for her. In some cases staff involvement was a facilitator to intervention implementation.

There were fewer references to parents/carers being involved in the intervention; when this was referred to, it was mainly around homework or gaining consent from parents. Lack of carer involvement was seen as a barrier for at least S4 and S1.

#### Pupil Related Factors – *Provider characteristics* and *Innovation characteristics* \*

For S1, S2, S4 barriers in relation to pupil characteristics were around pupil engagement and motivation. Issues around pupil school attendance were a significant barrier for one participant. Whilst such factors are related to '*provider characteristics*' and '*innovation characteristics*', it is argued here that they map onto a discrete category.

#### Supervisee/Implementer Characteristics – *Provider characteristics* \*

Supervisee characteristics that did not map directly onto Durlak and DuPre's '*provider characteristics*' were those focussed on supervisee's personal qualities and attitudes (e.g. motivation or attitude towards their roles), rather than characteristics associated with skill proficiency or self-efficacy, as identified by Durlak and DuPre. For example, participants from all schools were noted to be motivated to implement the intervention. Their motivation was demonstrated through: their presentation during supervision sessions (e.g. upbeat and enthusiastic about the intervention); comments they made about the intervention; and through their commitment to the intervention e.g. most individually supervised participants completed IDs and followed advice as agreed. Participant S4 was willing to use his own time to enhance the effectiveness of the intervention and was particularly enthusiastic about the potential benefits of the intervention.

#### Relationship Between Pupil and Participant – *Provider characteristics* \*

The relationship between the pupils and participants were often indicated to be a facilitator in that many participants reported having a positive rapport with the children. Whilst this is

related to '*provider characteristics*', it is argued here that a therapeutic relationship is dependent on the unique combination of provider *and pupil* factors.

It is argued here that the latter three factors are not captured adequately in Durlak and DuPre's model. This is discussed further under 'Summary Discussion'.



#### ***4. Interview Responses***

The following eight TA networks represent key themes identified through the interview data in relation to facilitators/barriers to intervention implementation. These themes map directly onto Durlak and DuPre's (2008) framework of intervention implementation: this section is structured using Durlak and DuPre's framework headings.

The final network in this section represents key themes identified through the interview data which are in addition to those identified by Durlak and DuPre's model of intervention implementation.

Each network is discussed independently and then as part of the summary discussion for RQ 3.

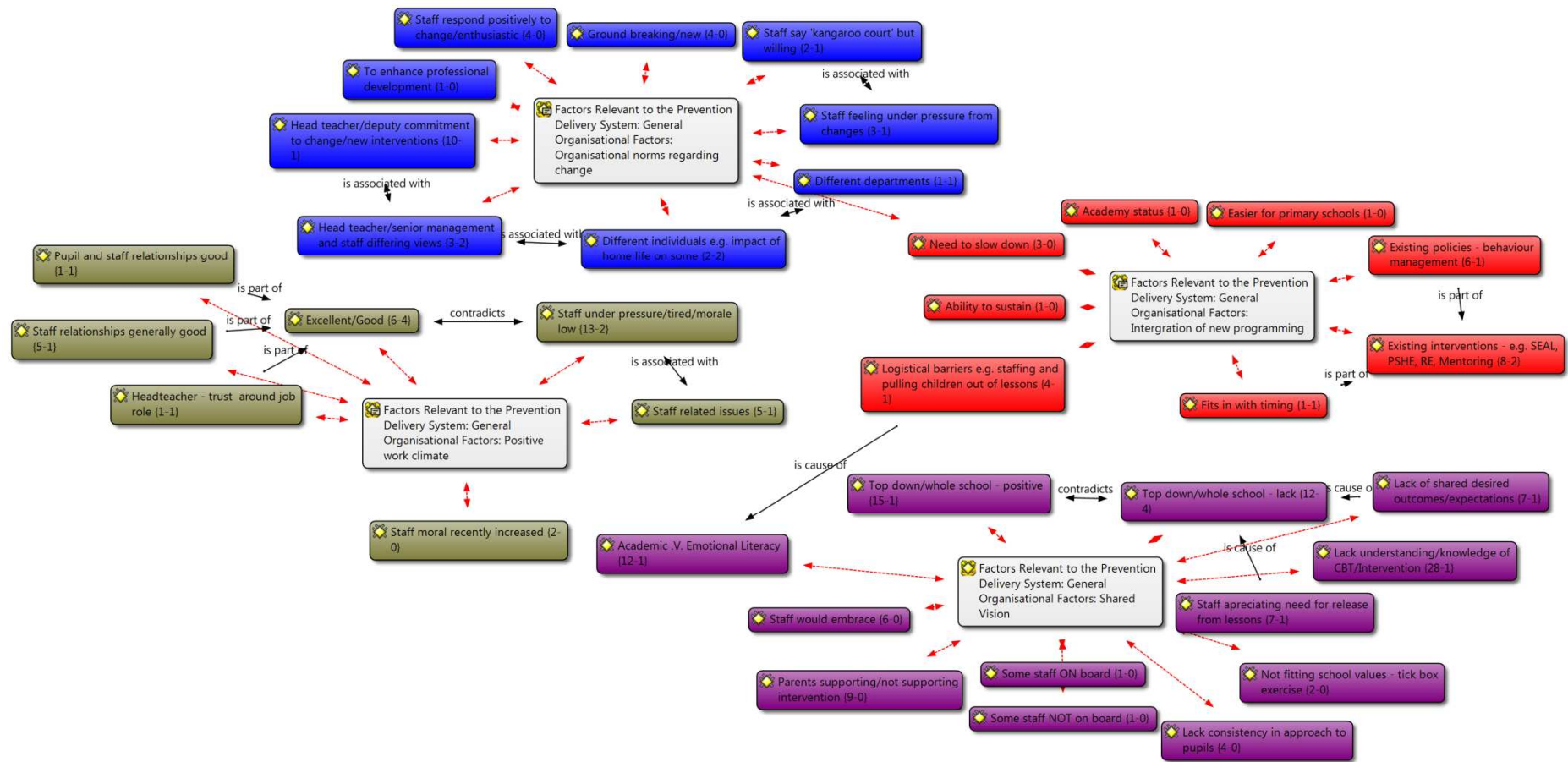


Figure 7: TA Network - Factors Relevant to the Prevention Delivery System: General Organisational Factors

The following findings are in relation to Figure 7: Factors relevant to the prevention delivery system: general organisational factors.

The network 'Organisational norms regarding change' (blue) demonstrates a mixture of positive and negative school staff attitudes and responses in relation to change, as reported by participants. Relatively positive norms are represented by themes to the right and relatively negative norms are represented by themes to the left of the network. Themes to the bottom of the network ('different individuals', 'different departments' and 'head teacher/senior management and staff differing views') represent a divide between the norms of particular school staff or departments, thus demonstrating that norms within a school were not necessarily universal. This was indicated to be the case for S2 in particular:

"There are certain departments where the Head of the Department is very much ... 'I'm doing it this way' and then you've got other departments who would be much more open to try something new if it makes the children and their lives easier." (theme: Different departments)

Negative themes were mainly in relation to staff feeling under pressure, in some cases as a result of them experiencing too much change:

"there's lots of changes and lots of extra things that we're having to do on top of everything else" (theme: Staff feeling under pressure from changes).

"...some of the teachers sometimes express the opinion of kangaroo court: 'can we slow down here?'" (theme: Staff say 'kangaroo court' but willing)

There were several references, across a number of schools, to head teachers welcoming/promoting change, particularly when a head teacher was relatively new in post. For example:

"...(head teacher name) is very open to new stuff and she's changed the school massively in the time that she's been here. She might not have been here very long, about 2 yrs..." and "...our head teacher actually likes trying different things. She does not keep it all the same" (theme: Head teacher/deputy committed to change/new interventions)

There were four references to CBI being new and unique to other interventions in school. For example:

“...it’s all a bit ground breaking at the moment, it’s something that I haven’t done before. It’s very much like I’m treading new ground” and “I don’t think it’s [been] administered in school in this way before” (theme: Ground breaking/new)

The network ‘Integration of new programming’ (red) demonstrates how CBI was perceived by participants as fitting in with existing behaviour policies and interventions (e.g. SEAL, PSHE and mentoring); this is represented by themes to the right of the network. These themes can be considered as facilitators to implementation in that they imply that related interventions and policies have succeeded to be implemented thus enhancing schools ‘readiness’ to implement further related interventions.

It is argued here that whilst the theme ‘Need to slow down’ is part of the network ‘Integration of new programming’ it also relates to ‘Organisational norms regarding change’ (blue network) in that it reflects staff capacity and attitudes towards implementing new interventions. For example:

“...the job itself is so difficult, to fit everything in....to say that everybody is there wanting change? They’ll take it on board but sometimes they find it’s a big effort isn’t it? Because the Government themselves have brought in so many changes... they’re [teachers] constantly bombarded with this constant change and I think some of them at some point in their life, particularly when things are going on outside, they must think: ‘I’ve had enough’...it might feel a bit stressful when changes come in” (theme: Need to slow down)

The network ‘Shared Vision’ (purple) demonstrates a mixture of positive and negative themes: to the right are examples of how some participants worked as part of a system which lacked a shared vision in relation to the intervention, where as to the left are examples of how some participants reported positively around a shared vision. In particular, there were references to schools having, or lacking, a whole school vision/top down approach around the intervention. Such references mainly came from S2 and S3. For example:

“I don’t think it’s valued. That would be my gut feeling...nobody’s interested really...everybody jumps when these things come on board, and ‘yes let’s do it, let’s go for it’, and then it’s died a death really.” And

“I haven’t really spoken to the head about it...he will have very little to do with it because we just both [co-trainer] use it where we need it for.” (theme: Top down/whole school – lack)

This was in contrast to participants who reported effective whole school/top down vision. For example:

“...it heightened the awareness of the whole school and thinking of a head who is with us, which is great. She has taken it on board as a viable intervention strategy” and

“...the head teacher’s asked us if we could give some input at staff meetings...the basics of the approach and to make the staff aware of what we can use and maybe some of the kind of activities that you could translate into a classroom situation ... so that’s team fold really” (theme: Top down/whole school – positive)

As was argued earlier, a whole school vision can be considered an important facilitator to intervention implementation.

A relatively large number of references (28) were around other school staff having a lack of understanding or knowledge of the intervention. This was representative of several of the schools. For example:

“...because our line manager hasn’t had the training, she doesn’t fully understand it either”,

“...it would help if the staff who were going to be suggesting which children we do this work [with] had a better understanding of what CBT’s about.” And

“I can’t comment on the whole school yet because I don’t think anyone is aware of it yet” (theme: Lack understanding/knowledge of CBT/Intervention)

This may reflect the fact that only two members of staff from each school attended the training and these members of staff were not facilitated to disseminate information to other staff.

‘Work Climate’ (green) demonstrates a mixture of responses by participants: to the right are examples of relatively negative work climates reported and to the left are examples of relatively positive work climates, in some cases reported as being excellent. It is argued here that these factors are related to the themes around staff/staff relationships, staff/pupil relationships, staff related issues and the managers’ responses to staff. ‘Staff feeling tired/under pressure/low morale’ was a strong theme for some participants, mainly from S2 and S3. This is likely to be a barrier to implementation as it effects motivation towards their roles and intervention. For example:

“At the moment it’s [morale] very iffy...If we knew that this was valued, we would probably know for definite it would be carrying on next year, whereas at the moment we don’t know...if you are in a grumpy mood when you are going in to an intervention, you can’t necessarily help that.”,

“I could go to a manager whatever level where I worked before and if my idea was a valued idea it would be supported...it doesn’t happen here.”,

“That feeling of being dumped on: had we been told that then we might have felt differently, and said: ‘okay we will give it a go’, but I think also we haven’t had all that much back-up” and

“Morale is low because of the huge pressure of getting standards up” (theme: Staff under pressure/tired/morale low)

This data supports the hypothesis that ‘organisational factors’ are key variables in influencing intervention implementation. In this study, such variables were facilitators and barriers to implementation, often depending on individual schools factors.

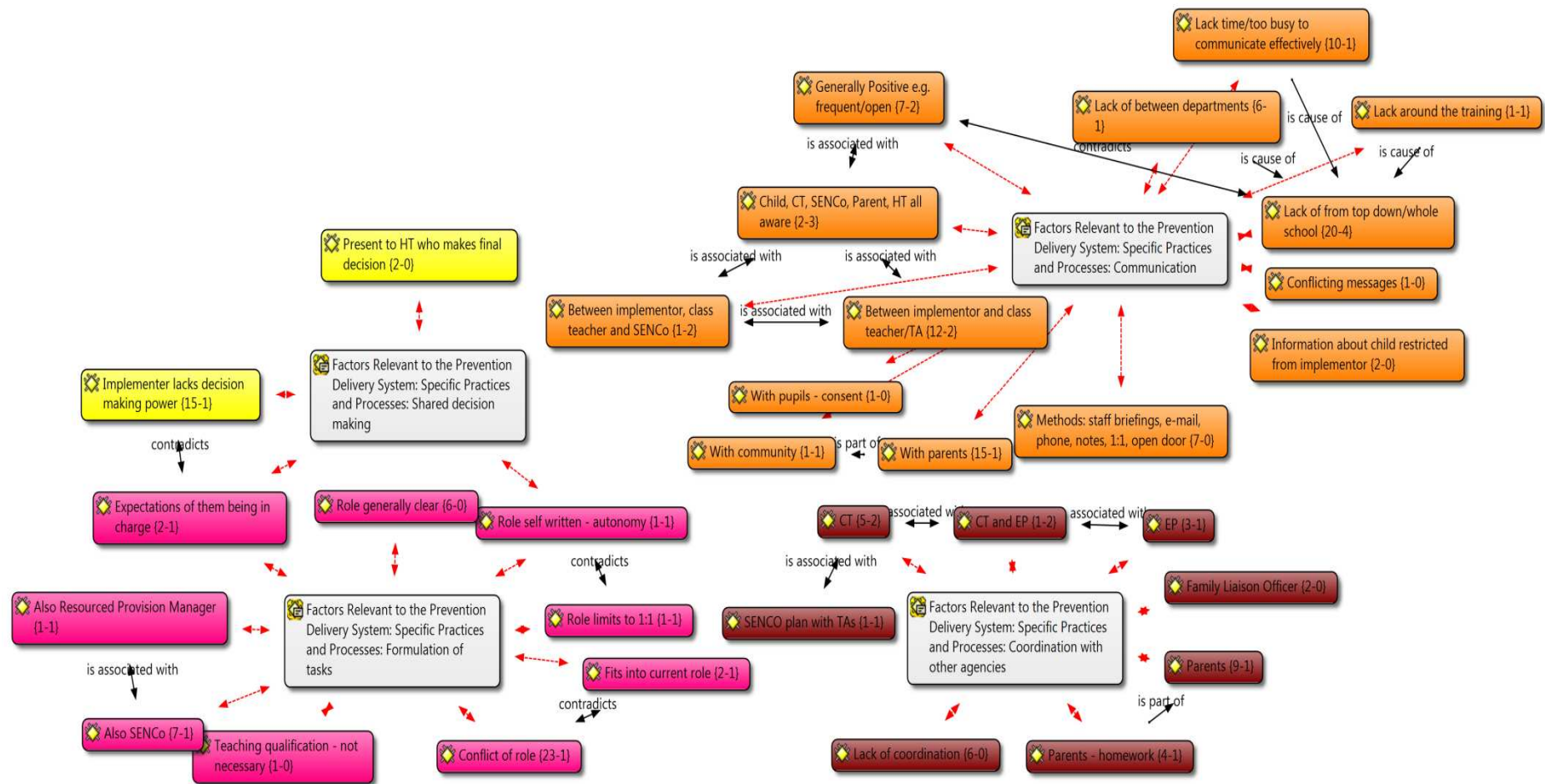


Figure 8: TA Network - Factors Relevant to the Prevention Delivery System: Specific Practices and Processes

The following findings are in relation to Figure 8: 'Factors relevant to the prevention delivery system: Specific practices and processes'.

The network 'Communication' (orange) demonstrates a mixture of responses from participants: to the right are examples of themes that represent relatively ineffective communication (e.g. around the training, between departments and conflicting messages) and to the left are examples of themes representing relatively effective communication. For example, there were several references to the implementer's communication with parents, class teachers, SENCo and head teacher in relation to the intervention. To the bottom of the network are examples of methods of communication referred to, including staff briefings, e-mails and one:one communication.

'Lack of whole school/top down' communication was a strong theme, with several references from several schools. Another strong theme relating to this was 'lack time/too busy to communicate effectively'. Examples of these themes are below:

"Our immediate boss will sometimes say: 'how did the session go? Was it okay?' and we will say: 'yes it was fine', and that is probably as far as it goes. Other than that nobody has asked us. The only time the school got involved was with...the safeguarding issue, and even that ... we weren't kept in the loop properly" (theme: Lack of whole school/top down)

"...because everyone is that busy, they haven't necessarily got the time to come and say: 'how's it going?'",

"...as a whole school we haven't had time, we haven't disseminated any of the practice or discussed it. There hasn't been the staff meeting time" and

"...there are often staff who don't know what things have been decided and what's happening but that is down to the fact that you are under a lot of pressure to get things done: you finish one lesson and getting prepared for the next lesson, staff rarely come down to the staff room for lunch. You get people coming down at 10 to 1 and grabbing what they have to do and rushing off out again... so things are discussed but between pockets of people"



(theme: Lack of time/too busy to communicate effectively).

The network 'Shared decision making' (yellow) represents a barrier for S2 in that the participants lacked decision making power within their school. On the other hand, the same school reported 'expectations of them being in charge' of the intervention, as seen under network 'Formulation of tasks' (pink). They felt that they were given responsibility over the intervention but not the decision making power around the intervention. This, naturally, caused participants feelings of frustration and low morale:

“We passed the letters to our boss, they passed it to their boss, and then it's gone to somebody else and everybody's got their own opinion on how this letter should look. And really all we wanted was a 'yes' or 'no'. We were quite happy ...we were going to show it to you and if you gave us the 'OK' we were just going to go with it.”,

“...we're not involved in any discussions or decision making at all to do with this. Which is a problem...you just think: 'just somebody make a decision please'...so that's stopped us really dead” and

“... having to go through so many channels can be really frustrating when we wanted to get stuff done...it seems to take forever just to get one simple answer and if you by-pass that middle person then again that's not right.”

(theme: Implementer lacks decision making power)

“Once it's up and running the expectation will be that we will run it and we will be responsible for it...we will be in charge of it.”

(theme: Expectations of them being in charge)

The same participants made several references to them experiencing a 'conflict of role' between their roles as intervention implementers and their wider roles. For example:

“It's not part of my job description... whether it's in my job description to do the intervention is a bit woolly”,

“They’re not the children that we work with [usually]. ‘Learning Support’ tend to focus on the children with Statements. And the children that we’re going to be focusing on [for the intervention]...I don’t think any of them have got Statements. So that’s where the barriers comes in” and

“No, I don’t think it should be me. Although I’m quite happy to do it and I’m quite looking forward to the challenge of it...I don’t know how to say this without sounding really horrible, I just think with what they pay us I think they’re getting a lot for their money.”

(theme: Conflict of role)

In contrast, other schools reported their implementer roles ‘fitting in with current role’, ‘roles being clear’ and ‘role self-written – autonomy’. For example:

“I’m ‘one-to-one’ and I’m also a Pastoral Mentor now which was what I was doing in my previous school and I was doing that sort of thing anyway; having children on a one-to-one basis and concentrating on what the issue was at the time” (theme: Fits into current role)

Three participants highlighted the impact of them being SENCo or Resourced Provision Manager on their intervention implementer role. Whilst for S1 participant being a SENCo was a barrier to implementation (providing less time for implementation), for S4 participant being a SENCo was a facilitator to implementation (providing more time for implementation).

The network ‘Coordination with other agencies’ (brown) demonstrates how there was a variety of ‘agencies’ involved in the interventions, including class teachers, teaching assistants, family support worker, Educational Psychologist and parents. Coordination with parents was often through the implementer providing ‘homework’ activities for pupils. However, on the whole there were relatively few references to coordination with others, and ‘lack of coordination was indicated by several participants. For example:

“...staff not being on board; it won’t change the way I’m doing it because nobody else is really involved in it”

(theme: Lack of coordination)

This data supports the hypothesis that ‘Specific practices and processes’ are key variables in influencing intervention implementation. This study shows that in some schools, communication, shared decision making and formulation of tasks can be considered as a facilitator to intervention implementation, whilst in other school such factors can be considered as a barrier to intervention implementation. Coordination with other agencies is indicated to be generally limited across schools.

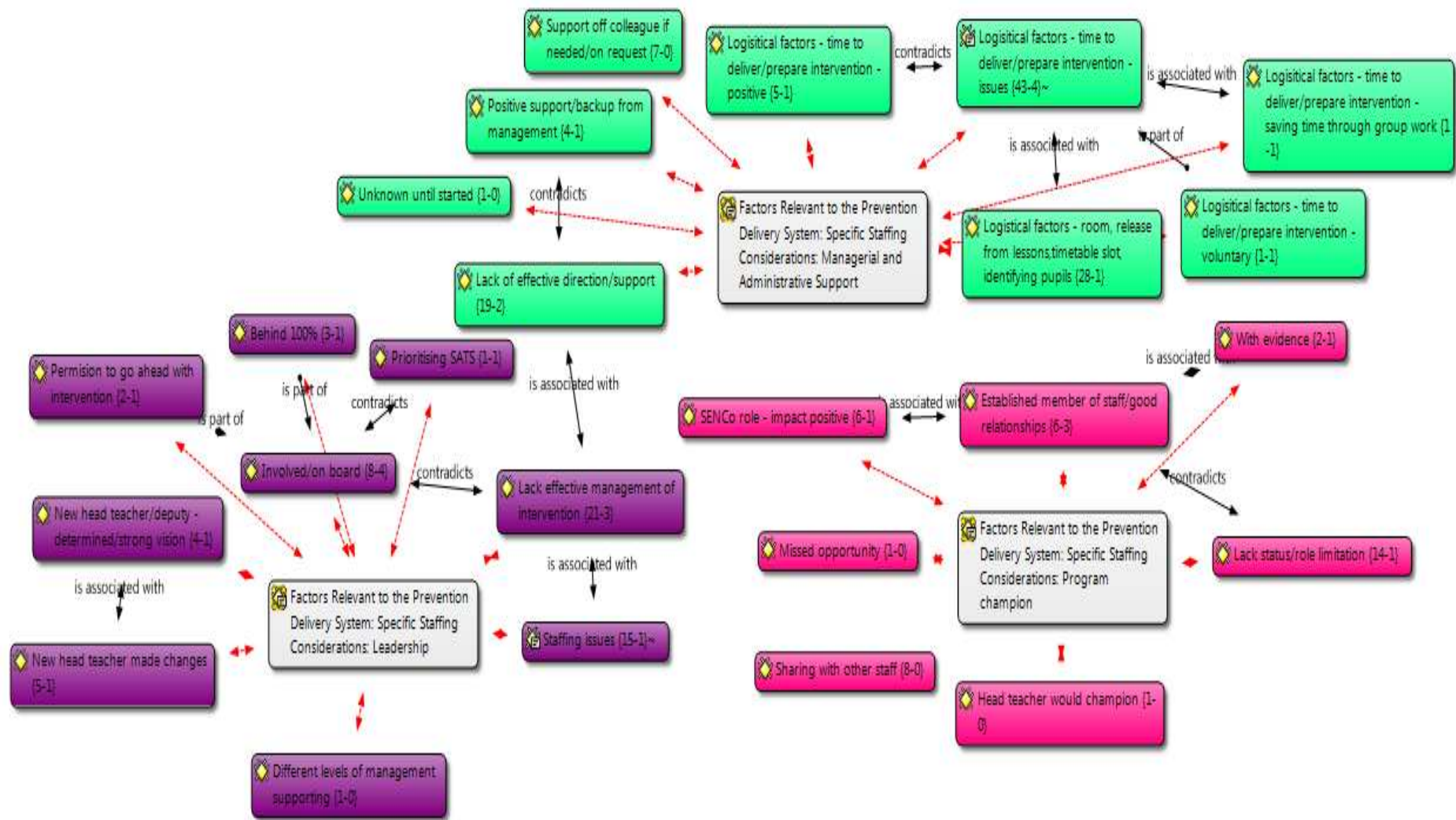


Figure 9: TA Network - Factors Relevant to the Prevention Delivery System: Specific Staffing Considerations

The following findings are in relation to Figure 9: 'Factors relevant to the prevention delivery system: Specific staffing considerations'.

The network 'Managerial and Administrative Support' (green) demonstrates how 'logistical factors' was a strong theme, in particular around staff being given the time and physical space to prepare and deliver the intervention but also in relation to timetabling and identifying children for the intervention. Whilst five references indicated that 'time' was a facilitator, over 43 indicated 'time' to be a barrier, in particular around time to prepare and evaluate the intervention. There were 28 references to issues/potential issues around room space, timetabling and identifying children for the intervention. These references represent all five schools. Overall, these factors indicate a lack of managerial and administrative support around setting up the intervention. Whilst such logistical factors are related to the wider theme of 'Factors relevant to the prevention delivery system: Specific staffing considerations', it is argued here that there is potential for 'logistical factors' to be an independent variable. This is discussed further under 'Summary Discussion'.

'Lack of effective direction/support' was only salient to S2, but was a strong theme. For example:

“...we haven't had all that much back up...It is a support mechanism ...we have been doing this for 11 weeks now and one person has asked me how it's going.”  
(theme: Lack of effective direction/support)

In contrast other participants referred to 'positive support from management'.

“I know that actually the head teacher is behind me 100% so I've always felt that...she's really gone along with my ideas and how I can develop my job, and supporting me all the way through” (theme: positive support/backup from management)

The network 'Programme champion' (pink) highlights issues around some participants experiencing 'lack status/role limitations' to champion the intervention effectively. Again this was only reported as an issue by S2. For example:

“It wouldn’t be my permission to do that [champion the intervention]...I would probably tell the teachers that I work with that I am doing it. If there is a student in there that I thought would benefit from it, I would maybe go and speak to their tutor or head of year, but I would have to be very careful about not treading on people’s toes. Because I usually have to go through my manager, who then has to go through her manager, who has to go through somebody else.”,

“I could only promote it to my line manager. Somebody within the department. Because if anything is said to people in higher up the hierarchy, it would always be: ‘you need to go to your line manager’, always.” and

“...each department has a line manager, that line manager goes to another line manager and says: ‘this is what we’re doing’...If we go to the head of department and say: ‘this is what we want to do, can we take the children out?’ it doesn’t carry as much weight. It’s not as important as if the line manager does it.” (theme: Lack status/role limitations)

In contrast other participants referred to themselves as being ‘established members of staff/good relationships’ or in roles that would facilitate them championing the intervention (see theme: ‘SENCo role – impact positive’). For example:

“...I have an awful lot of responsibility regarding my role and what I’m involved with in school...the teacher would want what I’m offering” (theme: Established members of staff/good relationships)

The theme ‘Sharing with other staff’ highlighted the intention of many participants to utilise the intervention at a wider organisational level, through sharing information with other staff in their school e.g. at staff meetings:

“Well I’m hoping in terms of doing a little bit of the staff meeting training with staff, just giving them some of the little techniques...just an introduction to what CBT is, what the intervention is, and an introduction to me doing a group intervention next year. Just to let them know what it will be about, so they can be thinking the children whom it would be useful for.” (theme: Sharing with other staff)

The network 'Leadership' (purple) highlighted some significant barriers, in particular around 'lack effective management of intervention' (only reported by S2), 'staffing issues' and 'prioritising SATS'; see themes to the right of the network. For example:

"We have had to go to SENCo and say we need time to plan the sessions, to reorganise the sessions and just to chat about what we feel because we don't get that, even setting up the sessions...no one has asked us what the issues are at all",

"...no one has actually asked us: 'is it working? Can you quantify it?' Because if that had happened we would done our homework better to start with and had more of a better list of criteria by which to measure health assessment things...we would have to justified what we are doing and why we are doing it and whether it's working" and

"We're at the minute floundering because we're making the decisions to whether we're doing it and what we're doing. We haven't got anybody taking control of that."

(theme: Lack effective management of intervention)

"I've been ... doing some extra supply cover for people who have been off sick so I'm hoping that next term I'll have time that I can set aside every week." (theme: Staffing issues)

In contrast S4 and S5 referred to effective leadership e.g. 'Involved' and 'behind 100%'. This was especially true for S5, who's head teacher attended the training. For example:

"In terms of the head having come on the training: I think that helped in terms of she knew what it was all about...I think she would have been supportive anyway, but I think because she enjoyed it and she was in to it, she got quite involved"  
(theme: Involved/on board)

To the left of the network are two codes which represent some schools having had new head teachers. These head teachers were referred to as being committed to change and having a strong vision, as indicated under 'Organisational factors'.

This data supports the hypothesis that ‘Specific staffing considerations’ are key variables in influencing implementation. In some schools, managerial, supervisory and administrative support, as well as programme champion and leadership, can be considered as a facilitator, whilst in other schools such factors can be considered as a barrier to implementation.



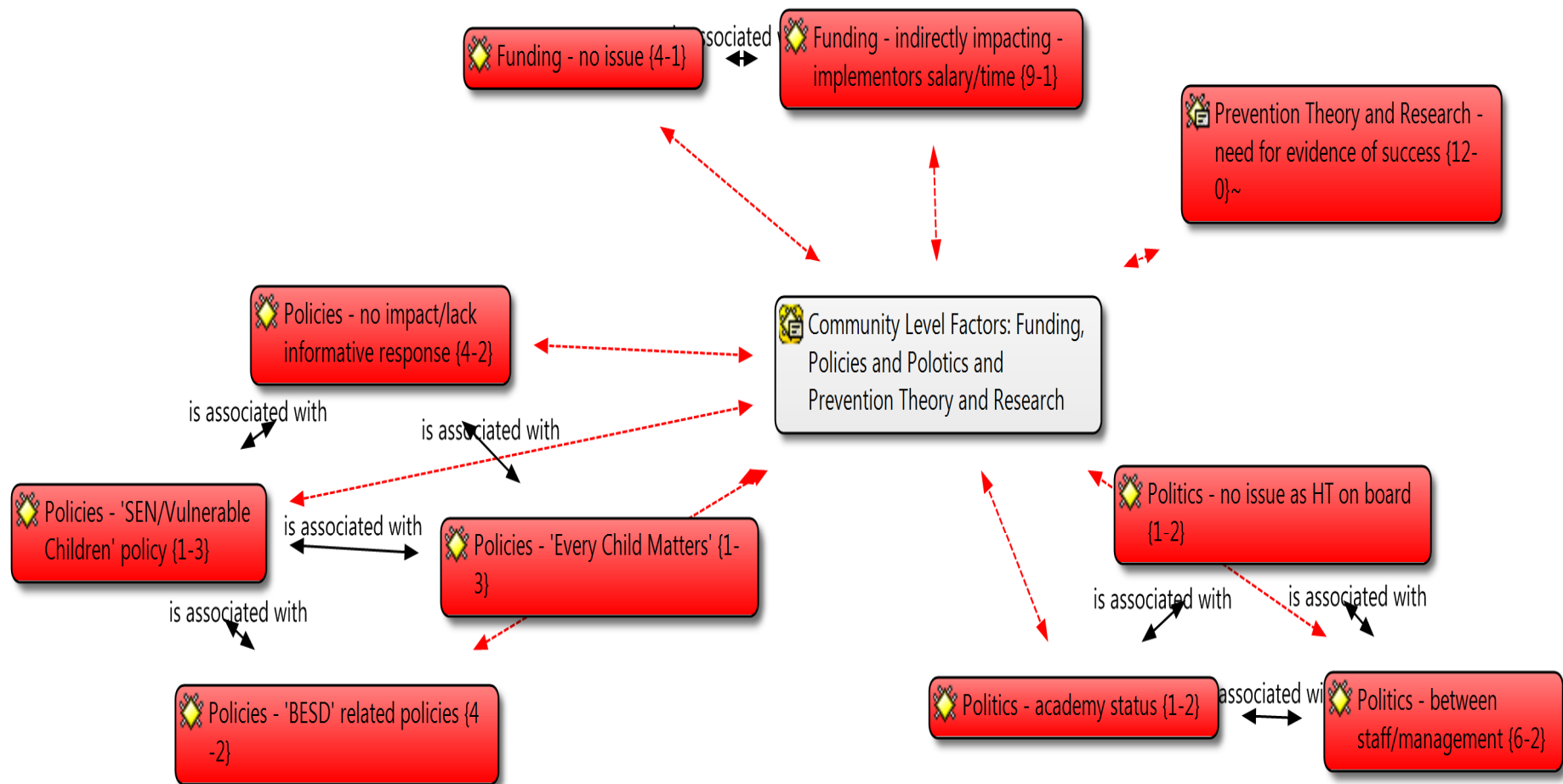


Figure 10: TA Network - Community Level Factors

The following findings are in relation to Figure 10: 'Community level factors'.

Politics, funding and policies were the weakest themes identified in the data, both in terms of the number of references and the depth of data gained. In response to questions about 'policies' and 'funding' (see top and left of network), most participants did not give informative responses or reported there being no issue around these factors in relation to the intervention. Funding was only reported as impacting on implementation indirectly; participants reported that without funding to pay their salaries, they would not be able to implement the intervention. The intervention was reported to fit in with existing policies, including 'SEBD' and 'Every Child Matters'. Most references to 'politics' (bottom right of network) were in relation to internal politics between groups of staff. This was particularly true for S2 where such issues were a barrier to implementation.

There were several references to the need for evidence of intervention success. For example:

"...because it's not proven methods, it's not traditional methods of intervention that parents would be aware of...it might be deemed to be a little bit 'new age'... until it is tried and tested and actually we can see an improvement in children's behaviour because of it, I think that is going to be the proof",

"If you're going to withdraw children from lessons for that length of time you've got to prove that it works." and

"...there's been a lot of very negative attitude towards this kind of intervention therapy because it's not something you can, you can't touch it, you can't see it, there isn't a direct result. It's actually getting down into the mind, into what's feeding these responses in children... you can't produce data necessarily from it" (theme: Prevention theory and research: need for evidence of success)

This data supports the hypothesis that 'Community level factors' are variables in influencing intervention implementation. However, policies, funding and politics can be considered relatively weak themes in the data compared to other themes identified.



The following findings are in relation to Figure 11: 'Provider Characteristics: Perceived Need for Innovation and Perceived benefits of innovation'.

The network 'Perceived Benefits of Innovation' (purple) demonstrates that participants reported the intervention being beneficial in a variety of ways. Whilst several references did not specify the nature of the benefits (see theme 'General e.g. valued and benefits individual children'), other themes to the right of the network indicate specifically what the benefits were perceived to be e.g. children having increased awareness/understanding of themselves, children having enhanced emotional literacy skills and children feeling empowered/improved self-esteem. Themes to the top of the network represent the potential for wider benefits of the intervention, such as addressing issues on the playground and addressing the root cause of problem/underlying cause of behaviour. Arguably the most powerful of the benefits reported was 'change the way speak to people/approach issue' as this indicates potential for the intervention to impact on the wider school community and potential for sustainable change. Moreover, this benefit was referred to by all schools apart from S3. For example:

"...school have put me in for a lot of training and I think it's probably the best training, the most useful that I've been on, because it's made such a difference to how I look at problems and sorting out a problem or just general chit chat to a child in the playground. It's not cut and dried, as you would normally just say: 'go and sort it out'...you would take a step back and think: 'how would I have done that?'"

"...it really have given me food for thought how I communicate with people" and

"...change the way that I speak to children and correcting myself, just by some of the things that you were telling us about in there [training room]" (theme: Change the way speaks to people and perceive/approach issue)

Other powerful references to benefits include:

"...it also heightens awareness of it...We all know that people do things for a reason, but the course just brought it to the forefront of, certainly, my mind and made me start thinking about one or two characters that I knew in school" and

“...thinking about the actual model is something I probably wouldn’t have done before....it’s something that perhaps you do naturally. Although you miss bits out of it. I would use that a lot more” (theme: Heightens awareness/thinking more)

“...it gave me much more insight into the pupil that I was talking to and helping...it was lovely to see us develop a better relationship, and that has continued throughout this year. The child actually talked to me in the corridor and he was very pleasant to me, where as that didn’t really happen...him and I have got a much closer understanding now as a result of it...he feels I get him. And I get why he does the things that he does, because he’s opened up and talked to me.” (theme: Children express themselves and Root cause of problem/underlying cause of problem)

“If I can put strategies in place for him, and it works for him, the teacher then hasn’t got to...takes up time from other children...So if I can help him put his little strategies in place ...that then takes the onus off the teacher, which then benefits the whole class, which then will benefit the whole school” and

“it would benefit the school quite well ...the other staff saw how other people were dealing with things, rather than ranting and raving or shouting at children. Maybe they might click onto there is another way of instilling a little bit of positivity...that would have a massive impact because it would just spread and spread and spread. If they saw how we were changing one individual they may be interested in seeing what was happening, and then we might go for 30 children in a class, then we might go to the Key Stage 1 assembly, then Key Stage 2...” (theme: Wider benefits e.g. whole class/whole school)

To the bottom of the network are themes that represented participants being sceptical about benefits of the intervention. There were several references to lack of intervention evidence/outcome measures as yet, or being sceptical due to the time frame of the intervention, thus indicating that the benefits could become more evident over time. One theme highlighted concerns in relation to the intervention; a disclosure during intervention had resulted in safeguarding procedures being implemented, which participants felt had impacted negatively on their relationship with the child:

“...we had an issue with one of the students that we had reported; that really put a downer on it for me, because I think the child suffered because of it.” (theme: Sceptical – concerned)

In this sense, the concerns were more around the safeguarding procedures than the intervention per se.

The network ‘Perceived Need for Innovation’ (pink) demonstrates a range of perceived need for the intervention, ranging from there being several children with poor emotional literacy skills to there being conflict during unstructured times. One theme relates to the need to address home issues; this was reported from schools with relatively affluent catchment areas (e.g. S5), and schools with relatively low-economic catchment areas (e.g. S3), for different reasons. For example:

“...typically there are not a lot of behavioural issues in this school because of the catchment area that the children come from: both supportive parents, pretty affluent area. So there’s not some of those problems that may occur in other schools, but ...that kind of background has its own coherent problems: parents who are really busy, perhaps working, children go to clubs, perhaps don’t get the attention, perhaps don’t get the emotional support from parents...” and

“...this community have pockets of very depressed families, a lot of social issues ...you have got to sort out the things that are troubling them...the intervention will give them strategies to understand why they are feeling like they do...if you are able to discuss it with them and then give them the vocabulary, the ability to discuss it”

(theme: Address issues related to home)

The themes ‘perceived need for intervention: whole school’ and ‘preventative/low level’ highlight potential for the use of CBI at a wider level, with all children. For example:

“It’s got to be helpful for every child to be able to understand the differences between ...the thoughts and the feelings and the impact on their behaviour... if we could make every child articulate about their thoughts and feelings, and have a

greater understanding of that, and the things they want to do as a result of those thoughts and feelings, I would say have to have a massive impact upon the general behaviour within classes and within school environment.” (theme: Perceived need for intervention: whole school and Preventative/low level)

The most referred to need was around its use with individual children and some themes highlighted the types of individual difficulties that the intervention was perceived to be needed for.

This data supports the hypothesis that ‘Provider Characteristics: Perceived Benefits of Innovation and Perceived Need for Innovation’ are key variables in influencing intervention implementation. A variety of benefits and needs for the intervention were identified. Some participants were sceptical about the benefits of the intervention.

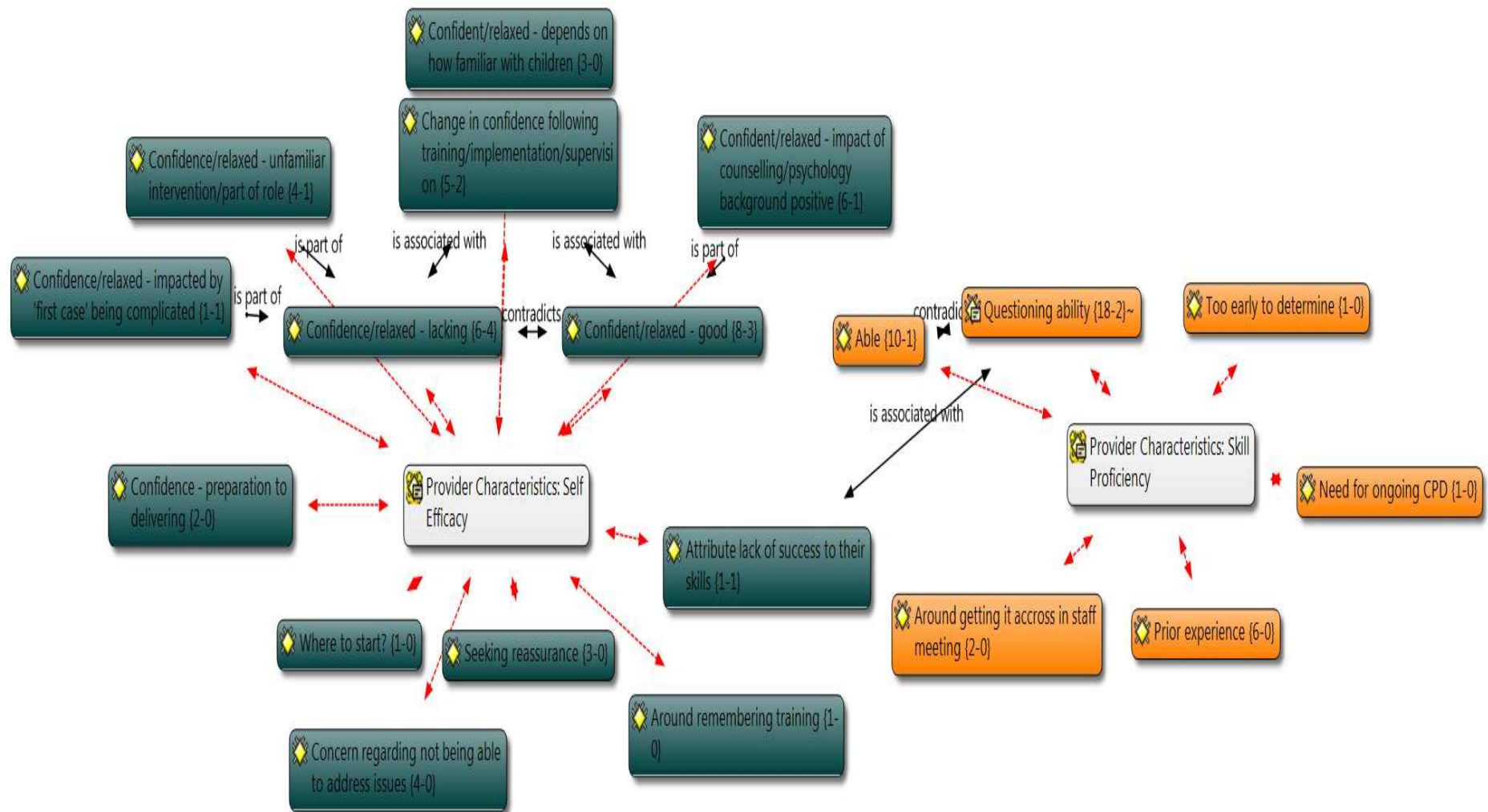


Figure 12: TA Network - Provider Characteristics: Self-efficacy and Skill Proficiency



The following findings are in relation to Figure 12: 'Provider Characteristics: Self Efficacy and Skill Proficiency'.

The network 'Self Efficacy' (blue/green) demonstrates how participants ranged in terms of how confident they felt around intervention implementation, with around half of the references indicating participants feeling confident (top right of network) and around half indicating participants lacking in confidence (top left of network). Examples of this are:

"I feel confident in doing it" (theme: Confident/relaxed: good)

"...a bit wobbly because there was so much information that you need to take in on them four mornings" and "I'm probably able but not confident" (theme: Confident/relaxed: lacking)

Two participants from S5 and S4 referred to their counselling/psychology background and this was felt to be a facilitator to their self efficacy. For example:

"I had worked with children before in a therapeutic way, so I feel quite confident doing that" and "If I'm coming from it as though I've never done any counselling before I would feel less confident" (theme: Confident/relaxed – impact of counselling/psychology background positive)

Interestingly one theme was around confidence growing over time, following training/implementation/supervision. Some participants lacked self efficacy in terms of their perceived ability to: address issues; remember the training; and 'know where to start' with the intervention. These themes highlight the potential benefits of supervision/support for participants around enhancing self efficacy. For example:

"When we started neither of us were confident...in our knowledge to deliver the sessions, but because we have done it between us we have been able to each say: 'you were really good when you said that'. We backed each other up and I think we found that we had more knowledge from the training than we gave ourselves credit for...but I don't think it would have been as easy without supervision.

‘That’s helped because we have been able to come back and say: ‘this hasn’t worked’ and actually get some advice on how to carry on with it.” and

“The confidence just came from that extra bit of applying it to a particular child with some supervision from yourself... I would have probably been able to do it without that but would have been a bit more: where do I go next?”

(theme: Change in confidence following training/implementation/supervision)

Some participants attributed lack of success with the intervention to their own skills (rather than external factors). This is associated with the wider theme ‘Skill Proficiency’ (yellow network), in particular the theme ‘Questioning ability’.

The network ‘Skill Proficiency’ (yellow) demonstrates a contrast between references which indicated participant skills as being effective (e.g. participants made effective decisions and demonstrated effective use of intervention) and references which indicated participant skills as being questionable. For example:

“...some bits I could tell she just wasn’t getting at all, so we adapted that and in the end we went down the ‘problem solving model’, because she was just on the edge of being old enough to understand, and she was still getting a little bit mixed up with thoughts and feelings, even though we went through those a few times in different ways. So the problem solving model seemed to help more for her”

(theme: Able)

“I was concerned that: is it us? Or are they just not getting it? We had the basket ball game out loads, they seem to get it when you talk about it but then come back the following week, and it’s completely gone...Every single time...that’s why the sessions have gone on and on...the fact that we have to go over that initial thoughts, feelings: what’s this? what’s that? takes up probably a third of the session each time” (theme: Questioning ability)

Several references for the theme ‘Able’ came from the two participants with additional training in Psychology/therapeutic interventions, thus implying that prior training in such fields is a facilitator to implementation. Finally, one theme was around participants feeling insecure

about their skills in relaying the intervention to staff through staff meetings, thus impacting on their ability to champion the intervention.

This data supports the hypothesis that 'Provider Characteristics: Self Efficacy and Skill Proficiency' are key variables in influencing implementation. Participants indicated having mixed levels of confidence. Participants were also indicated to have a range of skill levels.

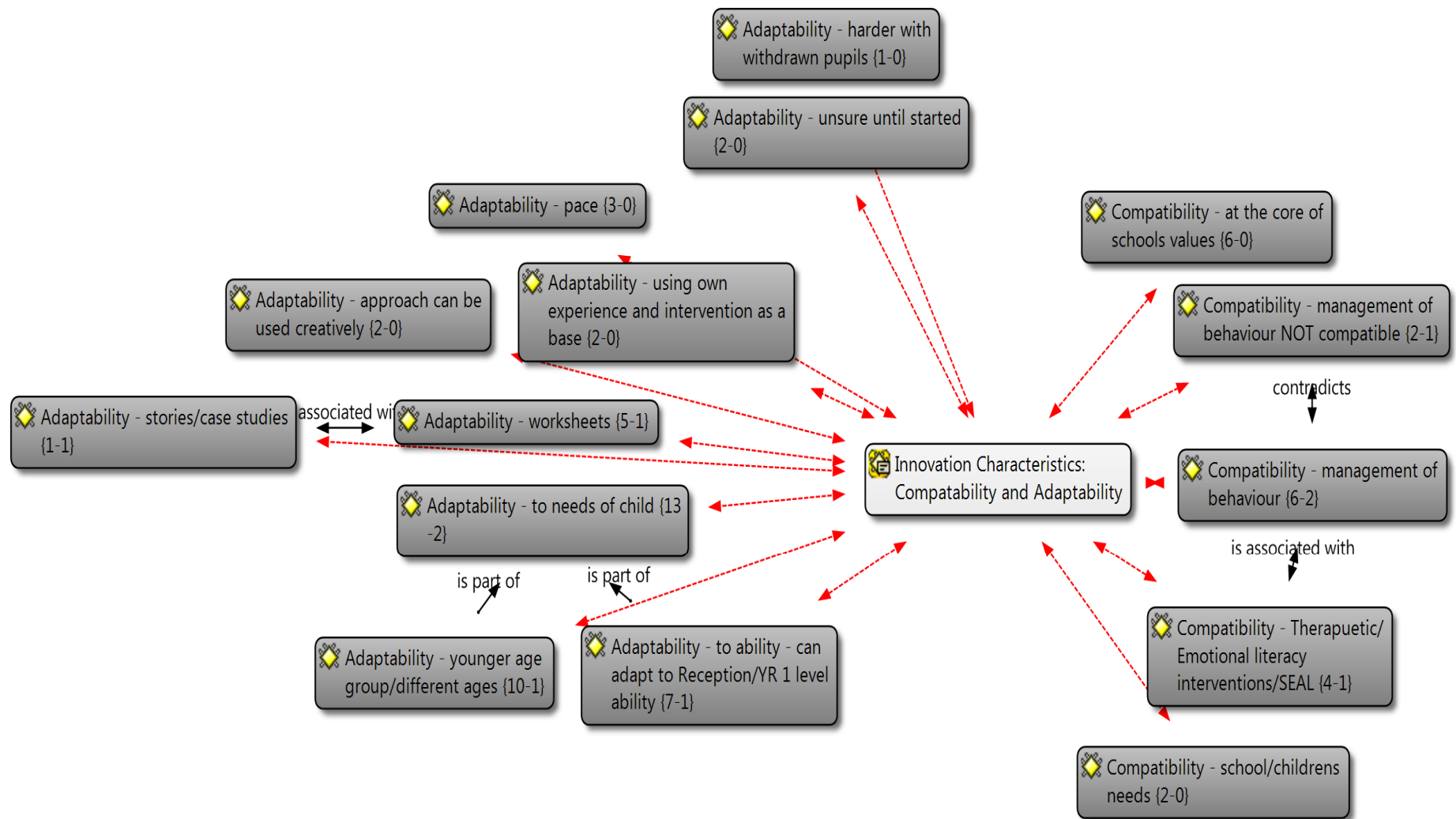


Figure 13: TA Network - Innovation Characteristics

The following findings are in relation to Figure 13: 'Innovation Characteristics: Adaptability and Compatibility'.

Themes related to 'compatibility' are represented to the right of the network. They demonstrate how, in some cases, the intervention was compatible with both other interventions implemented within the school (e.g. SEAL), existing behaviour management approaches and with core values of the school. For example:

“...it might be in the policy but more of the teachers here also genuinely care about the children and their emotional development as well as their academic development” and

“...the fact that the head teacher was so committed to it shows that that's something that's really important to her and it fits with the school's values, because it's 'looking after yourself and others in the environment', so...it fits very much” (theme: Compatibility: at the core of school values)

It is argued here that in these cases there is greater potential for the intervention to be embedded successfully within the school.

Themes related to 'adaptability' are represented to the left of the network. All themes demonstrate that participants either felt the intervention to be adaptable, or were unsure until they had started; there were no themes to indicate that the intervention was not adaptable. Methods of adapting the intervention included adapting the: pace; worksheets; and stories/case studies within the intervention. Examples of wider intervention adaptability are indicated through references to using the intervention creatively or as a base, drawing upon other therapeutic approaches/experiences where appropriate. For example:

“If she seemed more upset in a session about something, or was struggling, or wanted someone to talk about something, I can deal with that more from a person centred approach. I suppose the first few sessions were more directly for the CBT, and more educationally involved...but then it developed from that, and I put my own material” (theme: Adaptability – using own experience and intervention as a base)

There were several references to indicate adaptability of the intervention to the needs of individual children, of different ages and abilities in particular. For example:

“...there are some things that go across the age and ability range like coping, self talk or relaxing...even small children would be able to cope with that” and “I would feel confident adapting it to different ages” (theme: Adaptability: younger age group/different ages)

“We found it fun because we turned it into a game: the game would be identifying the feelings in story... early years stories that actually cover underlying morals or emotional issue, and I think it’s very easy to implement it through that in a very discreet way.”,

“ one of the children I work with has problems with speech ... and she gets a lot out of it...I don’t think ability matters because you can adapt it” and

“... one of the children that I work with in my class really struggles with his communication, but ...I think it could be lowered down enough for him to work with it ... there’s definitely scope for movement with it.” (theme: Adaptability: to ability: can adapt to Reception/Yr 1 ability)

“I started off doing it more by the book, and then gradually adapted it for the specific child...I found it quite good to adapt, there was quite a lot of stuff that you can go with, so you can take it in different directions” and

“...that’s what’s great: there are no specific barriers, no rule, it is open to interpretation by a practitioner and you can tailor it to a particular package, to the needs of a child” (both: Adaptability: to needs of child)

This data supports the hypothesis that ‘Innovation Characteristics: Compatibility and Adaptability’ are key variables in influencing implementation. In this study, these factors were perceived to be facilitators.

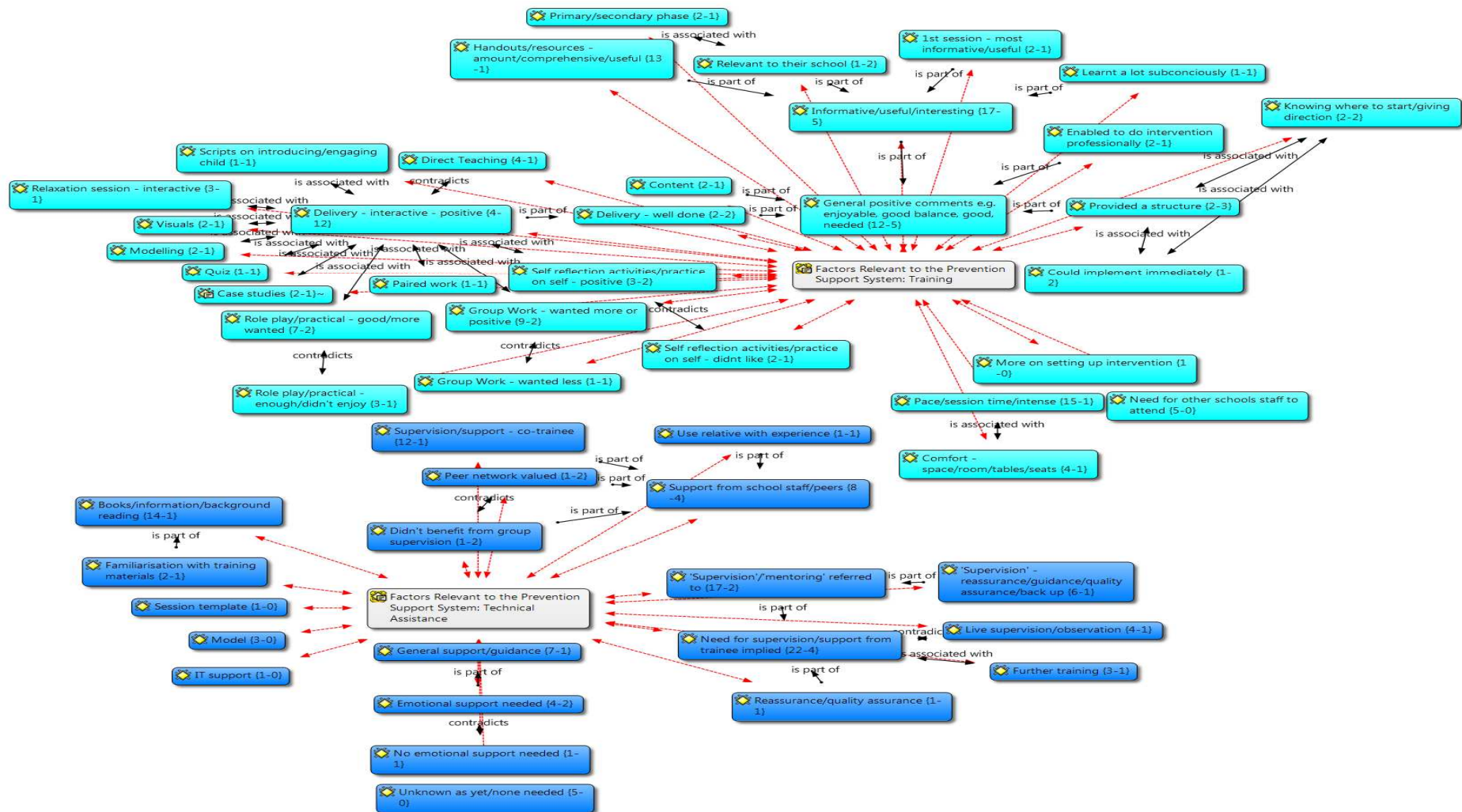


Figure 14: TA Network - Factors Relevant to the Prevention Support System: Training and Technical Assistance

The following findings are in relation to Figure 14: 'Factors Relevant to the Prevention Support System: Training and Technical Assistance'.

The network 'training' (turquoise) demonstrates: a range of positive themes in relation to the training (to the top of the network); a range of themes associated with the delivery of the training (to the left of the network); and some suggested improvements for the training (bottom right of network).

In terms of positive themes about the training, whilst one theme represents 'general positive' references, other themes represent more specific references to the training e.g. 'enabled to do intervention professionally', 'could implement immediately' and 'provided a structure' for the intervention. The themes indicate the training to have been a facilitator to intervention implementation, particularly when the range of positive references is considered. In particular, there were several references made to the intervention being 'informative/useful/interesting' and around 'handouts/resources – amount/comprehensive/useful'. Examples are given below:

"The training was very useful, it was great; a load of information and it will definitely be useful for me" and "...definitely gave all the information that I needed" (theme: Informative/useful/interesting)

"...you gave so many materials...there's plenty within there that I can adapt or use with the children" and

"...the activities that you have provided...I remember that they were very good...just the kits that you gave" (theme: handouts/resources – amount/comprehensive/useful)

"I felt ready to do it afterwards...I started it straight away and I felt quite confident" (theme: could implement immediately)

"...the problem with having a book is that you would never read it cover to cover, so I think having that background, being able to ask questions, it's been useful.



Given a better understanding...I don't think it would be very professional to do it without the training" (theme: enabled to do intervention professionally)

The themes refer to several delivery methods used within the training, including: role play; quiz; modelling; direct teaching; group work; and self reflection. Different participants preferred different methods. This demonstrates that the training met a variety of training style preferences and highlights the need to address different learning styles when planning training. Below are examples of different perceptions of the training methods used:

"I like learning. I like somebody talking to me if it's something I'm interested in. So for me it worked",

"All of the input on the slides and the printouts were all really useful ... the teaching bits all really useful" and

"The reading of the slides. I didn't really see the point of that...but again that's just a personal preference and everybody's completely different." (theme: direct teaching)

"Two Educational Psychologists that led it were super in their delivery, made it very interactive. Sometimes when you participate in things you sit and you listen and you don't actually take things in but at all times we actually felt that we were part of it" and

"...a very hands-on approach....the whole course" (theme: delivery interactive – good)

"I didn't like the bit where ...we had to talk about our own coping strategy, where you had to say something about where you don't cope very well, and I felt stupid because mine was flying, and we're not very good at looking into ourselves" (theme: self-reflection activities/practice on self – didn't like)

"...the fact that I've had to do it myself is now making me do it with a child I'm working with" (theme: self-reflection activities/practice on self – positive)

Themes that suggested changes to the training, included: ‘pace/session time/intense’, ‘comfort –space/room/table/seats’ and ‘need for other school staff to attend’. There were several references to the need for the sessions to be longer or for more time in between sessions. For example:

“I found it quite heavy in the sense that when I walked out from it I had to go through everything I’d been given... although I did actually enjoy it...to take everything in that morning: I thought more time over a period” and

“Some part of it, it seemed that we were trying to cram such a lot in, in the small time that we had” (theme: pace/session time/intense)

The network ‘technical assistance’ (blue) demonstrates a cluster of themes that imply the need for supervision/support from the trainee (middle right of network). Themes around support from colleagues/peers are found to the top of the network, themes around other types of technical assistance are to the left of the network and themes related to general technical assistance or emotional support are to the bottom of the network.

Themes around the need for supervision/support from the trainee were relatively strong, with several general and specific references made, including themes around participants need for ‘live supervision/observation’, ‘reassurance/quality assurance’ and ‘further training’. For example:

“If I uncovered some real deep seated thinking errors from somebody, I would probably need to get support or reassurance from someone more senior like yourself: ‘I’m not sure which direction to take this, can you give me some advice?’”

Trainer/interviewer: What support and resources do you feel that you’ll benefit from once you’ve started delivering the intervention?

Participant: You...speed dial!

Trainer/interviewer: What kind of support do you think I’d be able to offer?

Participant: ...reassurance that what we're doing is right or if we get something that we're not quite sure what to do with" (theme: Need for supervision/support from trainee implied)

"... if you did come up with another training session...other things that you couldn't squeeze in would be helpful, with maybe practical sessions in it, to check what we are doing is right" (theme: Further training)

Participants referred to support being available or needed from school staff/peers. Several participants valued support from the colleague that had participated in the training with them. Co-trainees from S2 implemented a group intervention together:

"We have managed to support each other...we are very good at saying: 'that didn't work very well' but then say to each other: 'you were really good when ....', so we can back each other up" (theme: Supervision/support – co-trainee)

This highlights the benefit of having two trainees from each school on the training, and it implied that this is a facilitator to intervention implementation.

Other forms of technical assistance represented by the themes included participants feeling the need for 'familiarisation with training materials' and to utilise 'books/information/background reading'. Participants were keen to purchase and utilise the two books which formed the basis of the training. These themes were evident across schools and indicate that participants were motivated to enhance their skills/knowledge further around the intervention. Emotional support was not frequently implied or referred to. However, when it was, it is indicated to be a potentially significant facilitator to implementation. For example:

"...emotional support I think is really important particularly if you've got a child that's very troubled you need somebody to talk to. You need to check you're doing the right thing, and to offload...I think it is important for your own well-being...on a day to day basis it does grind you down" (theme: Emotional support needed)

This data supports the hypothesis that ‘Factors relevant to the prevention support system: Training and Technical Assistance’ are key variables in influencing implementation. On the whole, training was perceived positively and thus can be considered a facilitator to implementation. The findings highlight the value and need for supervision and support following training.

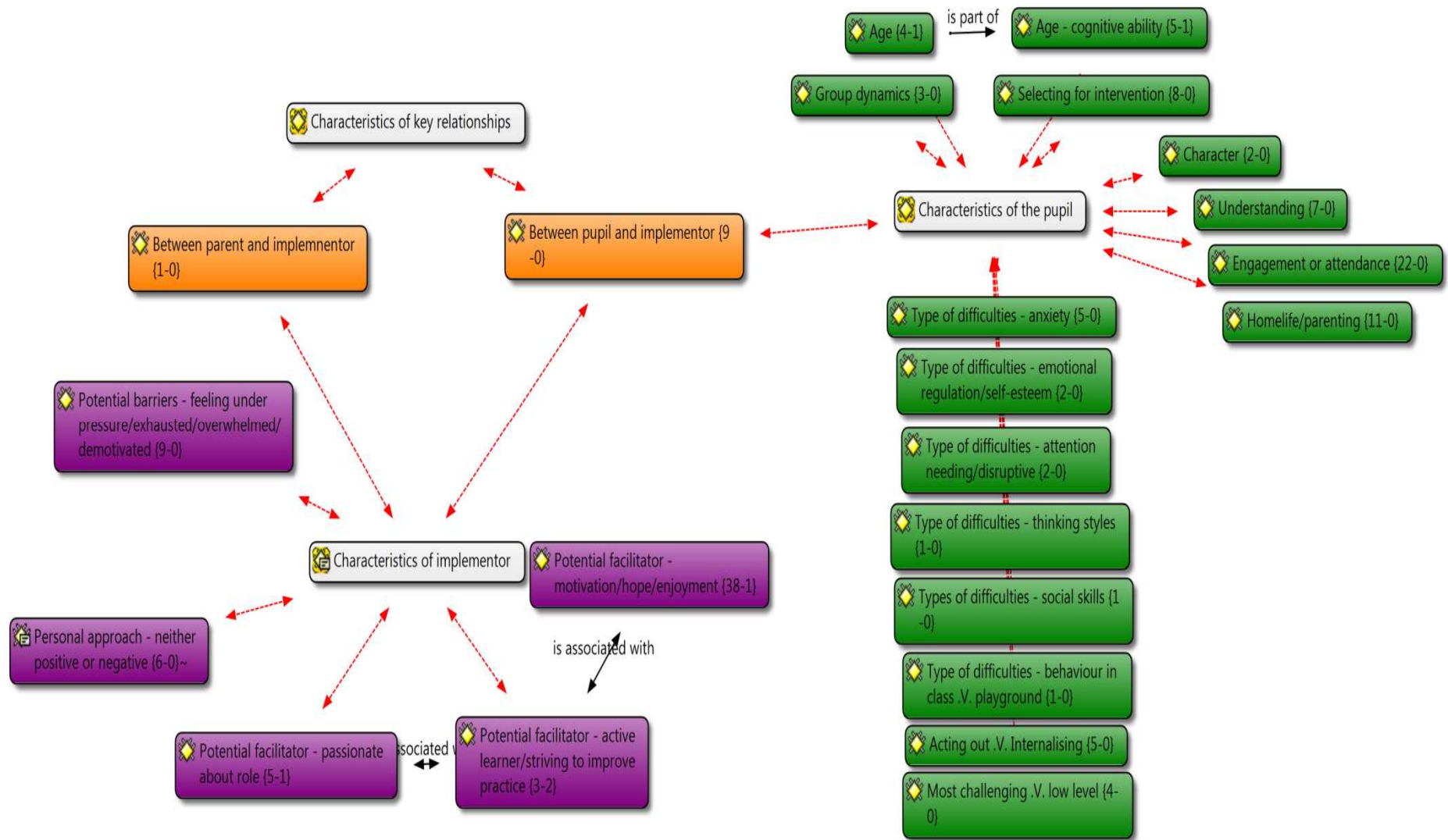


Figure 15: TA Network - Characteristics of Pupil, Implementer and Key Relationships

The following findings are in relation to Figure 15: ‘Characteristics of pupil, characteristics of implementer and key relationships’.

These themes emerged from the data as being potential facilitators/barriers to intervention implementation; they are in addition to factors identified by Durlak and DuPre’s model of intervention implementation. The themes demonstrate how characteristics of the: implementer (purple); pupil (green) and relationship between implementer and pupil and implementer and parent (orange) could impact on implementation.

Themes under ‘Characteristics of implementer’, which can be considered as facilitators to implementation, were around participants expressing motivation/enjoyment/hope in relation to the intervention and participants being passionate or active learners/striving to improve in relation to the intervention. For example:

“I find it fascinating trying to get an understanding of why people behave in the way that they behave, why children behave in a way they behave, how their cognitive development as they move through the school has an impact upon that independently, but the things that we can do via: intervention; talking; one:one work to help them on the right path...I’m really very keen to progress this in some way shape or form” (theme: Motivation/hope/enjoyment)

In contrast, a strong theme that can be considered a barrier to implementation was around implementer feeling under pressure/overwhelmed/de-motivated. This was a particularly strong theme for S2. For example:

“...I have not really enjoyed it, probably because I have not seen those instant results. Maybe that’s just me as a person that needs to see that instant result from it.” (theme: Feeling under pressure/exhausted/overwhelmed/de-motivated)

Strong themes under ‘Characteristics of pupil’ were around the nature of children’s difficulties, ranging from difficulties with ‘social skills’ to ‘attention needing/disruptive’. Several participants distinguished between children with internalising or externalising difficulties, with contrasting views around which type of difficulty the intervention could be most effective with. Overall, these themes indicate that the intervention was perceived as being suitable for a

range of difficulties. It raises debate around whether different pupil presentations might act as a barrier or facilitator to intervention implementation. Similarly, pupil: character; engagement; attendance; age; understanding; and cognitive ability were identified by participants as potential barriers/facilitators. For example:

“I’m in reception: there is a problem there in itself...where the children are very hard to get them to articulate why they do the things that they do because they can’t differentiate between how they feel, how they think, and how that impacts on what they do in their behaviour.” And

“The child that I’m working with is eight coming on to nine and from what I’ve worked with her before, I think she’s at a level where she will get it but I’m aware that it might be a little bit too early for her. The other child is Year 5 and I think he will probably get it” (theme: Age – cognitive ability)

“Last week’s session was fabulous...particularly when you’ve said that at that age they are not...I did expect a lot of muddling between the thoughts and the feelings” (theme: Age)

“The pupil I was working with was a good first candidate because she was really keen...I didn’t feel I was pushing her, she was actually enjoying it and she looked forward to coming out, and she looked forward to doing tasks at home” And

“...the people that you’re working with will have the most impact on it, because if they don’t want to do it...they’ll shape if we do it or not, or how you do it, how often you do it” (theme: Engagement or attendance)

The dynamics of the intervention group were felt to influence implementation for S2, whilst the children’s home life/parenting was a theme that emerged for several schools. For example:

“...the children I’m thinking of working with, they’ve got issues beyond the school setting that are impacting on their learning and their behaviour.” And

“We have so many social issues behind what’s going at the ‘chalk face’...when they’re given structure they respond to it and it’s the un-structured situations which you feel are similar to what’s happening at home. They’re not given those boundaries and they just don’t know how to relate to others in certain situations”  
(theme: Home life/parenting)

The relationship between the pupil and implementer was a theme that emerged and which is argued here to act as an important factor in the success of intervention implementation. A weaker but nevertheless relevant theme was identified around the implementer and parent relationship; it is argued here that a positive relationship would enhance implementation success.

This data supports the hypothesis that characteristics of the implementer, pupil and their relationship are key variables in influencing implementation. Such factors are discussed further, in relation to Durlak and DuPre’s model, under ‘Summary Discussion’.



## 5. Analysis of Training as a Facilitator/Barrier

Training evaluations provided further analysis of Durlak and DuPre's: *Factors relevant to the prevention support system: Training*' (described earlier). Indeed, Durlak and DuPre argued that training is one of two key elements of the Prevention Support System that lie at the centre of effective implementation. Data gathered from trainees is summarised below under 'Qualitative Data Summary' and 'Quantitative Data Summary'.

### *Quantitative Data Summary*

Whilst 30 trainees from 16 schools took part in the training, attendance at each training session, and completion of evaluation forms, was not consistent. Table 14 below demonstrates the number of evaluation forms completed for each training session.

**Table 14: Number of Training Evaluation Forms Completed**

	Session 1	Session 2	Session 3	Session 4
Cluster 1 & 2 combined	30	30	26	25

Table 15 below represents trainee ratings, based on their 'overall' impression of each training session. Trainees also rated the: 'content', 'handouts' and 'delivery style' for each session: these ratings are not presented as they offer similar findings to the 'overall ratings'.

**Table 15: Trainee Ratings for each Training Session**

	Rating 1 (worst)	Rating 2	Rating 3 (average)	Rating 4	Rating 5 (best)
<b>Session 1</b>	0%	0%	0%	33%	67%
<b>Session 2</b>	0%	0%	7%	31%	62%
<b>Session 3</b>	0%	0%	4%	38%	58%
<b>Session 4</b>	0%	4%	0%	24%	72%

Session 4 can be considered most representative of trainees' perceptions of the training since the training was progressive and cumulative in nature; trainees needed to have experienced all four sessions to fully benefit from the earlier sessions. Table 15 demonstrates that the majority of trainees rated each session as '5 out of 5', and most other trainees rated each session as '4 out of 5'. The 4% who rated Session 4 as '2 out of 5' represents one school's response; further analysis revealed this to be a special school and that the materials presented had been more difficult to adapt for the needs of this school.

## *Qualitative Data Summary*

TA was carried out to analyse trainee responses to each qualitative question asked on the training evaluation forms. Themes that emerged are reported below each question.

### **1. What they liked most about the sessions?**

- Understanding of CBT
- Training delivery style
- Group discussion
- Handouts
- Provided activities/strategies to deliver
- Course being interesting/informative
- Feeling enabled

Quotes included:

‘Interesting and informative delivery, a good balance of theory and discussion’

‘I am really enjoying these sessions. They are very informative’

‘Dead applicable and now have clear idea of how it’ll work as intervention with individuals, groups and a particularly challenging class’

‘Plenty of resources to take back to school to practice and refer back to’

‘Today really brought everything together and helped me to see big picture of what an intervention would consist of and how it would be implemented.’

### **2. What could have been better?**

- Nothing could be better (x5)
- More time
- Less reflection on homework activities

Quotes included:

“Felt it was a little rushed in places, time for course should perhaps be longer”

**3. What will you do differently as a result of this training?**

- Implement strategies/activities
- Use different approach about children and their difficulties
- Implement one to one
- Group or whole class interventions
- Evaluate interventions
- Introduce strategies/approach to colleagues

Quotes included:

‘Start to consider more carefully the reasons behind certain behaviour’

‘Clearer understanding how to support all children’s behaviour patterns through feelings, thoughts and behaviours’

‘Try and use these strategies day to day when dealing with challenging children’

‘Evaluate my own thoughts patterns’

‘I will take a wider view of a situation /scenario and think of CBT and try to implement it where possible’

‘Try to differentiate between feelings and thought and be aware of the impact these have on the behaviour of our children’

## Summary

The quantitative and qualitative data supports the hypothesis that the training was, overall, a facilitator to trainees implementing the intervention. The majority of trainees rated the training as '4 or 5 out of 5' and they reported on plans to use the intervention in a variety of ways, including on a one to one, group or whole class basis. Themes around what trainees liked about the training included them: feeling enabled; understanding about CBT and; having found the training informative. Arguably one of the strongest indicators that the training was an effective facilitator to implementation was the theme around trainees approaching pupil's difficulties differently following training: it could be argued that such a change is more likely to be sustainable than implementation as a structured intervention. That is, it indicates that the training had changed the way trainees would behave and think about children on a wider level.

Many trainees could not identify how the training could be better. For those who did, adjusting the length and/or timings of the sessions was key to improving the training: it follows that the length/timings of training may act as an indirect facilitator/barrier to implementation.

Training evaluation data presented under RQ 1 also supports the hypothesis that the training was a facilitator to intervention implementation.

## ***6. Analysis of Supervision as a Facilitator/Barrier***

Evaluation of supervision provided further analysis around Durlak and DuPre's: *Factors relevant to the prevention support system: Technical Assistance* (described earlier). Indeed, Durlak and DuPre argued that technical assistance was one of two key elements of the Prevention Support System to lie at the centre of effective implementation. The 18 individual supervision sessions were evaluated as follows:

1. Supervisee's were asked to: rate each session out of 5 (with 1 being least effective and 5 being most effective); identify the most and least useful element of the session; and identify actions to improve the supervision process.
2. The supervisee and supervisor identified the supervisee role, focus and medium used.
3. The supervisor identified the type of supervision support given: Educative (advice, skills and knowledge through reflection and exploration of work), Managerial (check working correctly and ethically and will have desired effect on client – quality control aspect) or Supportive (emotional needs addressed).

### *Key Findings*

See Appendix Q for the collated raw data. Below is a summary of the data, organised under the three sources of evaluation described above:

1. 100% of supervision sessions were rated as '5 out of 5', thus indicating that trainees perceived supervision to be effective. However, it should be noted that the supervision records were completed in the supervisor's presence; supervisee's responses might reflect a bias towards pleasing the supervisor. Supervisee's positive ratings were also supported by comments around what they found to be most and least useful; only one supervision session highlighted a 'least useful' factor and this was in relation to them needing more supervision time. In contrast, all supervision sessions highlighted factors that had been 'most useful'. Useful factors included supervisees gaining: reassurance, support to plan next steps, support to become unstuck and support to adapt the intervention.

2. The supervisor implemented all three types of support – educative, managerial and supportive supervision types, although ‘educative’ was the most frequent (used in every session).
3. The most common supervision role used was ‘inform-assess’ which can be considered as more direct advice-giving than, for example, ‘listen-reflect’.

Overall, the evaluation data indicates that individual supervision is valued and may be a facilitator to enhancing participants’ skill proficiency.

## **RQ 3 - Summary Discussion**

### **What are the barriers and facilitators to school staff implementing CBI?**

All factors identified by Durlak and DuPre as being key to influencing intervention implementation were supported by the data in this study. Each of these factor categories will now be considered in relation to key findings in this study. Following this, additional implementation factors identified in this study will be discussed.

#### Factors relevant to the prevention support system: training and technical assistance

Training, supervision and support were identified as themes by the data in this study. Overall, training and supervision were considered as facilitators to intervention implementation. Trainees and supervisees rated the training and supervision sessions highly and a range of positive themes were identified. As Durlak (1998) points out, good training is critical to good implementation and ongoing supervision are often essential once the intervention begins. Durlak also points out that many successful programmes emphasise opportunities for peer collaboration and problem-solving. The support provided in this study mirrored these methods of support (e.g. group supervision and network support between schools).

Themes that emerged from the data indicated that the training facilitated participants to feel: enabled to implement the intervention professionally, that they understood about CBT and that they could implement the intervention immediately. This counteracts Stallard and Buck (2013) suggestion that teachers delivering CBT interventions may not feel skilled or knowledgeable about CBT, and is in line with Greenberg (2005) and Durlak and DuPre (2008) who state that training should enable trainees to be knowledgeable, skillful and confident in their ability to implement the programme effectively. Participants were indicated to have found the training informative/useful; in particular the handouts and resources provided were valued. Trainees reported that they would change their practice as a result of the training, including through implementing the intervention in a variety of ways and through changing the way they approached children and issues. The latter in particular is seen as a strong indicator that the training was a facilitator to implementation as it could be argued that such a change is more likely to be sustainable than implementation of the intervention merely as a manualised intervention. That is, it indicates that the training had changed the way trainees

would behave and think about children on a wider level. The training venue, training session pace/length and need for other school staff to attend the training were identified as factors that could be improved. There were several references to the need for the training sessions to be longer or for more time in between training sessions.

Participants referred to several training delivery methods used, with different participants preferring different methods. For example use of: role play, quiz, modelling, direct teaching, group work and self reflection were referred to in the training. This demonstrates that the training met a variety of training style preferences and highlights the need to address different learning styles when planning training. Indeed, Pettigrew et al. (2013) found that when teachers balance student directed learning (e.g. activities, role play) with teacher-directed instruction (e.g. lecture, demonstration), children showed a higher range of participation. Sanetti et al. (2013) propose using strategies to enhance implementer's self-efficacy and their intentions to implement, which include modelling, role play and motivational consulting. These strategies were used as part of the training and supervision provided in this study. The training used some active forms of learning (e.g. role play) which Durlak and DuPre (2008) argue promote skill acquisition.

Themes around the need for support from the trainer/supervisor beyond initial training (e.g. in relation to supervision and further training) were relatively strong. Participants also referred to support being available or needed from school staff/peers. More specifically, several participants valued support from their colleague that had participated in the training with them. This highlights the benefit of training at least two trainees from each school, and it implied that this is a facilitator to implementation. Some trainees indicated the need for trainees to come together on a regular basis to problem solve around their interventions (peer supervision). Consequently, the researcher set up ongoing 'self-facilitated' problem-solving networks between the clusters of school. This concurs with Harris et al. (2013) who argue the importance of strengthening network capacity for successful intervention implementation and Greenberg et al. (2005) who argue that programme implementation is enhanced by a supportive, problem solving atmosphere.

Participants' need for 'support' was a theme identified in this study. Data revealed participants ranging in how much support they needed in relation to delivering and adapting the intervention. Participants with additional experience/training in Psychology/therapeutic



interventions were perceived to be the most able, thus implying that additional experience in such fields is a likely facilitator to implementation. Supervision reflection data revealed that many participants benefitted greatly from supervision to plan and adapt interventions effectively. This can be considered in line with supervision evaluation data which identified the most commonly used supervision type to be 'educative' and the most commonly used supervision role to be 'inform-assess': these indicate that the supervisee made more use of direct and informative approaches, over more reflective and non-direct approaches. It was noted that most participants adapted their practice well in response to supervision. Supervisee reports indicated that they found individual supervision sessions valuable in a number of ways, including them having been supported to plan and adapt the intervention.

Overall the data highlights the potential need and benefits of supervision/support following training. These factors can also be considered as facilitators related to Durlak and DuPre's *'Provider characteristics'* and *'Innovation characteristics'* in that they contributed to trainees' skill proficiency and self efficacy, and reflect adaptability of the intervention. This data is in line with Beidas et al. (2012) who argue that recent literature reviews demonstrate the importance of incorporating training and consultation into implementation efforts. Similarly, in their discussion concerning teacher implementation of interventions, Gilbertson et al. (2007) argue that the first step to increase teachers' implementation of interventions is to remove all skill barriers to implementation with training. However they also demonstrate the importance of providing implementation support following initial training around an intervention. Their study demonstrated how the use of training paired with follow up support strategies, employed after teachers have had the opportunity to independently use interventions in their classroom, improved implementation. Finally, Goldberg Lillehoj et al. (2004) also identify lack of implementer training and ongoing support as being barriers to intervention implementation, and Shapiro et al. (2012) conclude that factors associated with post training environment (including implementation support) may be one of the most important aspects that determine the success of implementation. In their study, the ability to discuss cases and receive consultation/supervision significantly predicted programme use.

Provider Characteristics: perceived need for innovation, perceived benefits of innovation, self efficacy and skill proficiency

Implementer 'Confidence' was identified as a theme through the: training evaluation forms; IDs; and interview data. Participants ranged in terms of how confident they felt around delivering the intervention. The data also revealed that whilst 'confidence' had been predicted as a potential barrier immediately following training, it was reported as more of a facilitator following implementation and/or supervision; participant self efficacy (and possibly self proficiency) may have grown with experience and support. Indeed, one theme identified through interview data was around confidence growing over time, following training/implementation/supervision. Overall this highlights the potential benefits of supervision and/or support around enhancing self efficacy. This is important given that Cantrell et al. (2012) found teachers personal sense of efficacy to be positively related to intervention *outcomes*, even more so than teachers fidelity to a programme.

The intervention was perceived by participants to be beneficial and needed in a variety of ways; these were strong themes in the data. These variables (together with self efficacy and skill proficiency) can be considered facilitators for intervention implementation as they influence the likelihood of implementers implementing a programme with higher levels of dosage or fidelity (as reported by Durlak and DuPre, 2008). This is in line with the findings of Beidas et al. (2012) who found a positive relationship between provider attitudes and adherence to a CBT school-based intervention, and Shapiro et al. (2012) who found that implementer confidence and implementers perception of their knowledge in relation to the intervention were significant factors related to programme use. As Resnick et al. (2011) state, any intervention is more likely to be adopted if it is seen to offer a true advantage to the setting.

Arguably the most powerful of the benefits perceived by participants was in relation to the intervention having changed the way participants spoke to people/approached issues as this indicates potential for the intervention to impact on the wider school community and the potential for sustainable change. This benefit was referred to by all but one school. Some themes represented participants being sceptical about benefits of the intervention, for example, until they had build evidence around intervention effectiveness in their school.

Perceived needs of the intervention ranged from participants reporting there being lots of children with poor emotional literacy skills to the need to address issues related to home issues. The latter was reported from schools with relatively affluent catchment areas (e.g. S5) and schools with relatively low-economic catchment areas (e.g. S3), for different reasons, which were presented. Participants identified need for the use of CBI at a wider organisational level e.g. as a preventative whole school intervention. Despite this, the most referred to need was around its use with individual children.

The data in this study has highlighted the importance of implementer characteristics to implementation. This is in line with Sanetti et al. (2013) who argue that assuming consultees (such as teachers) will implement interventions is no longer defensible and that further understanding of factors at the implementer level is needed to promote implementation of interventions in school settings.

#### Innovation characteristics: adaptability and compatibility

Data indicated that participants found the intervention adaptable in a range of ways, for example through adapting the pace, worksheets and stories/case studies used within the intervention. Examples of wider adaptability of the intervention was indicated through some participants using the intervention creatively (e.g. opportunistically, through their interactions with children and adults) or as a base, drawing upon their other therapeutic experience to deliver the intervention. This is not surprising given that the intervention was designed to be used flexibly. The findings indicate that the intervention can be modified to suit different age groups; something which Reynolds et al. (2006), Cuyper et al. (2004), Ginsburg et al. (2008) identified as being important.

In some cases, the intervention was compatible with: other interventions implemented within the school; existing behaviour management approaches; and with core values of the school. It was argued that in these cases there was more potential for the intervention to be embedded successfully within the school. Durlak and DuPre report that programmes that can be modified to fit the needs of providers, and that fit with the organisations existing mission, priorities and practices are more likely to be implemented effectively.

Factors relevant to the prevention delivery system: general organisational factors, specific practices and processes and specific staffing considerations

‘Involving carers and school staff’ was identified as a theme in this study. Involvement with school staff (e.g. class teachers and SENCOs) was indicated to be a facilitator to implementation, whereas lack of involvement of carers/parents was reported more as a barrier. Involvement with carers/parents was mainly through participants sharing information/feeding back about their intervention with individual children, rather than discussion of the intervention more generally or around planning the intervention. This would be considered a barrier to implementation according to Dulaney (2013) as she found that the school community, including parents, must participate in data-driven decision making for successful intervention implementation. Lack of parental engagement was also found to be a barrier in Corboy and McDonald’s study (2007).

Supervision reflection and interview data revealed that participants from S2 benefitted greatly from planning, delivering and evaluating their group intervention together.

Coordination of the intervention with other agencies was indicated to be generally limited across schools in this study. This is an area considered key to successful implementation by many researchers. For example, Greenberg et al. (2005) describe involving key stakeholders at the pre-adoption phase of implementation. Harris et al. (2013) suggest that intervention teams should consider planning ‘advisory group’ membership involving key sectors, and fully engaging members in order to ensure that they have a ‘stake’ in the intervention. Finally, Durlak and DuPre (2008) report that situations involving shared decision-making (community participation, collaboration) have consistently led to better implementation. They argue that empowering community members can be an effective way to solve local problems. Shared decision making empowers individuals to have control over local services and facilitates tailoring of interventions to local needs. As a result, community ownership of a programme should be promoted. A lack of community participation and collaboration in this study might explain why implementation was a challenge in some schools.

‘School staff being on board’ and ‘leadership, communication and shared vision’ were other themes identified in this study. Trainees referred to the need for their colleagues to have a shared understanding and vision around the intervention, and to be supportive of it. Indeed,

as was argued in the background information to this research, a whole school vision can be considered an important facilitator to intervention implementation. However, a number of barriers were identified to some schools achieving this. For example, the wider school staff having a lack of understanding or knowledge of the intervention was reported by participants across schools. This may have partly reflected the fact that only two members of staff from each school took part in the training. It may also reflect that some schools seemed to lack whole school/top down communication and effective leadership in relation to the intervention. These factors did not facilitate dissemination of information about the intervention across staff within a school. However, many participants intended to utilise the intervention at a wider organisational level, through sharing information with other staff in their school, in some cases through staff meetings. This raises potential for the intervention to be disseminated to the whole school through a 'bottom up' approach, rather than 'top down' approach. There was a contrast between schools who seemed to lack a whole school vision and top down approach around the intervention and schools where the intervention was supported at a whole school and senior management level. This contrast was demonstrated through the brief descriptions of S2 and S5 under the supervision reflection data (section 3; 'Leadership, Communication and Shared Vision').

Overall, leadership, communication and shared vision were seen as significant barriers or facilitators, depending on the school; there were contrasting reports around these factors having a positive or negative impact on implementation. Leadership in particular can be seen as being important to intervention implementation. As Resnick et al. (2011) argue, leaders within an organisation are needed to support and reinforce the work of intervention champions during the implementation process e.g. by recognising and monitoring their work. Dulaney (2013) found that school leaders need to take the time to build consensus so that understanding is shared concerning the why and how of implementation in order to prepare their school for systemic improvement. Communication has also been highlighted as being central to effective intervention implementation: Moseley and Hastings' (2005) place communication at the heart of intervention implementation, arguing that effective communication ensures all stakeholders are kept informed, that the support of upper management is publicised, and that employers understand the importance of the change and how it affects the organisation.

Finally, the findings of Shapiro et al. (2012) support the importance of: management; organisation; and systems-level buy-in prior to implementation of EBP's, and highlight the need for clear communication about expectations for use. Lack of leadership, shared vision and communication might therefore explain why some schools found implementation a challenge.

Work climates differed between schools, with some schools reporting relatively positive (sometimes excellent) work climates, and other's reporting relatively negative work climates, thus acting as facilitators or barriers to implementation depending on the school. These factors were related to themes around staff relationships and leadership and management. This finding is in line with Gregory et al. (2007) who found school-level climate to be a significant factor influencing intervention implementation: teachers who perceived administrators as being open and collaborative and who perceived higher levels of support between staff had higher implementation ratings.

In terms of general organisational factors, there were a mixture of positive and negative attitudes and responses of school staff in relation to change. Barriers to staff responding positively to change were mainly in relation to staff feeling under pressure e.g. from other changes. There were references to CBI being new and unique to other interventions in school. However, CBI was perceived to fit in with existing behaviour policies and interventions (e.g. SEAL, PSHE and mentoring). This is considered a facilitator to intervention implementation in that if related interventions and policies have succeeded to be implemented in a school, this may reflect school's 'readiness' to implement further related interventions.

For one school, there was a 'conflict of role' between participants' roles as intervention implementers and their wider roles. In contrast, other schools reported their implementer roles 'fitting in with current role', 'roles being clear' and 'role self-written – autonomy'. Three participants highlighted facilitators and barriers to them being SENCo or Resourced Provision Manager on their implementer role. For some participants, being in roles with less responsibility seemed to be a barrier to them championing the intervention. Indeed, Durlak and DuPre (2008) point out that programme champions who are highly placed in an organisation and have the respect of other staff can be particularly effective. Interestingly, Durlak (1998) suggests that there should be designated staff whose primary responsibility is planning and monitoring programme implementation and resolving conflicts and problems; this was not the case in this study as these responsibilities were generally secondary to

participants' wider full-time roles in school. Overall, factors in relation to implementer roles presented as facilitators or barriers, depending on the school and participant.

#### Community level factors: politics, funding, policy and prevention theory and research

The weakest of Durlak and DuPre's variables in this study were policies, funding and politics; these themes produced the least data, in terms of number of references and richness of data. This may reflect these themes being less salient to participants. Some participants identified 'funding' as having an indirect impact on the intervention as funding was needed to pay for their salaries/time to implement the intervention. In terms of prevention theory and research, participants identified the need for evidence of intervention success, especially in relation to tangible and local evidence. That is, evidence of the intervention being effective in changing the behaviour of children at their school.

Demiris et al. (2014) argue that whilst research into the factors that influence effective implementation is not a new discipline, one of the differences in research focus today is around the broader organisational, geographical, political and cultural context in which these factors exist. The findings presented under the previous category (particularly organisational factors) contribute to this research focus, whereas the findings presented under this category (particularly around political factors) fail to contribute to this area.

The data revealed a number of factors that are argued to be independent of those identified by Durlak and DuPre's model. These are discussed below.

#### Logistical/Practical Resources

The strongest themes identified under facilitators/barriers across training evaluation forms, supervision reflections and IDs were 'time' and 'space' (and also 'resources' in two data sources). These were also strong themes identified in the interview data. The data indicates that these factors were considered to be both needed and a potential barrier for successful implementation immediately after training, and remained as facilitators/barriers during the intervention. Interview data included five references which indicated 'time' to be a facilitator, but over 43 references which indicated 'time' to be a barrier. These references represented all schools. Closer analysis through supervision and interview data indicated that for most

individually supervised participants, having a regular timetabled slot to deliver a structured intervention was *not* an issue; rather the issue was around having time to prepare and evaluate the intervention, or provide additional intervention to children where this was identified as beneficial. Further analysis also revealed that ‘space’ (having an appropriate intervention room) only materialised as an issue for S1, all be it a significant issue. Whilst these themes can be considered related to Durlak and DuPre’s ‘*Factors relevant to the prevention support system*’ in that they refer to resources required for implementation, they are more basic, concrete and practical resources than those described by Durlak and DuPre’s description of this category. That is, under this category Durlak and DuPre describe forms of support such as training, emotional support and mechanisms to promote local problem solving; these reflect methods of support rather than logistical factors. In line with the findings of this study, Nellis (2012) refer to ‘practical’ barriers to implementation, which they relate to aspects of implementation such as time.

The themes ‘time’ and ‘space’ also relate to Durlak and DuPre’s ‘*Factors relevant to the prevention delivery system*’ as having adequate time and space for intervention implementation indicates the need for adequate organisational capacity. For example, without effective leadership over the intervention and staffing considerations trainees would not be released from their other duties and may not have the ‘time’ needed to prepare and deliver the intervention. As Dulaney (2013) states, leaders must identify available resources, both human and capital, to build an intervention infrastructure, and leaders must schedule the necessary time to collaborate and implement intervention processes to support this infrastructure.

Despite ‘time’ and ‘space’ being related to these two categories, is argued here that there is a potential need for a discrete category around ‘logistical/practical resources’, particularly as these themes feature so strongly across all data sources. These findings are in line with other research. For example, ‘time’, ‘resources’ and/or ‘space’ were identified as implementation barriers or facilitators by: Beidas et al. (2012); Stallard and Buck (2013); Acosta et al. (2013); Ramirez et al. (2012); Lee et al. (2006); Peru, Robert et al. (2006); Dulaney (2013); Amaral et al. (2010); Briesch et al. (2013); Bolton et al. (2012) and Moseley and Hastings (2005). Some of these studies were school-based.

The evidence suggests that ‘time’ is an implementation issue across interventions and not just CB based interventions. Indeed, CBT has long been argued to be brief and time-limited



compared to other interventions. For example, Beck and Emery (1985) state: “cognitive therapy is brief...therapy is task-oriented and focuses on problem-solving...Time is a limited resource: each intervention has to have a purpose and a rationale”. They suggest strategies for keeping CBT brief, which include: making treatment specific and concrete; staying task-relevant and; making ongoing assessments. Given the salience of ‘time’ as a facilitator/barrier to intervention implementation, and the potential brief nature of CBT, CBIs may have more chance of implementation success than other time costly interventions. This is especially relevant to schools where time and resources are scarce and where staff are being asked to do more with less (Hawken, 2006).

### Pupil Related Factors

Another theme identified across all data sources, which did not clearly map onto a category identified by Durlak and DuPre, was ‘pupil related factors’. For example, interview data revealed children’s: identified difficulties; character; engagement; attendance; age; understanding; and cognitive ability as being potential facilitators/barriers to implementation. Indeed, the literature review reported how some pupil characteristics (e.g. age and cognitive ability) are a barrier to CBT success (e.g. Pattison and Harris, 2006 and Dunsmuir and Iyadurai, 2007).

Whilst this theme is related to ‘*innovation characteristics*’ in that interventions that are adaptable can overcome many potential barriers relating to pupil characteristics, it is argued here there are some pupil related factors which will act as a facilitator/barrier despite the interventions characteristics. For example, if a pupil is a poor school attendee, this is likely to be a barrier to intervention implementation despite characteristics of the intervention. Similarly, whilst pupil factors are related to ‘*provider characteristics*’, in that pupil engagement in the intervention is somewhat reliant on the implementer having adequate skills to overcome issues with pupil engagement, it is also true that the pupil’s individual traits and attitudes would act as a facilitator/barrier regardless of the implementers skills. That is, a pupil might not engage for reasons outside of the implementer’s control. This was demonstrated by data presented under section 2 – IDs. As Sanders and Wills (2011) state, some clients may find collaborative relationships with therapists difficult, leading to them not cooperating or ‘going through the motions’ but not really engaging with therapy. It is argued here that whilst this theme is related to two of Durlak and DuPre’s categories, it is a discrete category.

In their study, Pettigrew et al. (2012) describe differing levels of student engagement which range on a continuum from disconnected to attentive to participatory. They argue that, in combination with certain teaching delivery styles, such factors influence intervention outcomes. Also, Helmink et al. (2012) state that factors which impact on intervention implementation include those related to the intervention user (e.g. compliance and attitude). Finally, Beck (2011) states that therapists need to be aware of key factors affecting patients and their treatment, such as their age, developmental level, intellectual level or cultural milieu. These findings provide further support for the importance of pupil related factors to intervention implementation.

### Implementer Related Factors

An umbrella theme identified through the supervision reflection and interview data was ‘supervisee/implementer characteristics’. This covered characteristics that did not map directly onto Durlak and DuPre’s *‘provider characteristics’* as the former focuses on personal qualities and attitudes towards intervention implementation (e.g. motivation or attitude towards their roles), rather than characteristics associated with skill proficiency or self-efficacy as identified by Durlak and DuPre. It is argued here that the personal qualities of an implementer are likely to influence their implementation of the intervention. For example, facilitators to implementation were considered to be participants expressing: motivation/enjoyment; passion; or striving to improve, in relation to their intervention implementation. This is supported by Briesch et al. (2013) who argue that implementers personal interest in, and enthusiasm for, carrying out the procedures are factors to be assessed when considering intervention implementation. An example of a study which does include measures of implementer qualities is Spoth et al. (2011). They included observer ratings of ‘facilitator qualities’ (such as their friendliness) and ‘student engagement’ (such as their attitude towards the lesson and their interest in the content). Goldberg Lillehoj et al. (2004) refer to studies which have demonstrated that implementers who are more outgoing, adventurous and analytic rate higher on programme implementation. The implementer characteristics referred to by the above researchers include personal qualities rather than those solely associated with skill proficiency or self-efficacy, as referred to by Durlak and DuPre’s model.

Some barriers to implementation identified in this study were around participants feeling under pressure/overwhelmed/de-motivated. Goldberg Lillejoj et al. (2004) report that low teacher morale and burnout as barriers to implementation. As Durlak and DuPre (2008) point out, school staff who feel pressured to offer new programmes often do not implement them very effectively, probably because they do not become committed to the intervention. Durlak (1998) states that good implementation may be dependent on securing the participation of the most eager and committed schools and staff rather than the typical school and teacher, thus highlighting the impact of implementer characteristics.

In their study, Goldberg Lillejoj et al. (2004) found that implementer characteristics (such as gender) were significantly predictive of youth outcomes. However, they argue that there is a lack of research around the relationship between implementer characteristics and intervention *implementation* (rather than outcome). This study has provided some insight into this area.

#### Relationship Between Pupil and Implementer

A theme identified through the IDs, supervision reflections and interviews was the 'relationship between pupil and participant'. Whilst this is related to '*provider characteristics*' in that the relationship between participant and pupil is partly dependent on the implementers qualities and skills, it is argued here that it is also dependent on the unique combination of implementer and child factors that determine a therapeutic relationship. Durlak and DuPre (2008) do report on a study which indicates the importance of the quality of relationship between mentor and youth to intervention outcomes. However, this relationship is not adequately represented in their model. The relationship between a therapist and patient has been shown to be a very important factor in determining the success of a therapeutic intervention (Lambert, 1992).

In support of this factor being distinct as an implementation barrier/facilitator, Pettigrew et al. (2012) refer to research which demonstrates that certain teacher-student relationships tends to facilitate more interactive delivery methods of teaching, which in turn have been shown to facilitate intervention outcomes. Also, Lee et al. (2006) found 'relationships' between nurses and clients to be one of two key intervention implementation factors. When translated into school-based interventions, this could be seen as relationships between the implementer/teacher and pupil. Sanders and Wills (2011) argue that research into cognitive

therapy supports that the quality of relationship between therapist and client is central. They report on studies which have demonstrated that relationship factors make a significant contribution to the outcome of cognitive therapy, and in some cases such factors have been demonstrated to be more important to outcomes than methods or treatments used. They also state: “Most of the things that go wrong in cognitive therapy have an echo in both therapist and client, reminding us of the interpersonal nature of therapy.” The importance of the therapeutic relationship in CBT has long been recognised. For example, Beck and Emery (1985) argue that without a warm therapeutic relationship based on trust and acceptance, the techniques and procedures of cognitive therapy are unlikely to work. It is argued here that the same principles can be applied to a teacher/pupil relationship during CBI.

Sanders and Wills (2011) describe characteristics which are necessary for an effective therapeutic relationship, which include empathy, understanding, respect and unconditional positive regard. These characteristics are more attributable to the therapist rather than client. However, Sanders and Wills (2011) also report on research which supports that the characteristics of clients impact on therapy, such as the persons willingness and ability to be open about the problems. They conclude that in order to consider what works in therapy, it is necessary to look at the interaction between the qualities of the client, therapist and the therapeutic method. They argue that this refers to the so called ‘common factors’ across all the therapies, which include: “the therapeutic relationship, the qualities of the client, therapeutic hope and expectation of change, and the technical aspects of therapy” (p. 56). This supports the possibility that factors related to the: pupil; implementer; and the relationship between the pupil and implementer are distinct and important to intervention implementation.

## Chapter 8: Overall Findings

### **RQ1. What CB competences do school staff believe they implement with training and support?**

This study has demonstrated potential for school-based CBI's. This is in line with the literature presented earlier which supported schools being appropriate settings for: SEBD interventions (see, for example, Aggett, et al., 2006; Beidas, et al., 2012; Cole, et al., 2012; Gregory, et al., 2007; Maxwell, et al., 2008; Mychailyszyn, et al., 2012; Rait, et al., 2010; Squires, 2001, 2010; Yeo & Choi, 2013); and CBI's in particular (Christner, 2007; Gottfredson, et al., 2002; Mennuti, et al., 2006; Platts, 2000; Squires & Caddick, 2012; Zyromski & Joseph, 2008).

The study demonstrated potential for CBI implementation by school staff, which also supports literature presented earlier (Buckley, et al., 2013; Gregory, et al., 2007; Mennuti, et al., 2006; Mychailyszyn, et al., 2012; Squires, 2010). The findings suggest that school staff feel able to implement, and go on to implement, a range of CB competences following training and supervision, including: psycho-educational work around thoughts, feelings and behaviours; the general CB model/approach; and specific strategies. These findings are especially relevant given that the literature review argued that the demand for therapeutic interventions outweighs the provision of trained therapists to implement such interventions (Stallard, et al., 2007). The study demonstrates potential for school staff to be trained and supported to use some of the CB competences recommended by IAPT (2011). However, the study also recognises limitations to school staff implementation of CB competences: many CB competences require a greater skill set, such as competences related to core beliefs (Beck, 2011; Sanders & Wills, 2011). Such skills are unlikely to be appropriate for school training.

### **RQ2. How do school staff implement these CB competences with training and support?**

The study demonstrated potential for school-based CBI as a multi-tiered strategy; something which the literature identified as being important for effective and sustainable intervention (Burns, et al., 1999; Marulanda, 2010; Maxwell, et al., 2008; Mychailyszyn, et al., 2012; Weare & Gray, 2003). Most commonly, the intervention was used at an individual child level, then at a group level. The benefits of providing intervention through group work have been identified

by several researchers (Carnwell & Baker, 2007; Crombie, Lowe, & Sigston, 1989; Dodd, 2004; Dwivedi & Gupta, 2000; Flitton, Buckroyd, & Vassilou, 2006; Humphrey, Kalambouka, Wigelsworth, & Lendrum, 2010; Ruttledge & Petrides, 2011; Squires, 2002). The study also indicated intervention implementation at a wider, whole school level. This highlights potential use of CBI at a preventative level, to enhance the emotional intelligence of all children. Indeed, some of the CB competences most frequently used in the study were those around identifying thoughts, feelings and behaviours: skills which could be considered part of a preventative emotional intelligence curriculum. The value of intervention at this level should not be underestimated. There is a wealth of evidence to suggest that effective emotional intelligence skills are a key factor in promoting emotional wellbeing, positive behaviour, success in relationships and success in school (Coppock, 2007; Poulou, 2005; Royer, Desbiens, Bitadeau, Maltais, & Gagnon, 1999; Salovey, 2010) (Buchanan, et al., 2009; 2007; Elias, 2003; Hoffman, 2009; Marulanda, 2010; Morgan, Izard, & King, 2008; Nettelbeck & Wilson, 2005; Weare & Gray, 2003; Williams, Daley, Burnside, & Hammond-Rowley, 2009). Domitrovich, Cortes and Greenberg (2007), Dwivedi and Gupta (2000), Esturgo-Deu and Sala-Roca (2010), Weare and Gray (2003) and Poulou (2005) promote development of emotional intelligence as a method of preventing mental health problems.

The study demonstrated flexible use of CB competences: some staff implemented the competences as a structured programme (with individual children or groups) whilst others implemented competences creatively e.g. implicitly in their personal lives and in the way they approached issues. CBI was also adapted to suit various ages and abilities, thus supporting literature presented earlier (Gleaves & Latner, 2008; Greco & Morris, 2001; Greig, 2007; Macklem, 2008; Mennuti & Christner, 2005; Robin & Kendall, 2005; Seligman & Ollendick, 2005; Zyromski & Joseph, 2008). Such flexible use of an intervention seems especially resourceful in a climate where school staff need to have the capacity to work with children who are engaging in extreme behaviours as well as focus on prevention intervention with groups of children (Hawken, 2006). Whilst school staff implemented CB competences with flexibility, training and supervision were used to ensure that they implemented competences appropriately, remaining true to the intended purpose or concept underlying the model (Greenberg, et al., 2005). This study has supported the view presented earlier that adaptation should not be seen as opposing fidelity and that both are important to implementation (Dane & Schneider, 1998; Stevens, et al., 2001; Telzrow, et al., 2000).

### **RQ3. What are the perceived barriers and facilitators to school staff implementing CBI?**

This study contributed to our understanding of intervention implementation processes in ‘real-world’ settings: the need for further understanding around this area was identified in the literature (Beidas, et al., 2012; Briesch, et al., 2013; Cole, et al., 2012; Corboy & McDonald, 2007; Durlak, 1998; Goldberg Lillehoj, et al., 2004; Greenberg, et al., 2005; Kalafat, et al., 2007; Pas & Bradshaw, 2012). This study can be used to facilitate implementation of EBI’s into practice, a challenge which Mychailyszyn et al. (2012) termed as ‘bridging the gap’. In relation to Bond’s (2008) description of programme evaluation models, this study can be considered an example of ‘*goal-free*’ programme evaluation as it emphasised ‘the views of stakeholders distinct to the intervention being evaluated’.

The findings support Durlak and DuPre’s (2008) model of intervention implementation in that all factors identified in their model were identified in this study as being barriers/facilitators to intervention implementation. However, this study identified four factors which, whilst related to existing categories in Durlak and DuPre’s model, are either inadequately represented, or not represented at all, in their model. These factors are:

1. Pupil related factors
2. Personal qualities of implementer
3. Relationship between child and implementer
4. Logistical factors/resources.

The absence/inadequate representation of the above factors in Durlak and DuPre’s model might reflect their model representing implementation of preventative interventions, typically implemented on a wider/universal scale. In such contexts the characteristics of individual implementers or pupil’s, and the relationship between them, may not be as salient. It follows that in order for their model to be applied effectively at a smaller systems level (i.e. implementation at an individual or group level), consideration of the additional factors identified in this study may be necessary. Indeed, Durlak and DuPre (2008) report that what is specifically required for effective implementation depends on a combination of factors because local contexts differ, thus implying that implementation factors differ depending on the context. Durlak and DuPre also point out that they do not provide an exhaustive list of

implementation factors, particularly as they only include factors in their model that were identifiable in at least five of their reviewed studies. They recognise that it is possible that investigators have overlooked some important factors.

In light of the above, an enhanced implementation framework, specific to school-based intervention implementation, is proposed in Figure 16 below:

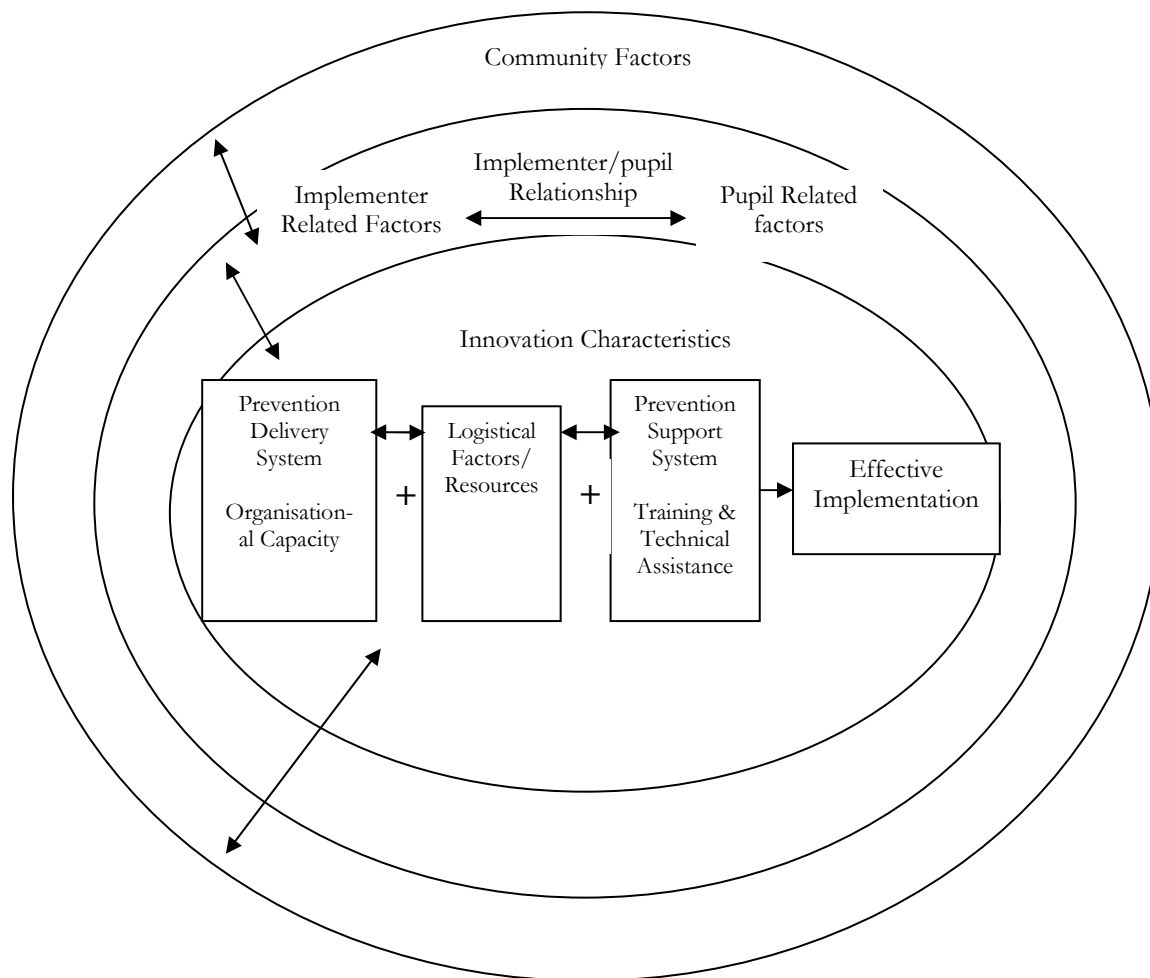


Figure 16: Caddick's School-based Intervention Implementation Framework, based on Durlak and DuPre (2008)

Whilst each of the additional four factors were discussed in Chapter 7, the differences between Durlak and DuPre's (2008) framework of implementation and Caddick's framework of implementation (above) will now be highlighted. Figure 16 demonstrates how 'Pupil related factors' and 'Implementer related factors' can impact on implementation. 'Pupil related factors' are an addition to the framework. Whilst 'Implementer related factors' mirrors Durlak and DuPre (2008) 'Implementer characteristics', 'Implementer related factors' in Figure 16 also covers personal qualities of implementers. The 'Implementer/pupil relationship' is an



addition to the framework as this is argued to impact on implementation. This relationship is linked to 'Implementer related factors' and 'Pupil related factors'. Finally, 'Logistical/resource factors' are identified as an addition to the framework as this is argued to impact on implementation as a discrete category. These factors are linked to the 'Prevention delivery system' and 'Prevention support system'.

The study highlighted the importance of considering the personal qualities of the implementer when selecting intervention implementers. A limitation in this study was that selection of implementers was left to head teachers; the researchers had no say in this part of the process. As Goldberg Lillehoj et al. (2004) state, it is typical for a head teacher to mandate programme implementation, regardless of the teachers commitment. It is argued here that researchers/EPs should have a contribution to selecting implementers, perhaps through using models such as 'PRIME' (Sanetti, et al., 2013) which includes measures of implementer-level factors.

Systemic factors related to schools, such as: leadership and management; school climate; whole school vision; collaboration with others; and effective support systems within a school were identified in this study as being salient facilitators/barriers to intervention implementation. In some cases, this was a barrier to implementing the intervention at an individual child level, let alone embedding the intervention at a wider organisational level. Such factors are also identified as being salient to implementation by Salmivalli et al. (2005) and Dulaney (2013). Consideration around such factors is necessary when selecting and preparing a school for intervention implementation. There is a need to consider a schools 'readiness' to implement an intervention. Steps can be taken to address potential barriers, for example by disseminating information about an intervention to the wider school community, and involving others in the coordination of the intervention. Whole school training or meetings could be used to discuss, plan and share strategies in relation to the intervention (see, for example, Dulaney, 2013).

## **EP Role**

This study highlighted the value of effective training and supervision to facilitate school staff implementation of CBIs. Whilst training and supervision relate to each of the RQs, it is discussed here as it also demonstrates the EP role in supporting school-based CBI's: this is particularly important given the lack of available research relating to this, as identified earlier (Caddick, 2009). This study presents an opportunity to define a supportive, training and supervisory role for EPs that enables teachers to implement therapeutic intervention. Not only does this promote extended use of therapeutic intervention as school staff develop skills, confidence and materials for use following EP involvement, but this also allows the EP to switch roles, acting as supervisor instead of the time-intensive work needed to prepare and deliver interventions directly. This also supports the view (presented earlier) that EPs can use CBT at multiple levels within the school system (Boyle, 2007; MacKay, 2007; Squires, 2001; Yeo & Choi, 2013).

Supervision was perceived as being beneficial in: enabling participants to plan and adapt the intervention effectively; enhancing the range and frequency of CB competences used; and enhancing implementer confidence. This supports Durlak and DuPre's (2008) framework in that supervision was considered as a key facilitator to implementation. The study has also identified that supervision and training can be used to enhance implementation fidelity within a flexible CBI. These findings have significant implications given that many CBI's can be self taught and delivered 'off the shelf': there is an implied need for resources to be invested into training and follow up support for teachers to implement CBIs. This supports the views expressed in Chapter 2 (Buchanan, et al., 2009; Jennings & Greenberg, 2009; 2009; Marulanda, 2010; NICE, 2008; Weare & Gray, 2003; Yeo & Choi, 2013). As was argued earlier, the need for adequate training and supervision not only applies to school staff, but also to EPs delivering CBIs (e.g. Dunsmuir and Iyadurai, 2007; Squires and Dunsmuir, 2011).

Whilst support in the form of supervision from an experienced intervention practitioner was highlighted as a facilitator in this study, support from school colleagues was also highlighted as a facilitator. Hence the role of EP might include providing direct supervision, but it might also include facilitating the school to be supported in their absence e.g. through setting up peer support systems.

## **Unique Contributions**

The study has contributed to the research around CBI's in schools; this was identified in the literature as being much needed (Allen, 2011; Evans, 2004; Hoagwood, 1997; Mychailyszyn, et al., 2012; Silverman, et al., 2008a; Stallard & Buck, 2013; Zyromski & Joseph, 2008).

Moreover, it has researched the implementation of CBI in school settings, by non-clinical therapists, thus challenging the traditional view of CBT implementation. To the researchers knowledge this is the first example of school-staff being trained and supported to develop CB competences recommended by IAPT (2007).

The study has utilised Durlak and DuPre's (2008) implementation framework to explore school-staff implementation of CBI's; to the researchers knowledge, this is the first example of the framework being used for this purpose. Moreover, the study has proposed an enhanced implementation framework, which can be used to inform intervention implementation in school settings.

The study has demonstrated the unique contribution that EPs can make to the development of CB competences in school-staff. This is a particularly important contribution given the increasing concerns around children's mental health (discussed in the literature), a shift in thinking around the types of support that schools can provide, and therefore a need to focus on the support that EPs can provide to schools. A recently published consultation (DfE, 2011) resulted in a full review of the EP role which illustrates the development of a wider role for EPs, making the most of their specialist knowledge, expertise and skills. At such a crucial time, it is important for EPs to demonstrate the unique contribution that we can make.

## **Implementation Recommendations**

Gregory, Henry and Schoeny (2007) argued that research to guide intervention implementation was lacking. This study has identified guidance for EPs to consider when supporting schools to implement therapeutic interventions. Some of these recommendations are also identified by Durlak (1998):

- Specify the essential ingredients of an intervention. Plan training with essential ingredients in mind. Also consider timing/length of training, and training methods to suit various learning styles.

- Establish school readiness for the intervention. In particular, consider: compatibility of intervention with existing practices, contexts and work climate of school; shared vision amongst staff; and effective leadership.
- Present key stakeholders with evidence base for the intervention.
- Obtain a clear commitment to administer the intervention, including commitment from senior-management to providing resources such as time and space.
- Encourage ‘ownership’ of the intervention. In particular: involve senior-management within school in the initial stages (including implementation planning); meet with senior-management at regular intervals throughout the intervention; and designate staff with responsibilities for implementation.
- Consider coordination with other agencies involved with the school.
- Tailor the programme to the school setting, allowing for flexibility in implementation. Promote implementation across systems within a school.
- Select intervention implementers based on personal and professional characteristics (e.g. skill level, motivation and roles within school).
- Provide ongoing and regular supervision once the programme has begun. Utilise effective supervision models and guidance (e.g. Scaife, 1993; Squires & Williams, 2003; Turpin, 2011). Use supervision to ensure essential ingredients of the intervention are implemented as planned.
- Promote peer support in schools (e.g. between co-trainees).
- Promote opportunities for networking with other schools.
- Promote positive relationships between implementers and pupils.
- Involve parents/carers wherever possible and appropriate.

## **Limitations**

School staff perceptions of CBI implementation were measured, largely, through self-reports. The limitations to such measures were discussed in Chapter 6 (Durlak, 1998; Goldberg Lillehoj, et al., 2004; Scaife, 1993; Shapiro, et al., 2012).

A number of barriers to using CBI in the school setting were evident during the study, which could have been alleviated. Some of these are also identified by Squires and Caddick (2012). For example, whilst the intervention required key members of school staff to dedicate time

and commitment to the intervention, this was not always seen as a priority for school. Also, there were issues around the engagement of the wider school community, and parent engagement was minimal. Such barriers could have been alleviated through clarifying further the commitment and requirements of school prior to training and through promoting methods of engaging parents. The importance of involving parents in CBT is well documented (see Robin and Kendall, 2005; Kendall et al., 1995; Greco and Morris, 2001; Maxwell et al., 2008; and Probst, 2008). Whilst the researcher involved the head teachers in making an informed decision about whether to take part in the research, attempts could have been made to engage the wider school. Indeed, the need to set up formal arrangements for engaging the wider social network of the school has been emphasised (Burton, 2006, 2008; Greco & Morris, 2001; Squires, 2010).

### **Further Research**

This study indicated that participants were more likely to implement a greater range of CB competences when they implemented the intervention for longer, and participants expressed the need for evidence that the intervention was effective in their school before championing the intervention further. Some participants gained confidence in relation to the intervention over time. Such observations imply the need for follow up research to determine the longer term implementation of CBI. Indeed, the data collected in this study can be considered as having been collected at the initial stages of implementation, according to Moseley and Hastings (2005) implementation model. Moreover, Durlak and DuPre (2008) identify studies which indicate that implementation can deteriorate over time. Data collected early in the intervention may, therefore, overestimate the level of implementation delivered at the end of the programme, indicating the need for data collection at multiple time points.

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## Appendices

### **Appendix A – Ethical Clearance Authorisation**

Dear Katie

Ref: PGR-7467237-A1

I am pleased to confirm that your ethics application has been approved by the School Research Integrity Committee (RIC) against a pre-approved UREC template. This approval is granted with the below conditions:

The student provides an email (to [ethics.education@manchester.ac.uk](mailto:ethics.education@manchester.ac.uk)) confirming that:

- The project will start on “receipt of ethical approval” and not necessarily November, as stated on the SoE form.
- The post intervention interview will last a maximum of 1 hour
- A secondary contact (e.g. supervisor or research office) will be added to the participant information sheet in-case issues arise with the student.
- It will be noted on the participant information sheet that the student is obliged to break confidentiality in the cases of:
  - o if person revealed that they are being harmed in any way, then the researcher has a duty to report to an appropriate authority. This will be done with the person’s knowledge and it will be agreed with them whom to tell.
  - o if the participant states that they have, or intend to harm someone
- Data will be analysed in a private location (university grounds are listed, but this must not be somewhere public, like the library).
- Any adverse event will be reported to the UREC committee

If anything untoward happens during your research then please ensure you make your supervisor aware who can then raise it with the RIC on your behalf

Regards

**XXXXX**

PGT & Quality Assurance Administrator

School of Education



## Appendix B – Samples of Training Presentation

Below are examples of ‘Power Point’ slides taken from the training presentation used in this study. It should be noted that this only provides a snap shot of each training session: for a full understanding and appreciation of the training design, the complete training would need to be accessed. For example, each session involved: an overview of the last session; a quiz; a review and presentation of homework tasks; practice and discussion activities; case study examples; handouts; and worksheets.

### Training Session 1:

### Agenda

- Word of Warning
- What is Cognitive Behavioural Therapy (CBT)?
- Setting up an intervention
- The Typical CBT model
- CB intervention - activities related to thoughts, feelings and behaviours

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(Psychology Team)



This course is designed to provide CB strategies to use within a school context.

To become an accredited CBT practitioner/ therapist further courses and training need to be accessed. For more information;  
[www.babcp.com](http://www.babcp.com)

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### Linking thoughts, feelings and behaviours



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### CBT .v. CB Strategies

What is CBT?	What are CB strategies?
<ul style="list-style-type: none"><li>▪ CBT involves teaching new skills and new ways of thinking through a collaborative process between the client and therapist.</li><li>▪ Involves shared understanding and formulation of a problem through the use of specialist strategies.</li><li>▪ This shared formulation informs treatment.</li><li>▪ Carried out by a trained therapist.</li></ul>	<ul style="list-style-type: none"><li>▪ Aims to increase pupil's awareness of thoughts, feelings, body signals and behaviours. Through this awareness, change can be initiated.</li><li>▪ The strategies aim to encourage broader and more flexible thinking.</li><li>▪ Carried out by an individual qualified to work with children. If an individual is not qualified, they should receive forthrightly discussions about the intervention from someone who is qualified to work with children.</li></ul>

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### Summary of Session

We have:

- Compared CB strategies with CBT
- Introduced CB theory
- Looked at thoughts, feelings, and behaviours
- Looked at how thoughts, feelings and behaviours connect

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### Child Based Activities Covered



1. Behaviour detectors	1. Identifying own behaviours and what they look like
2. Body Signals	2. Identifying own body signals and what they look like
3. Feelings	3. Understanding what a feeling is
4. Thoughts	4. Understanding what a thought is
5. Connecting the cycle	5. Connecting thoughts, feelings and behaviours.

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## Training Session 2:

### Agenda

- Negative Automatic Thoughts (NAT's)
- Hot Thoughts
- Thinking Errors
- Managing and Challenging NAT's

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(Psychology Team)

### Helping Children to Understand NAT's



- Introduce as 'Hot Thought'
- Scenario's – negative trap
- Tape Analogy
- Worksheet activities
- 'Downward Digger' question

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(Psychology Team)

### Summary of Session

We have:

- re-visited the thought/ mood/ behaviour link
- looked at what NATs are
- looked at how NATs are perpetuated by this cycle
- looked at ways of identifying NATs
- looked at ways of challenging and coping with these NATs

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### Thinking Errors

1. **Overgeneralization** - Taking isolated cases and using them to make wide generalizations.
2. **Mental filter** - Focusing exclusively on certain, usually negative or upsetting, aspects of something while ignoring the rest, like a tiny imperfection in a piece of clothing.
3. **All-or-nothing thinking** - Thinking of things in absolute terms, like "always", "every" or "never". Few aspects of human behavior are so absolute.
4. **Personalization (or attribution)** - Assuming you or others directly caused things when that may not have been the case. When applied to others, blame is an example.
5. **Magnification and Minimization** - Inappropriately understating or exaggerating the way people or situations truly are. Often the positive characteristics of other people are exaggerated and negative characteristics are understated. There is one subtype of magnification:  
**Catastrophizing** - Focusing on the worst possible outcome, however unlikely, or thinking that a situation is unbearable or impossible when it is really just uncomfortable.

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### Child Based Activities Covered



- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Thought trackers – hot thoughts</li> <li>2. Thermometer/ Red, Amber, Green</li> <li>3. Downward Digger</li> <li>4. Scenario's</li> <li>5. Thinking Errors</li> <li>6. Thinking Errors assessment</li> </ol> | <ol style="list-style-type: none"> <li>1. Identifying own NATs within thought, feeling, behaviour cycle</li> <li>2. Identifying own NATs within thought, feeling, behaviour cycle</li> <li>3. Identifying deeper NATs</li> <li>4. Understanding NATs within thought, feeling, behaviour cycle</li> <li>5. Understanding types of thought errors</li> <li>6. Identifying own thought errors</li> </ol> |
|---|---|

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### Child Based Activities Covered



- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>7. Thought tracker – thought errors</li> <li>8. Distraction</li> <li>9. Talk to someone</li> <li>10. Positive Self-talk</li> <li>11. Coping Self Talk</li> <li>12. Thought Stopping</li> <li>13. Throw Them Away</li> <li>14. Test Them</li> </ol> | <ol style="list-style-type: none"> <li>7. Identifying own thought errors in relation to specific events/thoughts</li> <li>8 – 14. Managing and challenging NATs</li> </ol> |
|---|--|

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## Training Session 3:

### Practice: Controlled breathing



- There are times when you may suddenly notice that you have become anxious and need a quick way to regain control.
- Controlled breathing is a quick method that can help. The idea is to concentrate on your breathing and this will help you relax. You can use this method anywhere and often people don't even notice.
- Slowly draw in a deep breathe, hold it for five seconds and then very slowly let it out. As you breathe out say to yourself 'relax'.
- Try doing this a few times.

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### Diary Keeping

Diary keeping is probably one of the principle tasks you will ask a child to complete.

- Involves recording variations in feelings, behaviour and thoughts.
- Some may not like the idea of writing so alternatives can be agreed.
- Alternative's could be devising a rating scale and sending number on in a text message or filling in a simple pre-designed form with rating scales.
- Facilitates discussion and problem solving.

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### Josh and Amy....

*It's a typical day for Josh in Anytown School: he's in trouble again! A shout of protest from the back of the class, "Miss, Josh kicked me". "Why did you do that?", his teacher asks. As usual, he doesn't know, or at least that's what he tells his teacher. This happens at least once a day, often outside of the classroom. (Squires, G. 2001)*

*It's a typical day for Amy in Anytown School; she's stood by herself in the playground alone again. When peers approach Amy to ask her questions, she answers briefly and shows no further interest. Miss Unknown is concerned that Amy seems so withdrawn.*

**Possible negative automatic thought = people are always out to get me**

**Possible negative automatic thought = no one wants to play with me**



### Feelings and Behaviour - Child Based Activities Covered

- |                           |                            |
|---------------------------|----------------------------|
| 1. Relaxation activities  | Controlling your feelings. |
| 2. Do more fun activities | Behavioural interventions  |
| 3. Monitor behaviours     | Behavioural interventions  |
| 4. Take small steps       | Behavioural interventions  |
| 5. Face fears             | Behavioural interventions  |
| 6. Dump habits            | Behavioural interventions  |

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### Problem Solving and Homework - Child Based Activities Covered



- Learning to stop and think by using traffic lights
- Identifying different solutions
- Thinking through consequences
- Remind yourself what to do
- Practise getting it right
- Plan to be successful
- Talk yourself through it
- Behavioural experiments
- Thought diaries

Problem solving

Problem solving  
Problem solving  
Problem solving  
Problem solving  
Problem solving  
Problem solving  
Homework  
Diary keeping

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### Homework

- To practise the previously discussed interventions and strategies with at least one pupil.
- Choose a child/young person that will be easy to work with i.e. not the most vulnerable. This is for you to practice your skills.
- As with any intervention, parents will be involved and will be aware of the work you are doing with their child.
- Practise using some feelings and behaviour based strategies.
- It is unlikely that you would be able to do any of the activities in under 20 minutes.
- The intention is to feedback to the group at the next session about your experience of these.

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## Session 4 Agenda

- Intervention Overview
- Evaluation
- Typical session content
- Good Practice

## Quiz from Session 3

1. Name at least one way to control feelings....
2. Name some CB techniques to change behaviour....
3. Name CB based homework activities....

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## Intervention Framework

1. Assess needs & agree intervention
2. Plan logistics
3. Consent & rapport building
4. Work on general knowledge of thoughts, feelings and behaviours. Can explore the problem.
5. Work on link between thoughts, feelings and behaviours. Can explore the problem.
6. Work on changing thoughts, feelings and/or behaviours
7. Evaluate intervention
8. Decide on next steps

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## Identifying Children/Young People who will benefit from this intervention

- The judgement as to whether a pupil would benefit from the intervention needs to be made between you, the SENCo, teacher(s), parents and pupil themselves.
- All involved will need to agree on the issue/s causing concern and that this approach would be a beneficial next step.
- There is a criteria to help you make this decision.
- It is assumed that assessments and data collection will have already taken place to identify the pupil's needs, difficulties and strengths.
- It is useful to read/ liaise with professionals involved with the pupil to seek their opinion on the pupil's needs, difficulties and strengths.

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## Good Practice

Based upon	<b>P</b> artnerhsip working
Pitched at the	<b>R</b> ight developmental level
Uses	<b>E</b> mpathy
Is	<b>C</b> reative
Encourages	<b>I</b> nvestigation & experimentation
Facilitates	<b>S</b> elf discovery and efficacy
Is	<b>E</b> njoyable

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## Typical Session Content

1. 'Check in'- how are things?
2. Events in between sessions e.g. 'homework'
3. Present activities
4. Tackle the activities
5. Set 'homework'
6. Summarise

Jude Joughin and Katie Caddick  
(Psychology Team)

## **Appendix C – Participant 1 Information Form**

**Dear School Staff,**

You are being invited to take part in a research study as part of my Doctorate studies. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Then decide whether or not you wish to take part.

Thank you for reading this.

### **Who will conduct the research?**

Katie Caddick. I am a doctoral student at the University of Manchester and a qualified Educational Psychologist.

### **What is the aim of the research?**

The aim of this research is to explore how school staff can be trained and supported to use cognitive and behavioural (CB) intervention to support children with emotional, behavioural and/or social difficulties.

### **Why have I been chosen?**

You are a member of school staff who has received training around CBIs.

### **What would I be asked to do if I took part?**

- To be interviewed twice; once before and once after completing CBI with a young person/young people. Each interview will take an hour.
- To take part in monthly supervision sessions with me. Each supervision session will last between 30 minutes and 90 minutes, depending on your needs and what you want. You will be released from your other duties during the day for this to take place.
- To keep a brief record of your use of CBI. See record sheet attached.

Anonymous information resulting from these will be used as part of research if you consent to this.



**What happens to the data collected?**

The data will be used to write about how you have used CBI, the barriers and facilitators to you using CBI and what you need to implement it successfully in school. The interviews from all the participants will be looked at for themes. This information will be given back to you so you can comment on it.

**How is confidentiality maintained?**

The data collected will be kept only by myself and kept securely in encrypted format so that no-one else will have access to it. No names will be used in any data or quotations that are reported. This means that you will not be identified in any way. Names will be changed in written reports and papers to ensure that you remain anonymous.

I am only obliged to break confidentiality if you reveal that you are being harmed in any way, or you state that you intend to harm/have harmed someone. In this case, I have a duty to report to an appropriate authority and we would agree who to tell.

**What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself. If you do decide to withdraw, then any data that has been collected about you will be removed from the study and destroyed.

**What is the duration of the research?**

From when you have taken part in the training, to when you finish using the intervention with a pupil/children or July (whichever comes first). See ‘**What would I be asked to do if I took part?**’ for duration of each activity.

**Where will the research be conducted?**

At your school.

**What will the research be used for?**

The research will be written up as a thesis and submitted to the university as part of my doctorate work.

**Criminal Records Check**

I have undergone a satisfactory criminal records check.

**Contact for further information**

Katie Caddick

Educational Psychology Service, Area Education Office, Ellesmere Port, Cheshire, CH65 6QL

Tel: 0151 3376819

Dr Garry Squires, Director of the Doctorate in Educational Psychology

Ellen Wilkinson Building – A6.6, School of Education, The University of Manchester, M13  
9PL

## **Appendix D – Participant 2 Information Form**

**Dear School Staff,**

You are being invited to take part in a research study as part of my Doctorate studies. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Then decide whether or not you wish to take part.

Thank you for reading this.

### **Who will conduct the research?**

Katie Caddick. I am a doctoral student at the University of Manchester and a qualified Educational Psychologist.

### **What is the aim of the research?**

The aim of this research is to explore how school staff can be trained and supported to use cognitive and behavioural (CB) intervention to support children with emotional, behavioural and/or social difficulties.

### **Why have I been chosen?**

You are a member of school staff who has received training around CBIs.

### **What would I be asked to do if I took part?**

- To be interviewed twice; once before and once after completing CBI with a young person/young people. Each interview will take an hour.
- To keep a brief record of your use of CBI. See record sheet attached.

Anonymous information resulting from these will be used as part of research if you consent to this.

### **What happens to the data collected?**

The data will be used to write about how you have used CBI, the barriers and facilitators to you using CBI and what you need to implement it successfully in school. The interviews from

all the participants will be looked at for themes. This information will be given back to you so you can comment on it.

### **How is confidentiality maintained?**

The data collected will be kept only by myself and kept securely in encrypted format so that no-one else will have access to it. No names will be used in any data or quotations that are reported. This means that you will not be identified in any way. Names will be changed in written reports and papers to ensure that you remain anonymous.

I am only obliged to break confidentiality if you reveal that you are being harmed in any way, or you state that you intend to harm/have harmed someone. In this case, I have a duty to report to an appropriate authority and we would agree who to tell.

### **What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself. If you do decide to withdraw, then any data that has been collected about you will be removed from the study and destroyed.

### **What is the duration of the research?**

From when you have taken part in the training, to when you finish using the intervention with a pupil/children or July (whichever comes first). Both interviews will last an hour.

### **Where will the research be conducted?**

At your school.

### **What will the research be used for?**

The research will be written up as a thesis and submitted to the university as part of my doctorate work.

### **Criminal Records Check**

I have undergone a satisfactory criminal records check.

### **Contact for further information**



Katie Caddick

Educational Psychology Service, Area Education Office, Ellesmere Port, Cheshire, CH65 6QL

Tel: 0151 3376819

Dr Garry Squires, Director of the Doctorate in Educational Psychology

Ellen Wilkinson Building – A6.6, School of Education, The University of Manchester, M13

9PL

## **Appendix E – Parent Information and Invite Form**

**Dear Parent,**

You are being invited to give consent for your child to be part of a research study as part of my Doctorate studies. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Then decide whether or not you wish to give consent.

Thank you for reading this.

### **Who will conduct the research?**

Katie Caddick: I am a qualified Educational Psychologist and doctoral student at the University of Manchester.

### **What is the aim of the research?**

The aim of this research is to explore how school staff can be supported to use a cognitive and behavioural (CB) intervention to support children with emotional, behavioural and/or social difficulties.

### **Why have I been chosen?**

Your child has been chosen to work with a member of school staff who has had training around CBIs.

### **What am I being asked to consent to?**

For me to provide monthly support to your child's teacher/teaching assistant about her work with your child. More specifically, for me to provide guidance to the teaching assistant/teacher about her use of CBI with your child. I will not need to see your child for this at all and my focus will be around supporting the teaching assistant to provide the intervention.

### **What happens to the data collected?**

I will use information from discussions with the teaching assistant/teacher to write about what school staff need to use CBI successfully in school. The research will be written up as a thesis and submitted to the university as part of my doctorate work.

**How is confidentiality maintained?**

The information collected will be kept only by myself and kept securely in encrypted format so that no-one else will have access to it. No names will be used in any information reported. This means that your child will not be identified in any way. Names will be changed in written reports and papers to ensure that your child remains anonymous.

I am only obliged to break confidentiality if your child reveals that they are being harmed in any way, or state that they intend to harm/have harmed someone. In this case, I have a duty to report to an appropriate authority and you would be informed of this.

**What happens if I do not want to give consent or if I change my mind?**

It is up to you to decide whether or not you consent to this. If you do decide to give consent you will be given this information sheet to keep and be asked to sign a consent form. If you decide to give consent you are still free to withdraw at any time without giving a reason and without detriment to yourself. If you decide to withdraw, then any information that has been collected about your child will be removed from the study and destroyed.

**What is the duration of the research?**

I will provide support to your child's teacher/teaching assistant between now and July or when he/she finishes using the intervention with your child (whichever comes first).

**Where will the research be conducted?**

At your child's school.

**Criminal Records Check**

I have undergone a satisfactory criminal records check.

**Contact for further information**

Katie Caddick, Psychology Service, Area Education Office, Ellesmere Port, Cheshire. Tel: 0151 3376819

Dr Garry Squires, Director of the Doctorate in Educational Psychology

Ellen Wilkinson Building – A6.6, School of Education, The University of Manchester, M13 9PL

## Appendix F – Participant Consent Form

Title of Project: **Exploring perceptions around the implementation of cognitive behavioural intervention by school staff following training and support.**

**Name of Researcher:** Katie Caddick

**School:** School of Education, University of Manchester

### **Participant (volunteer)**

Please read this and if you are happy to proceed, sign below.

The researcher has given me my own copy of the information sheet which I have read and understood. The information sheet explains the nature of the research and what I would be asked to do as a participant. I understand that the research is for a student project and that the confidentiality of the information I provide will be safeguarded unless subject to any legal requirements. She has discussed the contents of the information sheet with me and given me the opportunity to ask questions about it.

In summary, if you sign this form you are agreeing to (tick each one you agree to):

- To be interviewed twice; once before and once after completing CBI ☐
- To take part in monthly supervision sessions with me ☐
- To keep a record of your use of CBI ☐
- Me using their data, anonymously, for research purposes ☐

I agree to take part as a participant in this research and I understand that I am free to withdraw at any time without giving any reason, and without detriment to myself.

**Signed:**.....

**Date:**.....

**Full Name BLOCK LETTERS:**.....

**Researcher**

I, the researcher, confirm that I have discussed with the participant the contents of the information sheet.

**Signed:**.....

**Date:**.....

## Appendix G – Parent Consent Form

Title of Project: **Exploring perceptions around the implementation of cognitive behavioural intervention by school staff following training and support.**

**Name of Researcher:** Katie Caddick

**School:** School of Education, University of Manchester

### **Participant (volunteer)**

Please read this and if you are happy to proceed, sign below.

The researcher has given me my own copy of the information sheet which I have read and understood. The information sheet explains about the research and what I am being invited to consent to. I understand that the research is for a student project and that the confidentiality of the information I provide will be safeguarded unless subject to any legal requirements. She has discussed the contents of the information sheet with me and given me the opportunity to ask questions about it.

In summary, if you sign this form you are agreeing to (tick each box you agree to):

- Katie Caddick providing support and guidance to your child's teacher/teaching assistant about the cognitive and behavioural intervention that she is doing with your child. ☐
- Katie Caddick using information gained through these support sessions, anonymously, for research purposes. ☐

I agree to the above and I understand that I am free to withdraw at any time without giving any reason, and without detriment to myself.

**Signed:**.....

**Date:**.....

**Full Name BLOCK LETTERS:**.....

**Researcher**

I, the researcher, confirm that I have discussed with the participant the contents of the information sheet.

**Signed:**.....

**Date:**.....

## Appendix H – CBT Competences

<p><b>CB Competences</b></p> <p>(selected from CBT Competency Framework: University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014)</p>
1. Obtain informed consent for interventions from pupil/s
2. Maintain confidentiality, and know the conditions under which confidentiality can be breached
3. An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need
4. Develop rapport
5. Adjust the level of session activity and structuring of the session to the children needs
6. An ability to structure sessions
7. Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem
8. Knowledge of the cognitive component in CBI – the way children think about their lives
9. Knowledge of the link between thoughts, feelings and behaviours
10. Help the pupil to identify what a behaviour, thought and feeling is
11. Help the pupil to identify automatic thoughts which arise for them in specific situations by a detailed focus on these events
12. Help the pupil to specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings, and to identify the thoughts which are most closely associated with distress
13. Help the pupil to identify specific situations associated with specific automatic thoughts and feelings
14. Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours
15. Help the pupil to evaluate an important automatic thought in the session, prior to their completing the full thought record
16. Identify the stage of intervention when “hot” thoughts can be focused on
17. Help the pupil to identify “hot” thoughts
<p>18. Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals:</p> <ul style="list-style-type: none"> <li>• All or nothing thinking – viewing a situation in only two categories rather than on a continuum (e.g. oversimplifying events or beliefs as good/ bad or as right/wrong)</li> <li>• Catastrophising – predicting the future negatively without considering alternative outcomes</li> <li>• Disqualifying or discounting the positive – telling yourself that positive experiences/ qualities do not count</li> <li>• Emotional reasoning – reasoning from how you feel rather than from any evidence</li> <li>• Labelling – putting a fixed, global label on self or others without considering evidence that would lead to a less disastrous conclusion</li> <li>• Magnification/ minimisation – exaggerating the negative and minimising the</li> </ul>



<p>positive (blowing things out of proportion or shrinking their importance)</p> <ul style="list-style-type: none"> <li>• Selective abstraction – paying undue attention to negative detail rather than seeing the whole picture</li> <li>• ‘Mind-reading’ – making (negative) assumptions about the way in which others think about you when there is no evidence for this</li> <li>• Overgeneralisation – drawing a sweeping conclusions from a single incident and applying it to related and to unrelated situations</li> <li>• Personalisation – relating external events to yourself when there is no basis for making such a connection</li> <li>• Making ‘should’ and ‘must’ statements (“imperatives”) – having an over- precise idea of how you and others should behave, and overestimating the consequences of how bad it would be not to meet these expectations</li> <li>• Tunnel-vision – only seeing the negative aspects of a situation</li> </ul>
19. Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts
20. Help the pupil to use and complete relevant written records
21. Helping the pupil to manage negative thoughts
22. Help the pupil to increase their awareness of early signs of anxiety reactions
23. Help the pupil to maintain and apply their relaxation skills
24. Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework
25. Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment
26. Help the pupil to anticipate any possible problems, along with ways of overcoming these
27. Review the outcome of experiments (whether positive or negative ) with the pupil in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them
28. Help the pupil to select problems, on the basis that they are relevant and are ones with achievable
29. Help the pupil to specify the problem, and break down problems into manageable parts
30. Help the pupil to “brainstorm” possible solutions
31. Help the pupil to select a preferred solution
32. An ability to help the pupil to plan and implement preferred solutions
33. An ability to help the pupil to evaluate the outcome of implementation, whether positive or negative
34. Agree appropriate and manageable homework tasks with clear and specific precise goals
35. Discuss and review homework with the pupil in the next session, with the aim of helping them identify what they have learned from their experiences
36. Help the pupil to appraise the outcomes of homework: when outcomes are in line with the prior expectations of the therapist and pupil and when there is a different outcome from that which has been predicted
37. Integrate self-monitoring into the sessions (e.g. using a scale to monitor extent of problem), ensuring that the agenda for the session includes regular and consistent review of self-monitoring records

## Appendix I – Training Evaluation Forms

### TRAINING EVALUATION FORM – Session 1

Job Role:\_\_\_\_\_School:\_\_\_\_\_

Please rate your satisfaction on the following items with **1 being poor and 5 being excellent**:

	1	2	3	4	5
1 Overall rating for session	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 Content	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 Handouts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 Course Delivery	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5 What did you like most about the session?					
6 What could have been better?					
7 What will you do differently as a result of this session?					
8 What other training would you be interested in attending?					

9 a/ Which of the following CB competences do you FEEL ABLE to use? (tick relevant items)

b/ Which of the following CB competences do you think you WILL USE? (tick relevant items)

c/ In what context do you think you will use each competency that you have selected?  
(add a code next to each item ticked using the code below)

Code:

I = Individual child, DP = Discussion with parent, DS = Discussion with school staff,  
G = Group of children, C = Class of children, Other (specify)

CB competency	Example of activity	Feel Able to Use (tick)	Will Use (tick)	Context Used:
Obtain informed consent for interventions from pupil/s	Discussion with pupil.			
Maintain confidentiality, and know the conditions under which confidentiality can be breached	Discussion with parent and/or safeguarding officer if needed.			
An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need	Demonstrating empathy and active listening.			
Develop rapport	Fun activities and getting to know the pupil.			
Adjust the level of session activity and structuring of the session to the children needs	Not jumping ahead too soon for pupil. Being creative to aid understanding of difficult concepts.			
Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem	Understanding how the pupil getting aggressive feeds into their unhelpful thoughts.			
Knowledge of the cognitive component in CBI – the way children think about their lives	Considering the impact of their thoughts.			
Knowledge of the link between thoughts, feelings and behaviours	Being able to identify the CB cycle in one's own life.			

Help pupil identify what a behaviour, thought and feeling is	Behaviour detectors. Behaviour, thought and feeling basketball. Worksheets.			
Help pupil specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings	Elaborating on the thoughts that accompany different situations and feelings. Worksheets on thought bubbles.			
Help pupil identify specific situations associated with specific automatic thoughts and feelings	Eliciting verbal examples of thoughts and feelings associated with situations in school. Worksheets on the link between thoughts, feelings and behaviours.			
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	Worksheets on unhelpful thoughts, feelings and behaviours. Discussion.			

10. What will facilitate your use of CB competences at school?

11. What barriers will there be to your use of CB competences at school?

## TRAINING EVALUATION FORM – Session 2

Job Role: \_\_\_\_\_ School: \_\_\_\_\_

Please rate your satisfaction on the following items with **1 being poor and 5 being excellent**:

	1	2	3	4	5
1 Overall rating for session	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 Content	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 Handouts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 Course Delivery	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5 What did you like most about the session?					
6 What could have been better?					
7 What will you do differently as a result of this session?					
8 What other training would you be interested in attending?					

9 a/ Which of the following CB competences do you FEEL ABLE to use? (tick relevant items)

b/ Which of the following CB competences do you think you WILL USE? (tick relevant items)

c/ In what context do you think you will use each competency that you have selected?  
(add a code next to each item ticked using the code below)

Code:

I = Individual child, DP = Discussion with parent, DS = Discussion with school staff,

G = Group of children, C = Class of children, Other (specify)

CB competency	Example of activity	Able to Use (tick)	Will Use (tick)	Context Used:
Help pupil identify automatic thoughts which arise for them in specific situations by a detailed focus on these events	Discussion around scenario's. Worksheets – thought tracker with support.			
Help pupil specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings	Elaborating on the thoughts that accompany different situations and feelings. Worksheets on thought bubbles.			
Help pupil identify specific situations associated with specific automatic thoughts and feelings	Eliciting verbal examples of thoughts and feelings associated with situations in school. Worksheets on the link between thoughts, feelings and behaviours.			
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	Worksheets on unhelpful thoughts, feelings and behaviours. Discussion.			
Help the pupil evaluate an important automatic thought in the session, prior to their completing the full thought	Thought tracker – basic one.			

record				
Identify the stage of intervention when “hot” thoughts can be focused on	Pupil demonstrates that they have understood the above.			
Help the pupil to identify “hot” thoughts	‘Thermometer’ or ‘Red, Amber, Green’ activities.			
Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals	Identifying different examples for each thought error.			
Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts	Thinking Errors Assessment. Thought tracker including thought errors.			
Helping the pupil to manage negative thoughts	Distraction. Talk to someone. Coping and positive Self-talk. Thought Stopping. Throw Them Away.			

10. What will facilitate your use of CB competences at school?

11. What barriers will there be to your use of CB competences at school?

## TRAINING EVALUATION FORM – Session 3

Job Role:\_\_\_\_\_School:\_\_\_\_\_

Please rate your satisfaction on the following items with **1 being poor and 5 being excellent**:

	1	2	3	4	5
1 Overall rating for session	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 Content	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 Handouts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 Course Delivery	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5 What did you like most about the session?					
6 What could have been better?					
7 What will you do differently as a result of this session?					
8 What other training would you be interested in attending?					



9 a/ Which of the following CB competences do you FEEL ABLE to use? (tick relevant items)

b/ Which of the following CB competences do you think you WILL USE? (tick relevant items)

c/ In what context do you think you will use each competency that you have selected?  
(add a code next to each item ticked using the code below)

Code:

I = Individual child, DP = Discussion with parent, DS = Discussion with school staff,  
G = Group of children, C = Class of children

CB competency	Example of activity	Feel Able to Use (tick)	Will Use (tick)	Context Used:
Help pupil increase their awareness of early signs of anxiety reactions	Worksheets on 'Body Signals'.			
Help pupil maintain and apply their relaxation skills	Practice relaxation skills with pupil.			
Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework	Challenging evidence for/against the thoughts through discussion and experiments.			
Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment	Ask the pupil to describe why they are doing the experiment and what thoughts are being tested.			
Help the pupil anticipate any possible problems, along with ways of overcoming these	Discussion around potential problems.			
Help the pupil select problems, on the basis that they are relevant and are ones with achievable	Discussion.			
Help the pupil specify the problem, and break down problems into manageable parts	Discussion and worksheets on problem solving.			
Help the pupil "brainstorm" possible	Brainstorm on flip			

solutions	chart.			
Help the pupil select a preferred solution	Discussion and problem solving worksheet.			
Agree appropriate and manageable homework tasks with clear and specific precise goals	Worksheets and discussion.			
Discuss and review homework with pupil in the next session, with the aim of helping them identify what they have learned from their experiences	Discussion every session regarding homework set.			
Integrate self-monitoring into the sessions e.g. using a scale to monitor extent of problem	Use the scale.			

10. What will facilitate your use of CB competences at school?

11. What barriers will there be to your use of CB competences at school?

## TRAINING EVALUATION FORM – Session 4

Job Role: \_\_\_\_\_ School: \_\_\_\_\_

Please rate your satisfaction on the following items with **1 being poor and 5 being excellent**:

	1	2	3	4	5
1 Overall rating for session	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 Content	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 Handouts	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 Course Delivery	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5 What did you like most about the session?					
6 What could have been better?					
7 What will you do differently as a result of this session?					
8 What other training would you be interested in attending?					

9 a/ Which of the following CB competences do you FEEL ABLE to use? (tick relevant items)

b/ Which of the following CB competences do you think you WILL USE? (tick relevant item)

c/ In what context do you think you will use each competency that you have selected?  
(add a code next to each item ticked using the code below)

Code:

I = Individual child, DP = Discussion with parent, DS = Discussion with school staff,  
G = Group of children, C = Class of children

CB competency	Example of activity	Feel Able to Use (tick)	Will Use (tick)	Context Used:
Obtain informed consent for interventions from pupil/s	Discussion with pupil.			
Maintain confidentiality, and know the conditions under which confidentiality can be breached	Discussion with parent and/or safeguarding officer if needed.			
An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need	Demonstrating empathy and active listening.			
Develop rapport	Fun activities and getting to know the pupil.			
Adjust the level of session activity and structuring of the session to the children needs	Not jumping ahead too soon for pupil. Being creative to aid understanding of difficult concepts.			
Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem	Understanding how the pupil getting aggressive feeds into their unhelpful thoughts.			
Knowledge of the cognitive component in CBI – the way children think about their lives	Considering the impact of their thoughts.			
Knowledge of the link between thoughts, feelings and behaviours	Being able to identify the CB cycle in one's own life.			
Help pupil identify what a	Behaviour detectors.			

behaviour, thought and feeling is	Behaviour, thought and feeling basketball. Worksheets on the model.			
Help pupil identify automatic thoughts which arise for them in specific situations by a detailed focus on these events	Discussion around scenario's. Worksheets – thought tracker with support.			
Help pupil specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings	Elaborating on the thoughts that accompany different situations and feelings. Worksheets – thought bubbles.			
Help pupil identify specific situations associated with specific automatic thoughts and feelings	Eliciting verbal examples of thoughts and feelings associated with situations in school. Worksheets on the link between thoughts, feelings and behaviours.			
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	Worksheets on unhelpful thoughts, feelings and behaviours. Discussion.			
Help the pupil evaluate an important automatic thought in the session, prior to their completing the full thought record	Thought tracker – basic one.			
Identify the stage of intervention when “hot” thoughts can be focused on	Pupil demonstrates that they have completed and understood the above.			
Help the pupil to identify “hot” thoughts	‘Thermometer’ or ‘Red, Amber, Green’ activities.			
Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals	Identifying different examples for each thought error.			
Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts	Thinking Errors Assessment. Thought tracker including thought errors			
Helping the pupil to manage negative thoughts	Distraction. Talk to someone. Coping and positive Self-talk. Thought Stopping. Throw Them Away.			
Help pupil increase their awareness of early signs of anxiety reactions	Worksheets on ‘Body Signals’.			
Help pupil maintain and apply their	Practice relaxation skills			

relaxation skills	with pupil.			
Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework	Challenging evidence for/against the thoughts through discussion and experiments			
Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment	Ask the pupil to describe why they are doing the experiment and what thoughts they are testing.			
Help the pupil anticipate any possible problems, along with ways of overcoming these	Discussion around potential problems.			
Help the pupil select problems, on the basis that they are relevant and are ones with achievable	Discussion.			
Help the pupil specify the problem, and break down problems into manageable parts	Discussion and worksheet on problem solving.			
Help the pupil "brainstorm" possible solutions	Brainstorm on flip chart.			
Help the pupil select a preferred solution	Discussion and worksheet on problem solving.			
Agree appropriate and manageable homework tasks with clear and specific precise goals	Worksheets and discussion.			
Discuss and review homework with pupil in the next session, with the aim of helping them identify what they have learned from their experiences	Discussion every session regarding homework set.			
Integrate self-monitoring into the sessions e.g. using a scale to monitor extent of problem	Use the scale.			

10. What will facilitate your use of CB competences at school?

11. What barriers will there be to your use of CB competences at school?

## **Appendix J - Factors Affecting the Implementation Process (based on Durlak & DuPre, 2008)**

### Community Level Factors

Prevention Theory and Research

Policies

Funding

Policy

### Provider Characteristics

Perceived Need for Innovation

Extent to which the proposed innovation is relevant to local needs

Perceived benefits of innovation

Extent to which the innovation will achieve benefits desired at the local level

Self-efficacy

Extent to which providers feel they are able to do what is expected

Skill Proficiency

Possession of the skills necessary for implementation

### Innovation Characteristics

Compatibility (contextual appropriateness, fit, congruence, match)

Extent to which the innovation fits with an organizational mission, priorities, and values

Adaptability (programme modification)

The extent to which the proposed programme can be modified to fit provider preferences, organisational practices, and community needs, values and cultural norms

### Factors Relevant to the Prevention Delivery System

#### General Organisational Factors

- Positive work climate
- Climate may be assessed by sampling views about morale, trust, collegiality, and methods of resolving disagreements
- Organisational norms regarding change (aka openness to change, innovativeness, risk taking)

- This refers to the collective reputation and norms held by an organisation in relation to its willingness to try new approaches as opposed to maintaining the status quo.
- Integration of new programming
- This refers to the extent to which an organisation can incorporate an innovation into its existing practices and routines
- Shared vision (shared mission, consensus, commitment, staff buy-in)
- This refers to the extent to which organisational members are united regarding the value and purpose of the innovation

#### Specific Practices and Processes

- Shared decision-making (local input, community participation or involvement, local ownership, collaboration)
- The extent to which relevant parties (e.g. researchers, providers and community members) collaborate in determining what will be implemented and how
- Coordination with other agencies (partnerships, networks, multi-disciplinary linkages)
- The extent to which there is cooperation and collaboration amongst local agencies that can bring different perspectives, skills, and resources to bear on programme implementation
- Communication
- Effective mechanisms encouraging frequent and open communication
- Formulation of tasks (workgroups, teams, effective human resource management, formalisation)
- Procedures that enhance strategic planning and contain clear roles and responsibilities relative to task accomplishments

#### Specific Staffing Considerations

- Leadership
- Leadership is important in many respects, for example, in terms of setting priorities, establishing consensus, offering incentives, and managing the overall process of implementation
- Programme champion (internal advocate)



- An individual who is trusted and respected by staff and administrators, and who can rally and maintain support for the innovation, and negotiate solutions to problems that develop
- Managerial/supervisory/administrative support
- Extent to which top management and immediate supervisors clearly support and encourage providers during implementation

### Factors Relevant to the Prevention Support System

#### Training

Approaches to insure provider proficiencies in the skills necessary to conduct the intervention and to enhance providers' sense of self-efficacy

#### Technical Assistance

This refers to the combination of resources offered to providers once implementation begins, and may include retraining in certain skills, training of new staff, emotional support, and mechanisms to promote local problem solving efforts

## Appendix K – Pre-intervention Interview Template

### Pre-Intervention Interview

#### Part 1 – warm up and open ended interview

1. How have you found the training and the intervention so far?
2. What do you think you will use from the training? What do you think you will not use from the training? E.g. particular: skills, activities, ideas, approaches, structures....
3. How do you think you will use the intervention in school? E.g. in what context – class, group, individual, discussions with adults, discussions with children....
4. Who do you think you will use this with? E.g. what are their characteristics – age, ability, difficulties, strengths...
5. What will help you to implement the intervention?
6. What will hinder your implementation of the intervention?

#### Part 2 – structured interview (based on Durlak & DuPre, 2008)

##### Factors Relevant to the Prevention Support System

7. To what extent do you think *the training* has prepared you to deliver the intervention?  
Both in terms of developing the skills necessary and in enabling you feel able/confident and motivated to deliver it?
8. What approaches were used, and were not used, in the training to influence your views on the above? E.g. role play, discussion, activities, visual aids, teaching, observation...

9. What support and resources do you feel that you need or would benefit from once you have started delivering the intervention? E.g. further training, materials, guidance, supervision, emotional support....

#### Provider Characteristics

10. How able do you feel to do what is expected for the intervention?
11. Do you feel that you have the necessary skills to implement the intervention?
12. What is your opinion on the need for this intervention in your school and wider community?
13. How much do you think this intervention will benefit your school? In what ways?

#### Community Level Factors

14. Do you think that any of the following factors might impact on your intervention implementation? If so, how?

Politics, Funding or Policy within the school or community.

#### Innovation Characteristics

15. To what extent do you feel that this intervention fits with your schools organizational mission, priorities, and values?
16. Do you feel that the intervention can be sufficiently modified to suit your needs, children's needs, the schools needs, families' needs?

#### Factors Relevant to the Prevention Delivery System

##### *General Organisational Factors*

17. Can you describe, in your view, what morale, trust and what methods of resolving disagreements are like in your school?
18. How would you describe your schools willingness to try new approaches as opposed to maintaining the status quo?
19. To what extent do you think that your school incorporates interventions into its existing practices and routines?
20. To what extent do you feel that school colleagues are united regarding the value and purpose of the intervention?

*Specific Practices and Processes*

21. To what extent do you think parents, children, other school staff and outside agencies will collaborate in determining what and how the intervention is implemented? In other words, how much do you think others will share the decision making?
22. To what extent do you think there will be cooperation and collaboration amongst local agencies that can bring different perspectives, skills, and resources to bear on programme implementation?
23. How would you describe communication within your school? E.g. is it frequent and open or poor and mistrusting? What mechanisms for communication are used?
24. Do you feel that roles and responsibilities in school are generally clear? What about in relation to the intervention?

*Specific Staffing Considerations*

25. How do you think leadership in your school will effect intervention implementation? E.g. prioritising and managing the overall process of implementation

26. Do you feel that you are in a position to promote the intervention? Do you feel you are in a position to negotiate solutions to problems that develop?
27. To what extent do you feel that you will get support and encouragement from relevant teachers and senior management during the intervention?

## Appendix L – Post-intervention Interview Template

### Post-Intervention Interview

#### Part 1 – Open ended interview

1. How have you found the intervention?

2. What CB competences have you used?

Prompts – show CB competences list. Which have you used most/least often?

Which have you developed the most/least? Why those ones? How able did you feel?

3. How have you used the intervention in school?

Prompts – in what context? Class, group, individual, discussions with adults, discussions with children? Prompt – Describe in as much detail as possible how you have used them. Why used in these contexts rather than others?

4. What has helped you to implement the intervention?

Prompt to get richer data – get to root of facilitators. Any others?

5. What has hindered your implementation of the intervention?

Prompt to get richer data – get to root of barriers. Any others?

6. What, if any, has been the impact of Supervision OR lack of Supervision?

Prompts – what difference did it make/what do you think would have been different without/with it? How could support have been better?

#### Part 2 – Semi-structured interview (based on Durlak & DuPre, 2008)

**Interviewee to prompt for more detail where needed – enhance on richness of pre-intervention interview.**

#### Factors Relevant to the Prevention Support System

7. To what extent do you think *the training* prepared you to deliver the intervention? Both in terms of developing the skills necessary and in enabling you feel able/confident and motivated to deliver it?

8. What support and resources do you feel that you would have benefitted from, or did benefit from, to support you to deliver the intervention? E.g. further training, materials, guidance (from link CEP or colleagues), supervision (group or individual), emotional support....
9. What approaches were used, and were not used, that aided/would have aided you to implement the intervention? E.g. styles or methods of supervision or support

#### Provider Characteristics

10. How able did you feel to do what was expected for the intervention? Prompt e.g. did you have the necessary skills?
11. What in your opinion was the need for this intervention in your school and wider community?
12. How much do you think this intervention has benefited your school? In what ways?

#### Community Level Factors

13. Do you think that any of the following factors impacted on your intervention implementation? If so, how?

Politics, Funding or Policy within the school or community.

#### Innovation Characteristics

14. To what extent did you feel that this intervention fitted with your schools organizational mission, priorities, and values?
15. Did you feel that the intervention could be sufficiently modified to suit your needs, children's needs, the schools needs, and families' needs?

## Factors Relevant to the Prevention Delivery System

### *General Organisational Factors*

16. Can you describe, in your view, what morale, trust and methods of resolving disagreements have been like in your school?
17. How would you describe your schools willingness to try new approaches as opposed to maintaining the status quo?
18. To what extent do you feel that school colleagues were united regarding the value and purpose of this intervention?

### *Specific Practices and Processes*

19. To what extent did you think parents, children, other school staff and outside agencies collaborated in determining what and how the intervention was implemented? In other words, how much do you think others shared the decision making?
20. Can you describe how communication has been within your school? Prompt e.g frequent and open or poor and mistrusting? What mechanisms for communication were used?
21. Do you feel that roles and responsibilities in school were generally clear? What about in relation to the intervention?

### *Specific Staffing Considerations*

22. How do you think leadership in your school effected intervention implementation?  
E.g. prioritising and managing the implementation
23. Did you feel that you were in a position to promote the intervention and negotiate solutions to problems that developed?
24. To what extent did you feel that you got support and encouragement from relevant teachers and senior management during the intervention?



## **Appendix M – Criteria for Intervention**

### Criteria for school staff using CBI

The children involved in this intervention should satisfy the following criteria:

- They are presenting with social, emotional and/or behavioural difficulties, including externalising behaviours (e.g. aggression or ‘acting out’ behaviours) and/or internalising behaviours (e.g. anxiety or withdrawn).
- Key adults have agreed that they are likely to benefit from the intervention – including the school SENCo, teacher, parent/s and any other professionals currently involved with the pupil.
- They are aware of the nature of the intervention and have consented to working with you.
- Their parents/carers are aware of the nature of the intervention and have consented to you working with their child through the use of this intervention.
- They are not already receiving professional support for their emotional and behavioural difficulties (e.g. counselling or other psychological input).
- They are at least 7 years old and have adequate cognitive abilities: children need sufficient linguistic and cognitive abilities to access CBI. You may need to adapt and present ideas and strategies to suit the child’s linguistic and cognitive abilities.

## **Appendix N – Individual Supervision Statement and Record**

### **Supervision Contract**

#### ***Aims and Purpose of Supervision*** (based on Squires & Williams, 2003)

1. Educative – to provide opportunities to explore and learn from practical, experiential and theoretical elements of practice.
2. Supportive and Managerial – to provide an opportunity to discuss potentially controversial or ethical issues.
3. Managerial – to enhance the quality of service delivery.
4. Supportive – to maintain and improve emotional health of supervisee.

#### ***Arrangements for preparation and recording***

The supervisee will be asked to consider items for discussion in advance to each session. Items must be related to the CBI: there are no other restrictions regarding items for discussion. The supervisor will record the supervision using a supervision record form. All comments will be agreed with the supervisee before recording them on the form. Both parties will sign the form on completion. A copy of the form will be left with the supervisee and a copy kept by the supervisor.

#### ***Description of model used*** (based on Scaife 1993)

The most helpful supervisory role (i.e. to inform-assess, listen-reflect or enquire), supervisory focus (i.e. actions and events, knowledge, thinking and planning or feelings and personal qualities) and supervisory medium (i.e. live, recorded sessions, role play or reporting) to use will be discussed and identified between the supervisee and supervisor in advance to the session. This will be reviewed and evaluation at the end of each session.

#### ***Responsibilities of those involved***

The supervisor will aim to demonstrate the core skills of: active listening, confidentiality, self-reflection, refraining from judgment, identifying boundaries and awareness of personal issues and feelings (based on Squires and Williams, 2003, and Osborne, 1993, cited in Nolan, 1999).

The supervisor is asked to engage with the process and be as honest as possible.

***Process (how monitored and evaluated)***

Each session will include an evaluation; this will inform any changes that need to be made to the supervision process to enhance its success.

***Record form***

The following supervision record form will be used, based on: Scaife, 1993; Squires and Williams, 2003; and University College London: Centre for Outcomes, 2011, CBT competences and Supervision Guidance.

### Supervision Record

*Date:*

*Time:*

*Supervisee:*

*Supervision Meeting Number:*

Item discussed	Actions agreed
<i>E/M/S/Eth</i>	
<i>E/M/S/Eth</i>	
<i>E/M/S/Eth</i>	
<i>E/M/S/Eth</i>	

*(E = Educative aim, M = Managerial aim or S = Supportive aim, Eth = Ethical aim)*

How effective was the supervision? (on a scale of 1 – 5, with 1 being least effective and 5 being most effective)

What was most useful about the session?

What was least useful about the session?

Any actions related to supervision process agreed for next session:

Supervisee signature:

Supervisor signature:

<b>1. Supervisor role</b>	Inform-Assess	Listen-Reflect	Enquire	
<b>2. Supervisory focus</b>	Actions and Events	Knowledge	Thinking and Planning	Feelings and Personal Qualities
<b>3. Supervisory medium</b>	Live	Recorded Sessions	Role Play	Reporting

NB: Researcher and supervisee identify which of the following competencies have been developed through the supervision session (tick box).

<b>CB Competences (selected from: University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014)</b>	<b>Developed through supervision</b>
Obtain informed consent for interventions from pupil/s	
Maintain confidentiality, and know the conditions under which confidentiality can be breached	
An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need	
Develop rapport	
Adjust the level of session activity and structuring of the session to the children needs	
An ability to structure sessions	
Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem	
Knowledge of the cognitive component in CBI – the way children think about their lives	
Knowledge of the link between thoughts, feelings and behaviours	
Help the pupil to identify what a behaviour, thought and feeling is	
Help the pupil to identify automatic thoughts which arise for them in specific situations by a detailed focus on these events	
Help the pupil to specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings, and to identify the thoughts which are most closely associated with distress	
Help the pupil to identify specific situations associated with specific automatic thoughts and feelings	
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	
Help the pupil to evaluate an important automatic thought in the session, prior to their completing the full thought record	
Identify the stage of intervention when “hot” thoughts can be focused on	
Help the pupil to identify “hot” thoughts	
<p>Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals:</p> <ul style="list-style-type: none"> <li>• All or nothing thinking – viewing a situation in only two categories rather than on a continuum (e.g. oversimplifying events or beliefs as good/ bad or as right/wrong)</li> <li>• Catastrophising – predicting the future negatively without considering alternative outcomes</li> <li>• Disqualifying or discounting the positive – telling yourself that positive experiences/ qualities do not count</li> <li>• Emotional reasoning – reasoning from how you feel rather than from any evidence</li> <li>• Labelling – putting a fixed, global label on self or others without considering evidence that would lead to a less disastrous conclusion</li> <li>• Magnification/ minimisation – exaggerating the negative and minimising the positive (blowing things out of proportion or</li> </ul>	

<p>shrinking their importance)</p> <ul style="list-style-type: none"> <li>• Selective abstraction – paying undue attention to negative detail rather than seeing the whole picture</li> <li>• ‘Mind-reading’ – making (negative) assumptions about the way in which others think about you when there is no evidence for this</li> <li>• Overgeneralisation – drawing a sweeping conclusions from a single incident and applying it to related and to unrelated situations</li> <li>• Personalisation – relating external events to yourself when there is no basis for making such a connection</li> <li>• Making ‘should’ and ‘must’ statements (“imperatives”) – having an over- precise idea of how you and others should behave, and overestimating the consequences of how bad it would be not to meet these expectations</li> <li>• Tunnel-vision – only seeing the negative aspects of a situation</li> </ul>	
Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts	
Help the pupil to use and complete relevant written records	
Helping the pupil to manage negative thoughts	
Help the pupil to increase their awareness of early signs of anxiety reactions	
Help the pupil to maintain and apply their relaxation skills	
Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework	
Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment	
Help the pupil to anticipate any possible problems, along with ways of overcoming these	
Review the outcome of experiments (whether positive or negative ) with the pupil in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them	
Help the pupil to select problems, on the basis that they are relevant and are ones with achievable	
Help the pupil to specify the problem, and break down problems into manageable parts	
Help the pupil to “brainstorm” possible solutions	
Help the pupil to select a preferred solution	
An ability to help the pupil to plan and implement preferred solutions	
An ability to help the pupil to evaluate the outcome of implementation, whether positive or negative	
Agree appropriate and manageable homework tasks with clear and specific precise goals	
Discuss and review homework with the pupil in the next session, with the aim of helping them identify what they have learned from their experiences	
Help the pupil to appraise the outcomes of homework: when outcomes are in line with the prior expectations of the therapist and pupil when there is a different outcome from that which has been predicted	
Integrate self-monitoring into the sessions (e.g. using a scale to monitor extent of problem), ensuring that the agenda for the session includes regular and consistent review of self-monitoring records	

## Appendix O – Intervention Diary Template

**Please use this record at least once a week and whenever you notice yourself using a CB competency. It is best filled in as soon after you have used CBI as possible:**

1. Identify which competency you have used.
2. Use the code below to describe in which context the competency was used (record in column next to relevant competency identified).

I = work with individual pupil, DP = discussion with parent, DS = discussion with school staff, G = work with group of children, C = work with whole class or Other (please specify)

3. Please add additional notes below the table.

### ***Date Filled In:***

<b>CB Competency</b> (selected from: University College London: Centre for Outcomes Research and Effectiveness (CORE), 1999 - 2014)	<b>Example of activity</b>	<b>Context Used:</b>
Obtain informed consent for interventions from pupil/s	Discussion with pupil.	
Maintain confidentiality, and know the conditions under which confidentiality can be breached	Discussion with parent and/or safeguarding officer if needed.	
An ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to children need	Demonstrating empathy and active listening.	
Develop rapport	Fun activities and getting to know the pupil.	
Adjust the level of session activity and structuring of the session to the children needs	Not jumping ahead too soon for pupil. Being creative to aid understanding of difficult concepts.	
An ability to structure sessions	Coherent structure to sessions	
Knowledge of the behavioural component in CBI – the ways in which children respond to distress by behaviours which can worsen their problem	Understanding how the pupil getting aggressive feeds into their unhelpful thoughts.	
Knowledge of the cognitive component in CBI – the way children think about their lives	Considering the impact of their thoughts.	
Knowledge of the link between thoughts, feelings and behaviours	Being able to identify the CB cycle in one's own life.	
Help pupil identify what a behaviour, thought and feeling is	Behaviour detectors. Behaviour, thought and feeling basketball. Worksheets on the model.	

Help pupil identify automatic thoughts which arise for them in specific situations by a detailed focus on these events	Discussion around scenario's. Worksheets – thought tracker with support.	
Help pupil specify the actual phrasing of their thoughts, to help them distinguish thoughts from feelings	Elaborating on the thoughts that accompany different situations and feelings. Worksheets – thought bubbles.	
Help pupil identify specific situations associated with specific automatic thoughts and feelings	Eliciting verbal examples of thoughts and feelings associated with situations in school. Worksheets on the link between thoughts, feelings and behaviours.	
Explain the rationale for a focus on behaviours and cognitions, including the association between thoughts, feelings and behaviour and how unhelpful thoughts can lead to unhelpful feelings and behaviours	Worksheets on unhelpful thoughts, feelings and behaviours. Discussion.	
Help the pupil evaluate an important automatic thought in the session, prior to their completing the full thought record	Thought tracker – basic one.	
Identify the stage of intervention when “hot” thoughts can be focused on	Pupil demonstrates that they have completed and understood the above.	
Help the pupil to identify “hot” thoughts	‘Thermometer’ or ‘Red, Amber, Green’ activities.	
Knowledge of the common thought errors (“cognitive distortions”) that are observed in all individuals	Identifying different examples for each thought error.	
Helping the pupil to identify their own cognitive distortions in relation to specific events/thoughts	Thinking Errors Assessment. Thought tracker including thought errors	
Help the pupil to use and complete relevant written records	e.g. feelings diary or emotional barometer	
Helping the pupil to manage negative thoughts	Distraction. Talk to someone. Coping and positive Self-talk. Thought Stopping. Throw Them Away.	
Help pupil increase their awareness of early signs of anxiety reactions	Worksheets on ‘Body Signals’.	
Help pupil maintain and apply their relaxation skills	Practice relaxation skills with pupil.	
Devise behavioural experiments which can directly test the accuracy of the children thoughts, which help children construct new, more helpful thoughts, and which can be carried out in the session or as homework	Challenging evidence for/against the thoughts through discussion and experiments	
Ensure that the aim of the experiment is clear and understood by the pupil, and that the pupil is aware of the thoughts being targeted by the experiment	Ask the pupil to describe why they are doing the experiment and what thoughts they are testing.	
Help the pupil anticipate any possible problems, along with ways of overcoming these	Discussion around potential problems.	
Review the outcome of experiments (whether	e.g. reviewing the effects of a	



positive or negative ) with the pupil in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them	strategy they have tried	
Help the pupil select problems, on the basis that they are relevant and are ones with achievable	Discussion.	
Help the pupil specify the problem, and break down problems into manageable parts	Discussion and worksheet on problem solving.	
Help the pupil “brainstorm” possible solutions	Brainstorm on flip chart.	
Help the pupil select a preferred solution	Discussion and worksheet on problem solving.	
An ability to help the pupil to plan and implement preferred solutions	e.g. consider specific actions to address identified issues	
An ability to help the pupil to evaluate the outcome of implementation, whether positive or negative	e.g. review how effective the strategy was	
Agree appropriate and manageable homework tasks with clear and specific precise goals	Worksheets and discussion.	
Discuss and review homework with pupil in the next session, with the aim of helping them identify what they have learned from their experiences	Discussion every session regarding homework set.	
Help the pupil to appraise the outcomes of homework: when outcomes are in line with the prior expectations of the therapist and pupil when there is a different outcome from that which has been predicted	e.g. reviewing a feelings diary.	
Integrate self-monitoring into the sessions e.g. using a scale to monitor extent of problem	Use the scale.	

Describe any difficulties/barriers you had around using the CB competences?

Describe any facilitators to you using the CB competences?

Any other thoughts about the CBI: (e.g. around how well it is going, what you are doing, whether it is having an impact.....) – if needed, continue on the back of the page.

## Appendix P – Intervention Diary Responses Collated for RQ3

Where a factor corresponds to a category identified in Durlak and DuPre’s model, this is presented in *italics*.

A \* denotes where a factor does not correspond directly/at all to a Durlak and DuPre category.

P1 = Participant 1 (individually supervised)

P2 = Participant 2 (group supervised)

School (and Partic- ipant)	Facilitators	Barriers	Other Reflections
S1 (1)	<p>Use the library as is private/relaxed area. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Being given the time. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Access to materials. <i>Factors relevant to the prevention support system</i></p> <p>Used with child in playground as she was upset. *</p> <p>Identify different feelings sheet – Feeling diary sheet. <i>Factors relevant to the prevention support system and Innovation characteristics</i></p> <p>Different feelings diary. <i>Factors relevant to the prevention support system and Innovation characteristics</i></p> <p>Child says feels relaxed with talking to me. <i>Provider characteristics*</i></p> <p>Knowing when and where we are going to speak. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention</i></p>	<p>Place to do the intervention <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Finding a place to work. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Also time consuming finding and printing off animals for the book. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Computer not working for us to print off pictures of different ‘feeling’ animals for our book. <i>Factors relevant to the prevention support system *</i></p> <p>Finding a place (quiet/private) for CBI. <i>Factors relevant to the prevention support system</i></p> <p>Finding a quiet place to take the intervention. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>References to pupil not understanding intervention</p>	<p>Opened up more about the feeling ‘sad’.</p> <p>Started to touch upon some of the competences (above).</p> <p>Pupil opened up about how he feels when he is angry (hot).</p> <p>Pupil spoke about a difficult situation and easy (situation). Difficult = literacy (Big write), Easy = numeracy. He also gave ideas about the book, thinking of words (feelings) to go in it.</p> <p>Talking about cycle and experiences linked to</p>

<p><i>delivery system</i></p> <p>Pupil is thinking more about it. *</p> <p>Supervision. <i>Factors relevant to the prevention support system</i></p> <p>References to children enjoyment and engagement in the intervention e.g. Pupil is relaxed and looks forward to the sessions (his words) and I feel today's sessions went well. Pupil identified his [problem] situation – 'Big Write' and thoughts, feelings and behaviour. *</p> <p>Have a good rapport with the child as he expressed his views. Potential facilitator to intervention implementation. <i>Provider characteristics *</i></p> <p>Using the management room as no other room available. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Pupil is discussing thoughts, feelings and behaviours quite openly [now]. *</p> <p>We now have a more private room (although located for adults/staff to be nearby). <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Pupil was very vocal in this session saying he had tried some skills in class. This session went very well. Pupil is now understanding his thoughts, feelings and behaviours that his anxiety</p>	<p>concepts under 'other reflections' (next column) e.g. ...although [pupil] is still not understanding all feelings. Potential barrier to intervention implementation. <i>Innovation Characteristics *</i></p> <p>Privacy – cleaner came in/asked cleaner to leave. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Finding space to talk. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Pupil didn't understand what feelings were. <i>Provider Characteristics *</i></p> <p>Unable to determine feelings! <i>Provider Characteristics *</i></p> <p>Parent wasn't happy to give consent at first – worried about singling his child out. <i>Factors relevant to the prevention delivery system: Specific Practices and processes</i></p> <p>Missed last week as had to help Miss P (TA observations). <i>Factors relevant to the prevention delivery system: General organisational factors, Specific practices and processes and Specific staffing considerations</i></p> <p>References made to father of pupil liaising with class teacher and intervention facilitator about the intervention, under 'other reflections' in next column. <i>Factors relevant to the prevention delivery system: specific practices and processes, although</i></p>	<p>worried/difficult situation. Easy/Happy. Touched on big write/worried Maths/Happy</p> <p>Took home feeling diary sheet (holidays). Still on the feelings diary as pupil did not fill it in over holidays.</p> <p>He is still relaxed, but not totally understanding feelings and how to describe them.</p> <p>Began to understand feelings but needs more input.</p> <p>Knows when his negative thoughts start that it links to behaviour.</p> <p>Just touched on some competences. Identify different feelings sheet and how strong is the feeling.</p> <p>Thought pupil would be</p>
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<p>causes. He was open and liked the traffic light system. He told me that he had already been using coping self talk and positive self talk ...(goes on to describe a session)...I spoke to pupil about a situation in maths; the class teacher said she could see him getting upset then he just stopped and carried on with his work. He said he did not understand the work and in his head he was saying “I can’t do it”. Then he used deep breathing, thinking “It is ok, I won’t be told off for not understanding”, calmed down and stopped worrying. Next time he said he would use the traffic light system as he doesn’t like to write anything down in class...all in all this was a very good session and children anxious moments seem to be happening less and less. <i>Provider characteristics *</i></p> <p>Uninterrupted during this session. <i>Factors relevant to the prevention support system but also indirectly linked to: Factors relevant to the prevention delivery system: General organisational factors and Specific Staffing considerations</i></p> <p>We now have a private room – we are not disturbed. New place to have our sessions. <i>Factors relevant to the prevention support system but also indirectly linked to: Factors relevant to the prevention delivery system: General organisational factors and Specific Staffing considerations</i></p> <p>Pupil is taking a very active part in these sessions asking relevant questions – “Can you have more than one feeling?” *</p> <p>After my conversation with the</p>	<p><i>parent not necessarily involved in decision making.</i></p> <p>None this week x3</p> <p>Pupil does not complete homework. <i>Innovation Characteristics *</i></p> <p>People coming in and out of the area where we work. Pupil prefers to be on our own. <i>Factors relevant to the prevention support system and factors relevant to the prevention delivery system: General organisational factors and Specific Staffing considerations</i></p> <p>People in and out. The area was too public; pupil was distracted and uncomfortable – not relaxed enough to go further into the discussion. <i>Factors relevant to the prevention support system but also indirectly linked to: Factors relevant to the prevention delivery system: General organisational factors and Specific Staffing considerations</i></p> <p>Would work better if pupil would remember to do his homework. <i>Innovation Characteristics *</i></p>	<p>nervous about moving into Year 5 (transition). Pupil said he wasn’t as he felt relaxed and if he got anxious he would deep breathe and use the traffic light system.</p> <p>Participant made references to talking through specific strategies with pupil.</p> <p>Sent pupil out with homework – thought for the week – unhelpful and helpful thoughts and ideas for our book.</p> <p>Still need to revisit some areas – tracker for thoughts and feelings etc.</p> <p>Dad spoke to me to ask how it was going. I asked if pupil spoke of our session, he said “No he didn’t”. I explained to</p>
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	<p>supervisor I feel better carrying on, following what we had decided to do – continue with our book. <i>Factors relevant to the prevention support system and Provider characteristics</i></p>		<p>dad how it was going but that I had given pupil homework to complete on a couple of occasions and they hadn't been completed. ....(explained about the homework tasks)...also dad spoke to class teacher asking if there was a difference in pupil within class. Miss C [teacher] said there was a noticeable improvement</p> <p>Talked mostly as pupil seemed comfortable with this [rather than completing recorded activities]. in pupil.</p>
S1 (2)	<p>Very useful having had the training – able to draw on elements of the training at various times during the term. <i>Factors relevant to the prevention support system and Provider characteristics</i></p> <p>Used with 2 children during a residential trip, with one child used twice e.g. when child was anxious about using the 'Zip Wire'. <i>Innovation characteristics</i></p>	<p>The children I was intending to work with following the training have been picked up by our family support worker instead. I have passed on some of the material from the course that she might find useful to use with these children. <i>Factors relevant to the prevention delivery system: specific practices and processes *</i></p> <p>At this present time another member of staff has been given children to work with instead of</p>	<p>Asked pupil to draw a picture of helpful/nice thoughts.</p>

		<p>me using SENCo management time (Family Support Worker who has not been to training in our setting, though is using similar materials/programme). <i>Factors relevant to the prevention delivery system: specific practices and processes *</i></p> <p>Timetabling not enough time to fit in children who would benefit. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p>	
S2 (1)	<p>Gaining confidence. <i>Factors relevant to the prevention support system and Provider characteristics</i></p> <p>Our increasing confidence meant we could tease discussion from some of the children. <i>Factors relevant to the prevention support system and Provider characteristics</i></p> <p>Having an impact on 25% of children. <i>Possible indirect link to: Factors relevant to the prevention support system and Provider characteristics *</i></p>	<p>Time – repeatedly referred to by participant. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Didn't get through [session] as well as planned. <i>Provider characteristics *</i></p> <p>Pupils not remembering difference between thoughts and feelings. <i>Provider characteristics *</i></p> <p>Time restraints. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Still taking longer than planned; explanations needed. <i>Provider characteristics *</i></p> <p>Pupils very quiet, all reluctant to participate. <i>Provider characteristics *</i></p> <p>Still no homework. <i>Possible Innovation characteristics and Provider characteristics</i></p> <p>Child protection issue – pupil didn't volunteer any information.*</p>	<p>Although I feel the sessions are not progressing as planned, the children feel they are benefitting.</p>

		<p>50% of group now unable to identify the reason for them attending the group. <i>Provider characteristics and indirectly linked to Factors relevant to the prevention delivery system: general organisational factors, specific practices and processes</i></p> <p>Stopped giving homework. <i>Provider characteristics *</i></p> <p>One pupil completely disengaged after issues reported.*</p>	
S2 (2)	<p>The more we do the better I feel, and more confident. <i>Provider characteristics</i></p> <p>Students said that they felt the sessions were helping in situations, they said they think about how they would react to things more now and how to deal with it. <i>Possible indirect link to: Factors relevant to the prevention support system and Provider characteristics *</i></p> <p>1 pupil seems to be getting it! <i>Possible indirect link to: Factors relevant to the prevention support system and Provider characteristics *</i></p>	<p>Students don't always remember from previous weeks and we have to keep re-iterating.</p> <p>Time restraints – unable to discuss with colleague [running the group with] prior and after the session. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Still not doing homework. <i>Provider characteristics *</i></p> <p>Group quiet – only wanted to participate in basket ball game [CB technique]. <i>Provider characteristics *</i></p> <p>50% of children still having to go backwards. Not sure why they are there. <i>Provider characteristics and indirectly linked to Factors relevant to the prevention delivery system: general organisational factors, specific practices and processes</i></p> <p>No homework being given since not doing it. <i>Provider characteristics *</i></p> <p>One pupil disengaged having reported issues [safeguarding].*</p>	
S3 (1)	<p>Problem solving strategies worked in situ, when negative situation arises. <i>Innovation</i></p>	<p>With one pupil, trying to take a step back at the moment – not intervening so directly – not</p>	

	<i>characteristics</i>	<p>using CBT. <i>Provider characteristics</i></p> <p>With group, dynamics meant that they refused to engage with the strategies – suspect on a one to one basis, would work. Once SATS are out of the way, can use more. <i>Provider characteristics, Factors relevant to the prevention delivery system: general organisational factors and specific staffing considerations</i> *?</p>	
S3 (2)	<p>Pupil didn't seem bothered by the lack of private and quiet space available.*</p> <p>Used examples of problems we had encountered that week in school as prompts for discussion. <i>Provider characteristics</i></p> <p>The child was chatty, could provide enough input to work with. *</p> <p>Good environment to carry out relaxation techniques. <i>Factors relevant to the prevention support system</i></p> <p>It's going well with this child. I am choosing different aspects of the intervention that are appropriate for this child. <i>Innovation characteristics</i></p> <p>First session of CBT for this child – chose specific areas to focus on which suited the child and the situation. <i>Innovation characteristics</i></p>	<p>No suitable private space (quiet and private). This is very rare though. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Possibly wasn't planned well enough. <i>Provider characteristics</i></p> <p>Possibly purpose wasn't clear between adult and pupil. <i>Provider characteristics</i></p> <p>Didn't feel session went that well – adult aware of inappropriate space and felt it was a rushed session. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Rushed session with pupil. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>None</p> <p>Worked well today – she opened up quite a bit. *</p> <p>Really enjoyed the relaxation technique. She said it 'brought a tear to her eye'.*</p>	



		<p>Normal room was unavailable. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>No relaxing music available when doing relaxation techniques. <i>Factors relevant to the prevention support system</i></p>	
S4 (1)	<p>Being allowed to use CB techniques on any of our 5 morning sessions I have with the pupil [more scope to engage him]. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>CBT was definitely making an impact on pupil. <i>Possible Provider characteristics*</i></p> <p>I am finding myself correcting the ways that I am doing things and communicating with children. <i>Provider characteristics and possibly Factors relevant to the prevention support system</i></p> <p>CBT has given me food for thought and I will continue to use the strategies. <i>Provider characteristics and possibly Factors relevant to the prevention support system</i></p>	<p>Childs exclusion and sporadic school attendance. <i>Factors relevant to the prevention support system. Community level factors *</i></p> <p>His attendance and disengagement with school some days is the only negative part. *</p>	
S4 (2)	<p>Package given to lead of Key Stage 1 at different school [with SENCo guidance]. <i>Innovation characteristics</i></p> <p>Calming strategies and Downward Digger given to family support worker to use with child with Individual Pupil Funding for emotional, behavioural and social</p>	<p>Time to explain for specific children. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p>	

	<p>difficulties. <i>Innovation characteristics</i></p> <p>Guidance given to Teaching Assistant around use of strategies with one pupil. <i>Innovation characteristics</i></p> <p>Review with Teaching Assistant. <i>Innovation characteristics</i></p>		
S5 (1)	<p>Training x2. <i>Factors relevant to the prevention support system</i></p> <p>Resources in books x2. <i>Factors relevant to the prevention support system</i></p> <p>Easier to judge level/extent of content having done first session. <i>Provider characteristics</i></p> <p>Pupil's engagement and interest. *</p> <p>Session plan discussed at supervision session very helpful. <i>Factors relevant to the prevention support system</i></p> <p>Own counselling skills. <i>Provider characteristics</i></p> <p>Supervision session regarding planning [was a facilitator]. <i>Factors relevant to the prevention support system</i></p> <p>Pupil works really hard in sessions.*</p> <p>Resource packs [are a facilitator] – the resources from 2 recommended books have been very useful. <i>Factors relevant to the prevention support system</i></p> <p>Pupil shared that the work is definitely helping she's feeling</p>	<p>Limited time for preparation. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>If time were available could benefit from more sessions than one per week. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Limited prep time. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Session changed due to school trip. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Rooming issues. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Some uncertainty over level/extent of content to present in session. <i>Provider characteristics</i></p> <p>Rooming and timetabling – very frustrating today. <i>Factors relevant to the prevention support system but also indirectly related to Factors</i></p>	<p>Pupil seems to be engaging and enjoying it – told me she had done the home activities soon after</p> <p>Checked out with child – she is finding it interesting and is learning things.</p> <p>Pupil commented that the work “is helping her in school”.</p> <p>Anecdotally from teacher and pupil – seem to be becoming more confident in class, even though we haven't worked on any specific thoughts yet.</p> <p>Pupil seems</p>

	<p>more confident with challenges. <i>Possible link to Provider characteristic</i></p> <p>Child commented that she is feeling more confident in work and friendship situations. <i>Possible link to Provider characteristic</i></p> <p>Feedback from teacher very positive – child’s learning behaviours much more self regulated, less intervention for teacher. <i>Possible link to Provider characteristic</i></p> <p>Resources from 2 book [are facilitators]. <i>Factors relevant to the prevention support system</i></p> <p>Resources from course and books very helpful. <i>Possible link to Provider characteristic</i></p> <p>Very positive impact confirmed by teacher – to share together with mum next week. <i>Possible link to Provider characteristic</i></p> <p>Pupil, teacher and parent confirmed that pupil is handling issues more effectively and using a range of CBT strategies to help – we talked about applying model to other problems. <i>Possible link to Provider characteristic, Innovation characteristics and *</i></p> <p>References to pupil engaging in and enjoying sessions, in ‘other reflections’ in next column. <i>Possible link to Provider characteristic and *</i></p>	<p><i>related to the prevention delivery system</i></p> <p>Sometimes the amount of paperwork/resources seems to ‘get in the way’ – feel more comfortable when in more psychological contact with student. <i>Innovation characteristics*</i></p> <p>Time constraints on this session, so unable to finish activity – to continue next week. <i>Factors relevant to the prevention support system but also indirectly related to Factors related to the prevention delivery system</i></p> <p>Possibly child’s age [is a barrier] – still equating ‘helpful thoughts’ with helpful actions – maybe change terminology. <i>Innovation characteristics and Provider characteristics *</i></p> <p>Pupil is having difficulty identifying ‘hot thought’. <i>Innovation characteristics and Provider characteristics *</i></p> <p>Pupils age – some limitation in full awareness of distinction between thoughts and feelings when working independently. <i>Innovation characteristics and Provider characteristics *</i></p> <p>Pupils age – probably a little too young to allow full cognitive intervention. <i>Innovation characteristics and Provider characteristics *</i></p>	<p>to understand definition of thoughts and feelings when working together but gets more confused with doing homework.</p> <p>Seems more relaxed in session and when interacted with her in other situations. Maybe it’s just the acknowledgement of her feelings that’s helped.</p> <p>Child seems keen to ‘say the right thing’ sometimes, so will use examples to affirm that all thoughts and feelings are ‘ok’.</p>
S5 (2)	No data collected		

**Appendix Q – Supervision Evaluations Collated for RQ3****Supervision Type Key:**

E – educative (advice, skills and knowledge through reflection and exploration of work),

M – managerial (check working correctly and ethically and will have desired effect on client – quality control aspect)

S – supportive (emotional needs addressed).

School	Rating Given (out of 5) and No. Sessions	'Most Useful' Comments	'Least Useful' Comments	Actions Identified	Supervisor Role, Focus and Medium Used	Super- vision Type
S1	5 x 6 sessions	<p>Sorting out how to use materials. "Know where I'm going with him and how to start it".</p> <p>Organising where to go next/what to use</p> <p>Reassurance and ideas to consider</p> <p>Help to get unstuck</p> <p>Ideas regarding story book and structure to intervention</p>	<p>Nothing x 4</p> <p>Needed longer time for sessions</p>	<p>Nothing x 4</p> <p>Focus on intervention now clear on use of assessment data and ID</p>	<p>Inform-assess</p> <p>Actions and events</p> <p>Thinking and planning</p> <p>Reporting/recorded sessions</p> <p>Listen-reflect</p>	<p>E x 5</p> <p>M x 1</p> <p>S x 2</p>
S2	5 x 4 sessions	<p>Confirm on the right track. Input with session planning and parent consent letter.</p> <p>Help with planning content of sessions.</p> <p>Planning session and help with individual pupil.</p> <p>Being reassured not doing the wrong thing.</p>	<p>Nothing x 4</p>	<p>Nothing x 4</p>	<p>Inform-assess</p> <p>Listen-reflect</p> <p>Actions and events</p> <p>Thinking and planning</p> <p>Knowledge</p> <p>Recorded sessions/reporting</p>	<p>E x 4</p> <p>M x 4</p> <p>S x 1</p>
S3	5 x 3 sessions	<p>Advice around adapting the intervention and about being creative with it.</p> <p>Checking if doing things right or wrong e.g. tailoring intervention to children needs. Reassurance and ideas.</p>	<p>Nothing x3</p> <p>Really helpful and answered a lot of what I wanted.</p>	<p>Nothing x 1</p> <p>Secure a private room for supervision.</p>	<p>Inform-assess</p> <p>Listen-reflect</p> <p>Actions and events</p> <p>Thinking and planning</p> <p>Recorded sessions/reporting</p>	<p>E x 2</p> <p>M x 2</p> <p>S x 1</p>

S4	5 x 3 sessions	<p>Finding ways to use CBI, thinking about looking after myself and how to start using the intervention.</p> <p>Helpful</p> <p>Going through sessions/sections and suggested worksheets</p>	<p>Nothing x 2</p> <p>It wasn't as pressurising as I thought it would be!</p> <p>Need to implement more to be able to comment more.</p>	<p>Nothing x 2</p> <p>Protected time – rearrange session if not suitable time to do properly.</p>	<p>Inform-assess</p> <p>Thinking and planning</p> <p>Reporting</p> <p>Listen-reflect</p> <p>Actions and events</p>	<p>E x 3</p> <p>S x 3</p> <p>M x 2</p>
S5	5 x 2 sessions	<p>Helping with planning intervention.</p> <p>Confirming thinking around second pupil.</p> <p>Confirming that thinking around next steps is fine and ideas for strategies to use.</p>	<p>Nothing x 1</p> <p>All useful.</p>	<p>Nothing x 1</p> <p>Next session make sure we review what's been done following this session.</p>	<p>Inform-assess</p> <p>Listen-reflect</p> <p>Enquire</p> <p>Actions and events</p> <p>Thinking and planning</p> <p>Recorded sessions and reporting</p>	<p>E x 2</p>

## Appendix R – Supervision Reflections Collated for RQ2&3

Where a factor corresponds to a category identified in Durlak and DuPre's model, this is presented in *italics*.

A \* denotes where a factor does not correspond directly/at all to a Durlak and DuPre category.

NB. In all supervision sessions, the provision of supervision and training can be considered as a facilitator, under '*Factors Relevant to the Prevention Support System*' (6 and 8), in addition to any other categories identified.

Codes for 'Method of implementation' are:

I – individual pupil

G – group of children

DP – discussion with parent/s

DT – discussion with teacher/s

C – whole class

S1			
Session No. and Date	Facilitators Identified	Barriers Identified	Method of implementation
1 14.12.11	<p>Intervention supported by HT e.g. implementer told by HT that she can have dedicated time to deliver intervention and to have supervision. SENCo also commented that HT totally supports it. <i>Factors relevant to the prevention delivery system: Specific staffing considerations.</i></p> <p>Implementer believes that individual pupil and group of children in the school need the intervention e.g. as a result of one expressing ongoing anxiety issues. <i>Provider Characteristics.</i></p> <p>Supervisee motivated to implement the intervention e.g. keeping detailed records of intervention and keen to use the activities suggested. <i>Factors relevant to the prevention support system.</i></p>	<p>Supervisee competences e.g. she seemed to need a high level of mediation around next steps with the intervention. <i>Provider Characteristics.</i></p>	<p>I – one pupil as a structured intervention.</p> <p>G – using activities with an existing group of children implementer works with.</p>

<p>2 25.1.12</p>	<p>Regular time to meet the pupil and CT supports this. <i>Factors relevant to the prevention delivery system: General organizational factors</i></p> <p>Pupil engaging with implementer e.g. motivated to attend and comments on enjoying the sessions. *</p>	<p>Change of room each intervention session as a result of other interventions taking priority for staff in higher authority; impacting on pupil's response to intervention. <i>Factors relevant to the prevention delivery system: General organizational factors and Specific Staffing Considerations.</i></p> <p>Supervisee competences e.g. she didn't go through emotional barometer thoroughly enough with pupil and lacks purpose/direction with the intervention. <i>Provider Characteristics.</i></p> <p>Lack of time available to complete full supervision session and supervisee anxious about time throughout the supervision. <i>Factors relevant to the Prevention Support System.</i></p>	<p>I– one pupil as a structured intervention.</p>
<p>3 22.2.12</p>	<p>TA motivated to implement intervention and engage with supervision e.g. carrying out activities agreed at last supervision and keen for feedback and guidance at supervision. <i>Factors relevant to the prevention support system.</i></p> <p>CT involved with intervention e.g. she supports with diary keeping around significant incidents in the classroom and gets updates from the implementer about the intervention. <i>Factors relevant to the prevention delivery system: Specific practices and processed.</i></p>	<p>Supervisee competences e.g. not adapting intervention when necessary without guidance and approach continues to lack direction without guidance. <i>Provider characteristics.</i></p> <p>Pupil would benefit from further/longer sessions but implementer feels can't give any more time to intervention as a result of other interventions she is involved with and sessions that pupil would miss. <i>Factors relevant to the prevention delivery system: General organisational factors and/ or Specific Staffing</i></p>	<p>I– one pupil as a structured intervention.</p>



		<i>Considerations.</i>	
4 Group Supervision 29.2.12	<p>Other school staff involved with, and seem to value, intervention (same examples as above but now literacy teacher involved also). <i>Factors relevant to the prevention delivery system: General organisational factors and Specific Practices and Processes.</i></p> <p>Implementer motivated to implement the intervention successfully. <i>Factors relevant to the Prevention Support System.</i></p> <p>Intervention can be modified to work on pupil's feelings and thoughts more indirectly. <i>Innovation characteristics.</i></p>	<p>Pupil would benefit from further/longer sessions but implementer feels can't give any more time to intervention as a result of other interventions she is involved with and sessions that pupil would miss. <i>Factors relevant to the prevention delivery system: General organisational factors and/ or Specific Staffing Considerations.</i></p> <p>Pupil not responding fully to intervention approach e.g. not revealing true feelings and thoughts through direct questioning. <i>Provider Characteristics and *</i></p> <p>Not had privacy for sessions; many interruptions. <i>Factors relevant to the prevention support system and indirectly linked to Factors relevant to the prevention delivery system: General organisational factors *</i></p>	<p>I– one pupil as a structured intervention.</p> <p>G– using activities with an existing group of children implementer works with. Also introducing activities to a literacy group that the individual pupil above is part of.</p>
5 28.3.12	<p>Following last supervision, implementer has felt more confident about delivering the intervention e.g. her presentation suggested this and she commented that this was the case. <i>Factors relevant to the prevention Support System.</i></p> <p>Pupil is more engaged with the intervention now that a different approach is being used e.g. he is expressing more around feelings, thoughts and behaviours, and making reference to himself. <i>Innovation characteristics *</i></p>	<p>Implementer competences e.g. she doesn't always have the skills to plan next steps appropriately without supervision. <i>Provider Characteristics.</i></p> <p>Pupil would benefit from longer sessions but implementer feels can't give any more time to intervention as a result of other interventions she is involved with and sessions that pupil would miss. <i>Factors relevant to the prevention delivery system: General organisational factors and/ or Specific Staffing</i></p>	

	<p>Intervention has been modified to suit children needs (see last supervision); reports suggest that this has been effective. <i>Innovation characteristics.</i></p> <p>Implementer identified benefits of the intervention for the pupil e.g. he is presenting with less anxiety and more emotional literacy skills. <i>Provider Characteristics.</i></p> <p>Good rapport between pupil and implementer.*</p> <p>Staff support there being a regular time for implementer to meet the pupil. <i>Factors relevant to the Prevention Delivery System – General Organisational Factors.</i></p> <p>Other school staff have been involved (see above for examples). <i>Factors relevant to the Prevention Delivery System – Specific Practices and Processes.</i></p> <p>Consistent room and area for intervention now being used; this seems to have occurred naturalistically.*</p>	<p><i>Considerations.</i></p> <p>Lack of parental/carer involvement e.g. homework not completed despite implementer having discussed with carers, and parent not showing an interest. <i>Factors relevant to the Prevention Delivery System – Specific Practices and Processes.</i></p>	
6 25.6.12	<p>Implementer has continued to feel more confident and satisfied about delivering the intervention e.g. her presentation suggested this; she was upbeat, was celebrating their success and did not request for as much support. <i>Factors relevant to the prevention Support System and Provider characteristics.</i></p> <p>Pupil is more engaged with the intervention now that a different approach is being used e.g. he is described as engaging more with the intervention. *</p>	<p>Pupil would benefit from longer sessions but implementer feels can't give any more time to intervention as a result of other interventions she is involved with and sessions that pupil would miss. <i>Factors relevant to the prevention delivery system: General organisational factors and/ or Specific Staffing Considerations.</i></p>	I – one pupil as a structured intervention.

	<p>Intervention has continued to be modified to suit children needs: reports suggest that this has been effective e.g. he is using strategies explored in sessions within the classroom. <i>Innovation characteristics.</i></p> <p>Implementer has continued to work with the pupil for the duration that he needed the intervention for (the intervention was not cut short). <i>Factors relevant to the Prevention Delivery System – General Organisational Factors and indirectly lined to Specific Practices and processes and Specific staffing considerations.</i></p> <p>Class teacher has noticed pupil using strategies in class. <i>Factors relevant to the Prevention Delivery System – Specific Practices and Processes.</i></p> <p>Supervisee is successfully completing actions agreed at previous supervision sessions. <i>Provider characteristics (9) and Factors relevant to the prevention support system (8)</i></p>		
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S2			
Session No. And Date	Facilitators Identified	Barriers Identified	Method of implementation
1 21.2.12	<p>Supervisee competences e.g. she asks appropriate questions about the intervention, chooses appropriate activities and has a clear direction for activities planned. <i>Provider characteristics.</i></p> <p>Senior management were involved in designing schools parent consent form, without request. <i>Factors relevant to the</i></p>	<p>Lack of communication within school e.g. between senior management and implementers regarding parent consent letter and discussions between supervisor and senior management. <i>Factors relevant to the prevention delivery system: Specific practices and processes.</i></p> <p>Supervisee commented on</p>	G – as a structured intervention. First time implementer has taken a group and planned their

	<p><i>prevention delivery system: Specific practices and processes.</i></p> <p>Supervisee gets support from colleague who also accessed the training. <i>Factors relevant to the prevention support system and Specific staffing considerations.</i></p>	<p>feeling that she did not have enough ‘clout’ in the school to make decisions about the intervention e.g. around when she could be released, who could be involved, the consent form design and how many sessions she could deliver; she was keen to gain direction and guidance from senior staff. <i>Factors relevant to the prevention delivery system: Specific Staffing Considerations.</i></p> <p>Lack of support within school around setting up the intervention e.g. around agreeing and arranging release time for her. She seemed to feel, generally, unsupported by senior staff around setting up this intervention. <i>Factors relevant to the prevention delivery system: General organisational factors and Specific Staffing Considerations.</i></p> <p>Lack of understanding by senior management regarding appropriateness of intervention for some children e.g. implementers did not feel that some children that had been suggested to them by staff met the criteria to be involved. <i>Factors relevant to the prevention delivery system: General Organisational Factors, Specific Staffing Considerations.</i></p> <p>Supervisee presented with some lack of confidence around intervention e.g. her comments suggested that she was somewhat nervous since this was the first group intervention of this sort that she had designed and run. <i>Factors relevant to the prevention support system.</i></p> <p>Supervisee unclear on role in setting up intervention e.g. what</p>	<p>intervention.</p>
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		role she was expected to play in designing the consent form and whether she needed authority to be released to implement the intervention. <i>Factors relevant to the prevention delivery system: Specific Practices and Processes.</i>	
2 20.3.12	<p>Weekly timetabled slot allocated for intervention. <i>Factors relevant to the prevention delivery system: general organisational factors.*</i></p> <p>Most parents were on board with group intervention e.g. implementers gained verbal and written consent for all parents of children involved; no issues reported. <i>Factors relevant to the prevention delivery system: Specific practices and processes.</i></p> <p>Supervisee gets support from colleague who also accessed the training. <i>Factors relevant to the prevention support system and Specific staffing considerations.</i></p>	<p>Intervention session disrupted and moved to another room due to room required for other uses at short notice by senior staff; seemingly senior management not respecting the importance of the intervention. <i>Factors relevant to the prevention delivery system: general organisational factors and Specific Staffing Considerations.</i></p> <p>On pupil within the group was not engaging as well in the intervention.*</p> <p>Number of intervention sessions delivered may not be flexible. That is, supervisee needs to support with exams in May, and she cannot be released to deliver 2 sessions in one week instead of 1; which may mean that the intervention is not completed in full. <i>Innovation characteristics.*</i></p> <p>Lack of involvement from other school staff e.g. implementer commented that they are 'left to their own devices' with this intervention; no one has asked about it. <i>Factors relevant to the prevention delivery system: Specific Practices and Processes.</i></p>	G— as a structured intervention. First time implementer has taken a group and planned their intervention.
3 8.5.12	Weekly session with group timetabled. <i>Factors relevant to the prevention support system and indirect links to Factors relevant to the prevention delivery system: specific practices and processes and Specific staffing considerations.</i>	Time to prepare for each session. <i>Factors relevant to the prevention support system and indirect links to Factors relevant to the prevention delivery system: specific practices and processes and Specific staffing considerations.</i>	G – as a structured intervention  I – On one

	<p>Supervisee gets support from colleague who also accessed the training. <i>Factors relevant to the prevention support system and Specific staffing considerations.</i></p> <p>Supervisee takes on board advice and follows it through; evidenced through reports of sessions completed. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Safeguarding issues identified by supervisee – ethical implications considered. <i>Factors relevant to the prevention support system</i></p> <p>Supervisee reflects on quality of data collected about pupil prior to intervention. <i>Provider characteristics</i></p> <p>Supervisee structures sessions according to CB model. <i>Provider characteristics</i></p>	<p>Time to deliver a complete session. <i>Factors relevant to the prevention support system and indirect links to Factors relevant to the prevention delivery system: specific practices and processes and Specific staffing consideration.</i></p> <p>Supervisee skills to plan next steps for the intervention i.e. to keep momentum and purpose of intervention in mind. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>No involvement from other school staff. <i>Factors relevant to the prevention delivery system: general organisational factors, Specific practices and processes and Specific staffing considerations</i></p> <p>Supervisee skills to address issues with homework engagement – to be child centred. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Poor pre-intervention data collection; implementers instructed to deliver intervention with certain children without clear understanding of intervention needs. <i>Factors relevant to the prevention delivery system: general organisational factors, Specific practices and processes and Specific staffing considerations</i></p>	occasion
4 21.6.12	<p>Supervisee takes on board advice given at supervision and follows it through; evidenced through reports of outcome of safeguarding issue. <i>Provider characteristics and Factors relevant to the prevention support system *</i></p> <p>Supervisee persistent in</p>	<p>No involvement from other school staff; supervisee feels unsupported within school. <i>Factors relevant to the prevention delivery system: general organisational factors, Specific practices and processes and Specific staffing considerations</i></p> <p>Supervisee skills to address</p>	G – as a structured intervention

	<p>completing intervention despite lack of within school support.</p> <p><i>Motivation*</i></p>	<p>issues with homework and engage children adequately.</p> <p><i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Poor pre-intervention data collection regarding children needs and problem areas. <i>Factors relevant to the prevention delivery system: general organisational factors, Specific practices and processes and Specific staffing considerations</i></p> <p>Pupil not agreeing on a shared problem, partly as a result of poor pre-intervention data and partly as a result of implementers skills. <i>Provider characteristics and Factors relevant to the prevention delivery system: general organisational factors, Specific practices and processes and Specific staffing considerations</i></p>	
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S3			
Session No. And Date	Facilitators Identified	Barriers Identified	Method of implementation
1 13.3.12	<p>Adapting intervention to be used more flexibly in an existing group academic based session e.g. using CB activities at the beginning and middle of sessions. <i>Innovation characteristics.</i></p> <p>Implementer more motivated to implement intervention by end of supervision! i.e. she started off being doubtful about opportunities to use the intervention but then made plans about how to use it, and presented as being enthusiastic, following suggestions. <i>Factors relevant to the prevention support system</i></p>	<p>Lack of time to deliver intervention on a one to one basis, seemingly as a result of academic based interventions/SATS being prioritized in the school currently. <i>Factors relevant to the prevention delivery system: General organisational factors and Specific staffing considerations.</i></p> <p>Lack of time for supervision e.g. session interrupted repeatedly due to supervisee's other duties and supervisee anxious about time to receive supervision. <i>Factors relevant to the prevention support system.</i></p> <p>Supervisee not feeling particularly supported by other</p>	<p>G – existing group taken for academic intervention ; implementer planning to use individual activities and strategies to enhance their emotional literacy skills and access to learning.</p>

		<p>school staff when pupil has serious outburst; part of supervision focused on how she could look after herself more and get further support. <i>Factors relevant to the prevention delivery system: specific staffing considerations.</i></p>	<p>I – using the odd strategy ad hoc with individual children.</p>
<p>2 25.4.12</p>	<p>School has effective SEBD interventions in place. <i>Innovation characteristics</i></p> <p>Supervisee used CB techniques on herself following work with a pupil. <i>Innovation characteristics</i></p> <p>Supervisee motivated to use CBI in medium term. <i>Factors relevant to the prevention support system *</i></p>	<p>Supervisee lacking time to use intervention: school prioritise academic needs over intervention, at least for her role. <i>Factors relevant to the prevention delivery system: General organisational factors and Specific staffing considerations and Specific practices and processes</i></p> <p>Supervisee lacks skills to use CBI in innovative ways and adapt to groups needs e.g. ‘didn’t work’ on first try with group. <i>Provider characteristics and Factors relevant to the prevention support system</i></p>	<p>G – existing group taken for academic intervention ; implementer tried to use individual activities and strategies to enhance their emotional literacy skills and access to learning.</p> <p>I – used relaxation strategies on self.</p>
<p>3 20.6.12</p>	<p>Supervisee demonstrates motivation to implement intervention in medium term; plans to adapt her role to focus more on SEBD. <i>Factors relevant to the prevention support system and Factors relevant to the prevention delivery system: Specific practices and processes *</i></p>	<p>Supervisee lacks skills to use CBI in innovative ways with group. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Implementer prioritise academic needs over intervention, at least for her role at the moment. <i>Factors relevant to the prevention delivery system: General organisational factors and Specific staffing considerations and Specific practices and processes</i></p> <p>Implementer lacks skills to</p>	<p>G – existing group taken for academic intervention ; implementer tried to use individual activities and strategies to enhance their emotional</p>



		<p>structure sessions and intervention with clear purpose in mind. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Supervisee wellbeing in school impacting on motivation to implement intervention. <i>Possibly linked to: Factors relevant to the prevention delivery system: Specific staffing considerations *</i></p>	<p>literacy skills and access to learning.</p> <p>I – used relaxation strategies on self.</p>
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S4			
Session No. And Date	Facilitators Identified	Barriers Identified	Method of implementation
1 8.3.12	<p>Highly motivated supervisee e.g. he seems very dedicated and enthusiastic about delivering the intervention and about his role in general. <i>Factors relevant to the prevention support system *</i>.</p> <p>Good rapport building skills and supervisee seems competent in many areas e.g. he described some effective strategies used to engage a ‘difficult pupil’. <i>Provider characteristics.</i></p> <p>Time set aside for implementer to deliver the intervention with one pupil; arranged and supported by HT. <i>Factors relevant to the prevention support system and Factors relevant to the prevention delivery system: Specific staffing considerations.</i></p> <p>Supervisee values the intervention e.g. he speaks highly of it and comments on its potential to be effective. <i>Provider</i></p>	<p>Pupil not engaging fully with intervention (yet); likely to reflect, to some extent, complexity of case.*</p> <p>Supervisee needed considerable guidance to adapt the intervention. <i>Provider characteristics</i></p>	<p>I – structured intervention.</p> <p>I – unstructured/g eneral discussions e.g. on the playground to resolve issues.</p>

	<p><i>characteristics.</i></p> <p>Intervention being modified to suit children needs e.g. more practical and creative activities and more indirect approach.</p> <p><i>Innovation characteristics.</i></p>		
2 19.6.12	<p>Implementer offering consistent intervention to pupil: time set aside for implementer to deliver the intervention with one pupil; arranged and supported by HT. <i>Factors relevant to the prevention delivery system: Specific staffing considerations.</i></p> <p>Supervisee values the intervention e.g. he speaks highly of it and comments on its potential to be effective. <i>Provider characteristics.</i></p> <p>Implementer motivated to support pupil's wellbeing.*</p> <p>Following supervision, implementer adapted intervention to match pupil's needs (e.g. use of indirect therapeutic strategies); this is proving to be effective in that pupil has engaged more genuinely. <i>Factors relevant to the prevention support system and innovation characteristics</i></p>	<p>Implementer lacking carer input when needed. <i>Factors relevant to the prevention delivery system: Specific practices and processes and possibly Provider characteristics and Factors relevant to the prevention delivery system: Specific practices and processes.</i></p> <p>Intervention sessions lacking structure and purpose. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Pupil not engaging fully with intervention (yet); complex case with many environmental barriers to engagement e.g. attendance.*</p>	I – structured intervention.

S5			
Session No. And Date	Facilitators Identified	Barriers Identified	Method of implementation
1 1.3.12	<p>HT supports the intervention fully e.g. she has identified children for the implementer to carry out the intervention with and she speaks highly of the intervention. This is also indicated by the HT's comments to the researcher. <i>Factors relevant to the prevention delivery system: staffing considerations</i></p> <p>Supervisee expressed her view that the intervention is totally in line with whole school mission and ethos. <i>Innovation characteristics</i></p> <p>Regular timetabled slot and room for intervention. <i>Factors relevant to the prevention delivery system: general organizational factors</i> *</p> <p>Supervisee demonstrates good competences and has relevant training around this type of intervention e.g. she is undergoing a counselling course and is trained in 'Drawing and Talking Therapy'. <i>Provider characteristics and Factors relevant to the prevention support system</i></p> <p>Implementer given ownership and respect over interventions within the school e.g. she commented around the HT trusting her to make decisions around interventions. <i>Factors relevant to the prevention delivery system: Specific Staffing Considerations.</i></p>	One pupil needs 'problem solving skills' work rather than thought error work since his anxieties are justified; only a small element of CB will be relevant to this pupil*	I – using as a structured intervention with one pupil and considering using elements of the intervention with another pupil
2 19.4.12	Weekly sessions timetabled. <i>Possible links with: Factors relevant to the prevention delivery system: general organizational factors, Specific practices and processes and Specific</i>	Room availability sometimes an issue. <i>Factors relevant to the prevention support system and possibly Factors relevant to the prevention delivery system.</i>	I – structured intervention with 2 children.

	<p><i>staffing considerations</i></p> <p>Supervisee skilled in therapeutic interventions e.g. she is training in counselling skills. <i>Provider characteristics</i></p> <p>Supervisee takes on board advice; evidence of this from action implemented following previous supervision. <i>Factors relevant to the prevention support system and Provider characteristics</i></p> <p>Supervisee able to adapt sessions to children needs. <i>Provider characteristics and Factors relevant to the prevention support system and Innovation characteristics</i></p> <p>Management on board with intervention. <i>Factors relevant to the prevention delivery system: Specific staffing considerations</i></p>	<p>Supervisee identified that more time per week would benefit the pupil but is not available. <i>Factors relevant to the prevention support system</i></p>	
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## **Appendix S – Additional data - Participant 1, S1**

*Notes made by Researcher based on additional data provided by participant:*

Supervisee collected baseline and follow up data of pupil's problem behaviours – data demonstrated a reduction in problem behaviours following intervention.

The pupil engaged in writing a story about characters that he invented (see overleaf). The story was then used to work indirectly around his problem. Notes suggested that this method was more successful than through directly referring to his emotions. The pupil automatically related the story to himself.

There was evidence of supervisee having used the following CB strategies over sessions: rapport building with pupil; exploring different emotions and the physiological responses associated with them; helping the pupil to express his feelings; helping the pupil to identify his behavioural and emotional responses in specific situations; monitoring his behavioural and emotional responses (e.g. through observations and 'feelings diaries'); identifying 'hot thoughts'; explaining the link between thoughts, feelings and behaviours; relating this cycle to the children problem situations; rating the problem; and problem solving around possible solutions. There were references to the intervention having been adapted by supporting the pupil to identify and express his own emotions through indirect methods (puppets and writing their own story).

There was evidence of supervisee having carried out actions agreed in supervision (e.g. "following meeting with Katie Caddick this afternoon....").

There was evidence of the relationship between the pupil and implementer developing over time e.g. him opening up more over time and him commenting that he enjoyed coming to school since he liked talking to the implementer and felt relaxed sitting with her. The notes also indicated that the pupil's engagement in the sessions increased over time e.g. he had commented on missing the sessions during 'SATS week' and the school holidays and at the beginning there were reports of him having struggled to express his emotions whereas later in notes there were reports of him expressing his emotions with more ease.

Pupils' story (unfinished) as noted in supervisee notes (20.6.12):

*Hi – I'm worried wolf. Do you ever get scared/worried? If you do, I have a story for you that could help.*

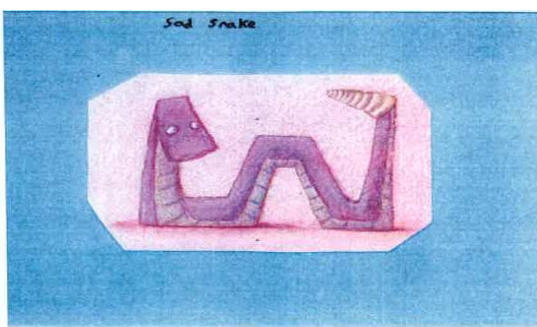
*Woodlands Primary school is where the story begins. At first I was ok, but as the school work got harder,*

*harder, I started to struggle and that's where my worries/anxious thoughts, negative feelings and behaviours*

*began. I decided to ask for help off my friends. Putting their names in a drawing of my paw. The first one was*

*Angry Ant; he said "I haven't got time for your worries, I've got plenty of my own. NOW out of my way!"*

*...(to be completed).*



## Appendix T – Sample of TA Coding in ‘ATLAS’

Below are 4 screen shots taken from ‘ATLAS’ to demonstrate TA in process:

**Screenshot 1: Transcript and Codes**

**Transcript:**

SD - without it I would not have had a clue of where to start, I think even I said earlier that I would have been acting very much upon instinct I'm unsure of the resources available in school, I think given the opportunity I would have been able to go and research my own resources but it heightened the awareness of the whole school and thinking of a head who is with us which is great, she has taken it on board as a viable intervention strategy, KC - Maybe because she could sit in on it SD - yes very much, whereas if just Sue and I had come to the training and said ooh yes it was fantastic you know we can do this we can do that! I'm confident that our head would have said ooh yes go ahead, you know because she's very keen on doing that kind of thing, but I'm aware that some schools that wouldn't be the case. KC - Yes - and do you feel that you've got the skills that are necessary to deliver SD I don't know really till I try I'm confident it delivering within my class, when I was actually doing the teaching, with, and I'm confident with the one to one, with the boy in year1, going higher up the school with children that I don't know I would be less confident I know saying that without doubt KC - because you don't know them as much? Or because they're older? SD yes I think it's because I don't know them as much and that I haven't built that relationship up with them over a period of time and I think it's quite difficult to go in at a particular point and then almost backtrack to find things out, because invariably there will be important things that you will miss, or that you haven't experienced with that child somebody can tell you they've done this and done that and they do this and do that but you just can't, there's no time to be released to shadow them, without the time to build up a true picture of what they are like KC - it's about that rapport and the assessment of the situation at the beginning, if you've got that you've got with that year 1 boy didn't you because you teach him. SD yes

KC - ok what approaches were used and where not used in the training to influence you views about the training for e.g. you know we used role play, discussion, activities, visual aids, teaching, observation those sorts of things, which of those approaches do you think worked and maybe were missing from the training.

SD - I think there was a good all round balance, maybe did you have videos? KC - no we wanted to at one point show a collective on the internet where do you mean you watch that would have been good wouldn't it - SD - because it's one thing for you to talk to us about the typical behaviours and the feelings that people were having, the negative thoughts, the hot thoughts and the types of things you can do to overcome those and intervene with those that to actually visually see that happening in front of you and seeing a practitioner delivering a strategy would have been very useful KC yes - no I agree

KC - and which of the approaches do you think works best for you?

SD - I think that depends on you yourself as a learner KC - but what you SD - I'm quite happy with facts that I can put into my head and deal with in my own way KC for the teaching bit you're quite comfortable with that SD - yes quite comfortable with that I do quite like that sort of academic side of it where they deliver you the information you, you cognitively process it and go away and think right I'm taking that tonight I'm going to think more about that I'm going to research that, KC - you know some people like a more hands on practical SD

**Codes:**

- Knowing where to start/giving direction
- Books/information/background reading
- Top down/whole school - positive
- Whole school
- Need for other schools staff to attend
- Head teacher would champion
- Permission to go ahead with intervention
- Top down/whole school - positive
- Confident/relaxed - depends on how familiar with children
- Between pupil and implementor
- Logistical factors - time to deliver/prepare intervention - issues~
- Modelling
- General positive comments e.g. enjoyable, good balance, good, needed
- Direct Teaching

**Screenshot 2: Transcript and Codes**

**Transcript:**

SJ I think it's quite useful to some of the insight just on casual interaction with children everyday interactions you know I kind of pick up on things more now it was very useful with my husband the other day I got him to see he was using his crystal ball ??

KC ok one of the thought errors! SJ yes but not in school, and also one of the head teacher's asked us if we could do/give some input at a staff meetings, KC ok That's fine SJ so hopefully to just sort of the basics of the approach and to make the staff aware of what we can use and maybe some of the kind of activities that you could translate into a classroom situation KC ok so not just making them aware of the training you went on but giving them things that they can go away and try SJ yes so that's team fold really this is what's available and if there are any children that you feel in your class that could use it this is what you could do, but also like your just saying these are some of the good interventions you might use in Circle time or whatever and just give them some resources as well and pass those down the line KC good - and when you say you've kind of used it in your general day to day conversations with children in what sort of situations have you found yourself stopping and thinking ah yes that's bits of the course SJ I think that it's kind of just like little gentle challenges really, because if they say I'll never be able to do that get them to think about that word never KC ok SJ can see or say I'm useless at this, well let's have a think about when you've done it before and you know just little gentle challenges KC so the thought testing SJ yes and like I think it seems to be generally an all or nothing thinking that you come across quite a lot KC a lot SJ and you can just them to think a bit more flexibly and maybe recognise some of there where that they have done it before and give them a bit of evidence against what they're saying, and put a bit more kind of positive kind of spin on things so that we can actually get into what we're doing KC ok and have you found that that seems to have a positive effect SJ yes definitely and I think it gives a good opportunity to let them you know that I'm behind them and to kind praise them as well "I saw you do this" so are you sure you say you'd never be able to do it you know KC yes SJ so that's quite !! KC it's almost like your taking them very seriously and respecting what they're saying but at the same time you're challenging them in a safe way SJ yes KC that sound good.

KC - What will help you to implement the intervention now, SJ I think the thing that's going through my mind at the moment is the amount of material that there was and kind of where do I start? I don't know, I was gonna bring this up in my supervision session actually but reading through the two books KC Yes SJ there's one that's for the group KC yes The Cool Connections SJ Cool Connections the way that's set out seems to be a nice kind of progression for parents KC ok SJ I was thinking of possibly basing it around that but obviously being flexible as to what the individual child needed, but that seemed to make sense to me, sort of the overall strategy so I think possibly using that and bringing some of the new worksheets as in the KC from the Think Good Feel Good SJ Think Good - yes KC yes that makes sense SJ so I think basically the one problem that I've had so far is not having the time to get some of me stuff prepared KC so that would help SJ so that's my today task, because I think I'm going to working with the children on a Thursday so I'm going to take this Thursday to do the preparation and then start them next week so that should be ok KC yes and I think at the beginning you will feel like it's more time consuming and then as you go along it will become much quicker SJ Yes - and I must admit that initially I thought oh I will have to prepare the whole series but then when I was looking at it I was thinking I don't think so because it's going to go in different directions depending on what the child needs so. KC you can probably have a rough plan SJ yes KC but it will change it will be delayed and then you can speed bits up and SJ the other thing I was trying to do because we've got the Think Good Feel Good book you can download it can't you KC yes SJ but I tried to do that the other day and for some reason it

**Codes:**

- Day to day/automatic use
- Personal life
- Generally Positive e.g. frequent/open
- Raise staff awareness - team meeting
- Whole school
- Sharing with other staff
- Top down/whole school - positive
- 'Thought testing/challenging'
- 'Thought errors'
- Child feels supported/reassured
- Empowering children/raising self esteem
- 'Supervision'/mentoring' referred to
- Handouts/resources - amount/comprehensive/
- Need for supervision/support from trainee implied
- Where to start?
- Structured intervention .x. adapting to individual
- Using the 2 suggested books
- Logistical factors - time to deliver/prepare intervention - issues~
- Structured intervention .x. adapting to individual
- Books/information/background reading
- IT support



RL – I think it's the difference between the behaviour and erm I always want to the bodily KC physiological responses RL yeh, because I don't think a lot of the children realise that and I think it's raising awareness of it, to make them think about what they do. KC yeh RL that's why I've kind of planned it in for quite a bit of the nurture sessions because I've got quite a bit across the school. KC yeh RL erm that I'll definitely use it for that for them to kind of raise their own awareness of it KC yes RL erm and then for in the nursery it's quite across school actually there's quite a few children that erm have had domestic violent somewhere going on, but they don't talk about a lot of things and I think that it's the fact that erm something that you went through on different session that they need to know who to talk to and how and when about what, there's certain bits of it that I want to use for that KC so almost like ideas that we talked about throughout the sessions is that what you mean? Rather than specific activities RL yes KC it was certain ways of working RL – it raising their awareness of how they can explain themselves and, with who and when because we have got loads of things through school that I know they do but there's quite a few children that keep coming up that I think that right I if spoke to them about this and put it in this way KC mmm RL- then they might be more likely to open up more ?? KC ok RL I'm hoping to use it with them as well KC are there any bits of the intervention that you think no I don't think I'm going to use that? In terms of ideas, approaches RL – we've said the Traffic Light that's just because of our school, we use the traffic light system KC I remember RL so we said we wouldn't use that because KC so you'll use the hot instead of the red light RL- use the scale at the moment, personally I've started using the scale because they seem to be able to do that a lot easier, because it kind of turns it round, you given them emotional ?? write is on a scale ?? then talks about it KC yeh RL that's something that I've found although they can pick it up a lot, when you use a lot of the pictures on the sheets they find it a lot easier to look at the pictures of the different expressions rather than talk about an actual word or to say their feelings KC so they've got something visual to prompt them RL yes KC they prefer that and are you saying that's the same as the scale they seem to like RL yes they like that, we did do it with a temperature we didn't seem to get the hot thoughts but we haven't done enough KC haven't got that far yet, RL so we stuck to the scale for the moment KC yeh – RL erm but yeh we definitely the traffic light one but there wasn't, I think it was the thought that we would have to just try them out to see because it's going to depend on who it's with KC yeh absolutely RL – erm some of the children have got quite, can get angry quite quickly depends on what you use with them KC yeh RL and other are really chilled out but it's

- Children increased understanding/awareness of selves
- Identifying behaviours and physiological res
- Whole school
- move/approach/structure
- Children express themselves
- Potential facilitator - motivation/hope/enjoyment
- Compatibility - management of behaviour NOT compatible
- NOT traffic light
- Rating scale
- Worksheets/packs
- Emotional barometre
- Not sure until started
- Acting out .V. Internalising

JP - The training, I thought some part of it, it seemed that we were trying to cram such a lot in, in the small time that we had erm I thought that the bits were we actually tried it out on each other it was quite I was I said to Jenny the same thing that I thought it was quite difficult to think of something, invent a problem or something like that I'm one of these sort of people that doesn't have that many negative thoughts about myself so it was quite difficult for me to say oh I'm not happy about this but other than that it was very very informative and you know generally talking to children and actually change the way that I speak to children and correcting myself just by some of the things that we, you were telling us about in there KC ok JP I thought it's got to be a good thing hasn't it KC so you think that perhaps it should have been spaced out more in terms of the time in between sessions or in terms of the session themselves needed to be longer? Or more often JP erm either / or really I don't think the space between them because obviously we can only take up one day for a session a week at the very most can't we, but maybe, maybe longer maybe a full day or something like that it just seemed that sometimes we were really rushing to get the last little bits in KC yeh JP it was such a lot especially for myself to take in KC yeh ok JP but very very informative KC and it seems to have had an impact on you JP yeh definitely KC and what was the other thing you mentioned oh so you mean when we asked you to do the activity on yourself JP an activity on myself KC sometime your were struggling to come up with something about yourself JP I struggled yeh but that's because that's just my make-up and I don't anything not that I blow my own trumpet or anything like that KC no, no JP but I try not to see negative things KC ye JP and that's probably why I found it difficult KC ok absolutely, anything else about the training JP really well delivered obviously, really well delivered erm all the bits of resources and that, that you were given us, I've already started to work with a pupil with some of the resources erm KC so you found the worksheets and things helpful JP the worksheets are really, really helpful yeh and I've also bought the book KC yes, was it the Think good Feel Good book JP yes obviously the room wasn't ideal KC no JP ideally we could've done with maybe a table or something KC yeh JP to give a bit more space but I thought the course itself was a really good course probably cos in all I've done a lot of training school have put me in for a lot of training and I think it's probably the best training that I feel is most useful the most useful that I've been on, cos it's made such a difference to how I look at problems and sorting out a problem or just general chit chat to a child in the playground it's not cut and dried as you would normally just say go and sort it out or you would take a step back and think how would I have done that KC yeh JP it in class so

- Pace/session time/intense
- Self reflection activities/practice on self - didn't like
- Change the way speaks to people and perceive/approach issue
- Informative/useful/interesting
- Pace/session time/intense
- Informative/useful/interesting
- Personal approach - neither positive or negative~
- Delivers - well done
- Handouts/resources - amount/comprehensive/useful
- Comfort - space/room/tables/seats
- Change the way speaks to people and perceive/approach issue
- General positive comments e.g. enjoyable, good balance, good, needed
- Intervention is useful, usable, adaptable
- Day to day/automatic use



## Appendix U - Coding Process Through ATLAS.ti

The following presents key steps taken to code data through ATLAS.ti. For readers unfamiliar with the ATLAS.ti programme, further information can be gained through visiting:

<http://www.atlasti.com/index.html>

1. An ATLAS project (or hermeneutic unit) consisting of the transcribed pre and post-interview data was prepared. Each interview remained as a separate document within the project.
1. Each intervention implementation category, based on Durlak and DuPre's (2008) model, was given a code and used as 'a priori' codes for pre-intervention interview analysis.
2. Through TA, additional codes were identified and some codes merged, deleted or changed. 362 codes resulted from analysis of the pre-intervention interviews.
3. The codes were organised into code families and colour coded.
4. The 362 codes were used as priori codes for post-intervention interview analysis.
5. Through TA, additional codes were identified and some codes merged, deleted or changed. See appendix V for examples.
6. Code families were updated to reflect additional, merged and deleted codes
7. Networks were produced to represent each code family.
8. Checks were carried out to ensure that all codes had been accounted for in one or more family and network.

Total number of individual codes = 358

Total number of code families = 24

Total number of items in networks = 382 (358 codes and 24 families)

## **Appendix V – Code Changes in ATLAS.ti**

### Examples of Code Changes

Some codes were found to be so closely linked that it was more appropriate to merge and rename a code, or delete a code and include it under an existing code (hence ‘unlinking’ and ‘re-linking’ the quotes to a different code in ATLAS.ti). Some codes were also re-linked to different code families following further analysis. Examples are given below:

- Quotes linked to the code ‘Several Options’ were re-linked to the code ‘not sure until started’ and the code ‘Several Options’ was deleted.
- Quotes linked to the code ‘Tracking thoughts and feelings’ were re-linked to the code ‘Identifying thoughts and feelings’ and the code ‘Tracking thoughts and feelings’ was deleted.
- The code ‘Model/approach/structure’ was linked to the code family ‘Methods of Using CB’ as well as ‘Competences, Skills and Knowledge Used’.
- The code ‘Ground breaking’ was removed from the code family ‘Miscellaneous’, and linked to the code family ‘Factors Relevant to the Prevention Delivery System: General Organisational Factors: Organisational norms regarding change’. The code family ‘Miscellaneous’ was deleted.

### Codes added following post-intervention interview analysis

The following codes were identified as codes exclusive to the post-intervention interview data: they were added to codes identified from the pre-intervention interview analysis. All other codes identified from post-intervention data analysis pre-existed from pre-intervention data.

Some participants expressed using the following CB competences:

1. ALL initial CB competences on list
2. Identifying thoughts, feelings and behaviours
3. Linking thoughts and behaviours

4. Linking thoughts, feelings and behaviours
5. Adjusting level of session
6. Identifying hot thoughts

Some participants expressed NOT having used specific CB competences:

7. NOT all CB competences in middle of diary log list
8. NOT relaxation
9. NOT thinking errors
10. NOT behavioural experiments
11. NOT problem solving

Other codes exclusive to post-intervention interviews were:

12. Perceived benefits of intervention – sceptical at first
13. Adaptability – pace of sessions

## Appendix W – Examples of Final Codes in ATLAS.ti



## Appendix X – Examples of Code Families in ATLAS.ti

Code Family Manager [HU: Post-Interview analysis merged with pre-interview analysis AND UNIFIED]

Families Edit Miscellaneous View

<Search> X

Name	S...	Created	Modified
Characteristics of implementor~	7	20/01/2013...	25/06/2013 ...
Characteristics of key relationships	2	10/03/2013...	25/06/2013 ...
Characteristics of the pupil	17	10/08/2012...	27/07/2013 ...
Community Level Factors: Funding, Policies and Politics and Prevention Theory and Research~	10	10/08/2012...	25/06/2013 ...
Competences, Skills and Knowledge Used	39	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: General Organisational Factors: Intergration of new programming~	8	20/01/2013...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: General Organisational Factors: Organisational norms regarding change~	10	20/01/2013...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: General Organisational Factors: Positive work climate~	7	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: General Organisational Factors: Shared Vision	12	20/01/2013...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: Specific Practices and Processes: Communication~	14	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: Specific Practices and Processes: Coordination with other agencies~	8	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: Specific Practices and Processes: Formulation of tasks~	9	20/01/2013...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: Specific Practices and Processes: Shared decision making~	4	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: Specific Staffing Considerations: Leadership~	9	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Delivery System: Specific Staffing Considerations: Managerial and Administrative Support~	9	10/08/2012...	22/11/2014 ...
Factors Relevant to the Prevention Delivery System: Specific Staffing Considerations: Program champion~	7	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Support System: Technical Assistance~	21	10/08/2012...	25/06/2013 ...
Factors Relevant to the Prevention Support System: Training~	32	10/08/2012...	25/06/2013 ...
Innovation Characteristics: Compatability and Adaptability~	15	10/08/2012...	25/06/2013 ...
Method of using CB	43	10/08/2012...	25/06/2013 ...
Provider Characteristics: Perceived benefits of intervention~	30	10/08/2012...	25/06/2013 ...
Provider Characteristics: Perceived need for intervention~	15	10/08/2012...	25/06/2013 ...
Provider Characteristics: Self Efficacy~	13	10/08/2012...	27/07/2013 ...
Provider Characteristics: Skill Proficiency~	6	20/01/2013...	25/06/2013 ...

Codes in family (7):

Codes not in family (331):