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Delivering Psychological Therapies in Schools and Communities

Sandra Dunsmuir & Julia Hardy

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The British Psychological Society

St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK

Telephone 0116 254 9568 Facsimile 0116 247 0787

E-mail mail@bps.org.uk Website www.bps.org.uk

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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Foreword

The importance of mental health is set out in *No Health without Mental Health* (DoH, 2011), with two overall aims identified:

- to improve the mental health and wellbeing of the population and keep people well; and
- to improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

More recently, *Future in Mind: Promoting, protecting and improving children and young people's mental health and wellbeing* (DoH, 2015) proposes a five-year plan for a complete overhaul of mental health services for children and young people.

The Children and Families Act (2014) and the associated Special Educational Needs and Disability (SEND) Code of Practice: 0 to 25 years (2015) have adopted a broader definition of SEND to include 'social, emotional and mental health'. This has further raised the profile of psychological health and wellbeing and highlighted the inter-relationship between achievement and mental health agendas in schools.

Practitioner psychologists are increasingly seeking additional training to further equip them to deliver interventions to support distressed young people and their families. Such interventions include the delivery of evidence-based psychological therapies. Although mental health services are inaccessible for many children and young people (Brown, 2002), there are indications that the majority who receive intervention do so through the education system (Burns et al., 1995; Leaf et al., 1996). In the UK, there is growing acknowledgement of the advantages of access to psychological therapies in school settings (Fuggle & Dunsmuir, 2013) and the role that educational psychologists (EPs) can play (Squires, 2010; Squires & Caddick, 2012).

A Working Group (see Appendix K) was convened by the Division of Educational and Child Psychology (DECP) committee in response to requests for professional practice guidance and clarification of the skills and competencies necessary for delivery of psychological therapies in schools and communities.

The Working Group had a number of aims. First, to consider the evidence-base for recognised psychological therapies, acknowledging that although there are many therapeutic approaches that can be drawn on when working with young people, the focus of the working group would be on the delivery of identified therapies supported by research evidence (e.g. Cognitive Behaviour Therapy, Mindfulness Based Therapies, Interpersonal Therapy, Family Therapy). Second, the remit of the group was to ensure that information was presented to assist decision-making about whether, when and for whom a particular therapeutic approach is appropriate. The practicality of delivering psychological therapies in schools and communities was an area for careful consideration, with an aim of providing guidance to help address some of the challenges. Another aim was to define ethical standards of training and supervision and to consider the impact of shifts in patterns of commissioning of individuals and services that deliver psychological therapies in schools. Finally, the Working Group sought to review methods of evaluating the outcomes of therapy with children and young people.

This report has been written primarily to support EPs when considering developing or offering therapeutic services. However, acknowledging that professionals from a wide range of backgrounds (including other areas of applied psychology) work in this field, psychologists delivering psychological therapies in schools and communities may wish to substitute the more generic term practitioner.

The discussions of the working group were wide-ranging and stimulating, leading to this report which represents the consensus that emerged. The contributors represented a wide range of perspectives, and so it is expected that this document will be used by EPs and other psychologists in a variety of ways. We wish to offer our warmest thanks to everyone who gave their time to contribute to the production of these guidelines.

Sandra Dunsmuir & Julia Hardy

Executive summary

Individuals involved in delivery of psychological therapies in schools and communities should ensure that assessment, formulation and intervention plans include two parallel strands: individual and systemic. Such work is complex and requires high levels of knowledge, experience and competence, both with the therapeutic approach but also in working with family and school systems.

Children and young people experiencing social, emotional and mental health difficulties face stigma in society, so EPs, along with colleagues from other professional and applied psychology backgrounds, should become involved in developing strategy to change perceptions concerning mental health, emotional wellbeing and resilience through promoting awareness raising initiatives in schools and communities.

EPs need to ensure that they are abreast of the developing evidence-base in relation to psychological therapies, although there are challenges in using and interpreting this. Methods of judging research quality and outcomes are outlined and it is recommended that EPs seek up-to-date information from recognised national and international review groups.

EPs are responsible for contributing to research into the effectiveness of therapeutic approaches, making efforts to disseminate and translate key research to academic communities and practitioners working in schools and communities.

EPs involved in delivering a recognised therapy must have regard to professional ethical guidelines and work within the limits of their competence. They should have successfully undertaken additional, post-qualification training, gained relevant experience, and demonstrate the essential competencies required for delivery of the specific therapeutic approach. In addition, they should make arrangements to receive regular supervision by an experienced practitioner with specialist knowledge and understanding of the chosen therapeutic approach (which may involve peer supervision) where required.

Practical issues faced by EPs working in schools are addressed and guidance provided in relation to case selection, criteria for starting and discontinuing therapy and expectations of settings where therapy is delivered (e.g. space, confidentiality, availability of staff, scheduling and so on).

Changes in commissioning arrangements in education, health and social care agencies have been associated with increased demand for access to services that deliver psychological therapies. Schools have become commissioners and this has had a direct impact on the EP role and potential service delivery.

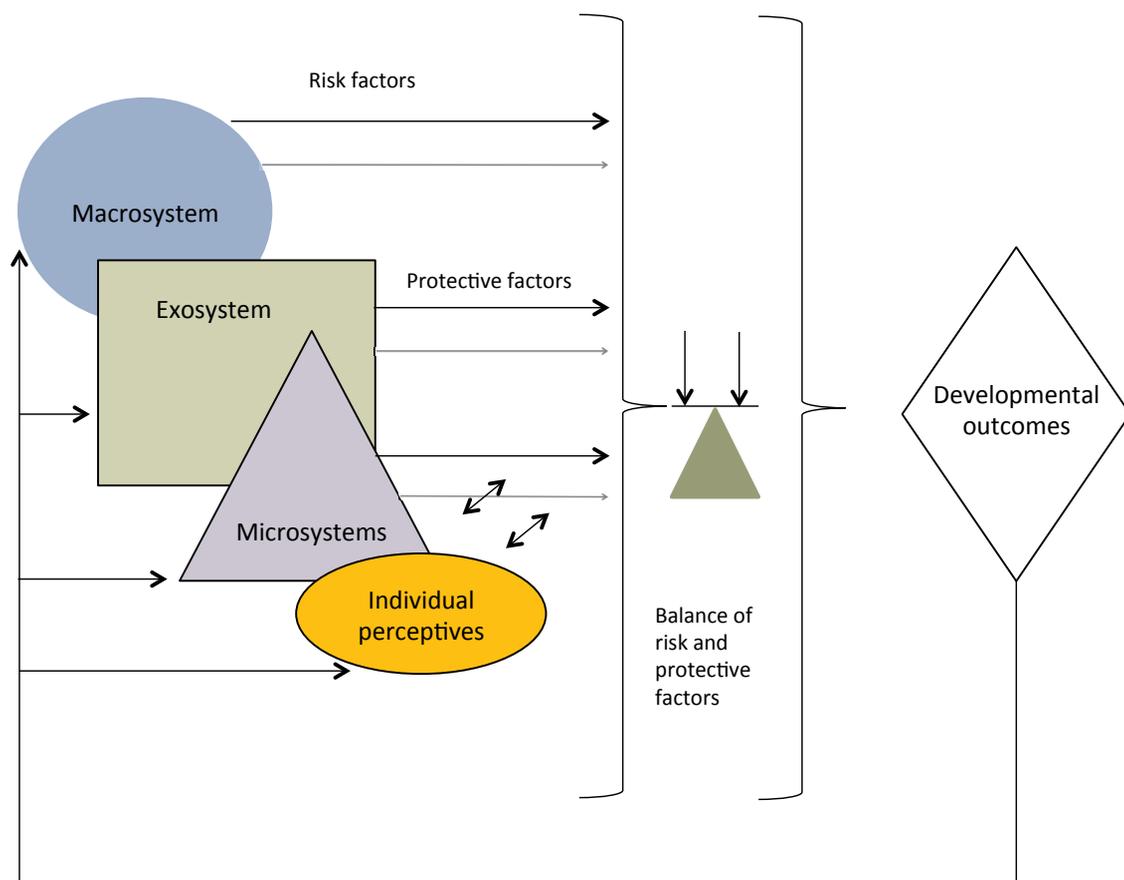
Finally, it is recommended that outcomes of psychological therapy are routinely evaluated and a common framework used to establish impact, which could include both quantitative and qualitative measures. In addition to self-report tools, information about the quality of the therapeutic relationship and the child or young person's engagement and motivation should be sought.

1. Theoretical frameworks and key principles

1.1 The child within the system

For those involved in providing support through delivering psychological therapies in schools and communities, it is essential to think about the child or young person within multiple systems. The environment plays a significant role not only in shaping and maintaining difficulties that may be experienced, but also in supporting positive change. It is important to bear in mind the interacting risk and resilience factors, ensuring that the child or young person is seen as one element within a wider context. Working with children and young people should be conceptualised as an ongoing dynamic process, dependent on the complex interaction between environmental and individual factors across contexts, cultures, families and within relationships. Bronfenbrenner's (2005) bioecological model, and Cicchetti and Lynch's (1993) refinement of this within the ecological transactional (ET) model of developmental psychopathology, provides a helpful conceptual framework, shown in Figure 1.

Figure 1: The Ecological Model of Development
(Adapted from Bronfenbrenner, 2005, and Cicchetti & Lynch, 1993)



It is, therefore, important to consider systemic and ecological influences on the development and maintenance of psychological distress in children and young people (Banerjee, 2010). From a therapeutic perspective, it can be seen that actively working with the child as one element within a wider system is fundamental in the delivery of psychological therapies in schools and communities.

Assessment and intervention plans should involve consideration of two core strands: individual and systemic. Such work is complex and requires high levels of competence in the delivery of evidence-based psychological therapies, and also established knowledge and experience of working with systems.

In order to ensure that interventions are appropriate, they must be tailored to the child or young person's needs. Service delivery can be conceptualised within three levels: universal (administered to every member of a population, irrespective of risk level), targeted (designed for at-risk groups) and specialist interventions (delivered to individuals and groups that require higher levels of support from professionals with greater expertise). These levels of service delivery and intervention draw on frameworks proposed in the UK (DfES, 2004, 2005; DoH, 2008), the US (Christner et al., 2007; Fox et al., 2009; Jimerson et al., 2007) and Australia (Sanders et al., 2004).

Children and young people are likely to have limited control of the systems in their lives and have reduced power to implement change. If the child is living in an environment in which their beliefs (however seemingly negative) make sense and are functional, understanding the need to change their responses (with regard to how they think, feel or behave) may be difficult and so it may be hard to motivate them to engage with a therapeutic intervention. The question of what 'recovery' means for the child may be problematic (Tew, 2011) and should be explored from the child's perspective. Recovery is, for example, not necessarily 'symptom-free' or culturally 'typical'; for some young people improvement might be gauged in terms of increased social acceptance of their 'difference', perhaps in parallel to adjustments in their immediate social and inter-personal world to reduce sources of stress or increase transactions with protective, compensatory influences in their lives.

1.2 Learning and development: Adaptation and access

Children grow up in families and attend schools. In these contexts, parents and other adults provide the most emotional and psychological support. Cognitive development occurs through complex processes of social interaction, primarily through relationships with attachment figures (Sharp, Fonagy et al., 2008), which support the development of emotional regulation and ability to understand the perspectives of others. As children develop, interactions with significant attachment figures help them to make sense of the intentions, internal experience and actions of others. It can be difficult for young children to report on events in their lives (in particular emotionally charged or salient ones), but the ability to reflect on past events and to anticipate the future increases with age, due to both changes in children's memory capacity and the development of more abstract and symbolic ways of psychological representation.

Research into learning in children and young people is highly relevant when planning therapy with children and young people as it provides insights into possibilities, constraints and aspects of practice likely to promote retention of concepts and effective therapeutic

change. There is compelling evidence of the importance of the adult responsiveness to feedback from a young person with regard to something they have been taught and the adjustments the adult subsequently makes to accommodate changes (Hattie, 2009). Only by ensuring clarity about the child's conceptions and misconceptions can the therapist develop an appropriate intervention. Some young people find the abstract nature of therapeutic conversations challenging, but research indicates that with sufficient practice a high degree of similarity between concrete and abstract domains, facilitates understanding (Gentner et al., 1993).

1.3 Views of therapy in society

Although there are established understandings about mental health and psychological interventions amongst professional applied psychologists, these conceptualisations are not necessarily understood across wider society. In the delivery of therapeutic services, it is necessary to consider what 'therapy' means to the outside world. Stigma is a key theme which individuals with mental health difficulties commonly encounter and this can influence decisions about whether or not to see a psychologist (Daggett, 2012). Families with children or young people with difficulties may reject the offer of therapeutic support, hypothesising that therapy may be perceived as medicalised and oppressive rather than supportive. EPs may, therefore, need to become involved in developing strategy to change perceptions of mental health, emotional wellbeing and resilience through promoting awareness-raising initiatives in schools and communities. Whole school training programmes are one option, with a focus on key principles, including:

- raising awareness of mental health within the community;
- recognising signs and symptoms of mental health needs;
- providing help, support and early intervention;
- reducing stigma and discrimination;
- enabling and maintaining recovery;
- signposting and enabling access to relevant support; and
- safeguarding.

The child within the system should be considered more broadly, not only focusing on the individual child or young person's needs, but ensuring that their supporters are also helped, through building knowledge and providing training in evidence-based or practice-based interventions.

2. Ethical practice

2.1 Definition and application of ethical frameworks

All applied psychologists delivering psychological therapies must have regard to the Health Care and Professions Council (HCPC) *Standards of Conduct, Performance and Ethics* (2016) and the British Psychological Society (BPS) *Code of Ethics and Conduct* (2009). Both documents concern ethical considerations for applied psychologists, focusing on the quality of decision-making whilst acknowledging sufficient flexibility for a variety of approaches and methods. Both documents set out to provide a framework to support professional judgement. As autonomous and accountable professionals, it is the responsibility for all practitioners to make informed and reasonable decisions in the best interest of clients. Any scrutiny of this process will consider situations in terms of the judgements, outcomes and processes involved.

There is the need for psychologists to recognise that their work, particularly direct therapeutic work, often presents them with difficult and ambiguous situations. Applied psychologists are used to dealing with dilemmas, but there is always a need for continual careful reflection drawing on agreed ethical principles.

In practice, there are usually multiple sources of accountability and multiple sources of obligation, but one way of simplifying this may be by regarding the client as the young person with whom the practitioner has direct interaction and establishes a therapeutic relationship.

The BPS *Code of Conduct and Ethics* is based on four ethical principles, which constitute the main domains of responsibility within which ethical issues are considered:

Respect, Competence, Responsibility and Integrity.

Respect

Psychologists value the dignity and worth of everyone, and are sensitive to the dynamics of perceived authority or influence over clients, with particular regard to people's rights, especially those of privacy and self-determination. They give due regard to individual, cultural and role differences. As far as possible and in line with legal requirements, they should ensure that clients understand and have given informed consent to the proposed professional action. They restrict any disclosure of information to that which is consistent with professional purposes and agreed with the client, except in exceptional circumstances when the client or others are at risk of serious harm.

Competence

Psychologists value the continuing development and maintenance of high standards of competence in their professional work, and the importance of preserving their ability to function optimally within recognised limits of their knowledge, skill, training, education, and experience.

Responsibility

Psychologists are required to act in a trustworthy and reputable manner towards clients and the community. They act to ensure the best service to clients, which may include referral to other services. They take appropriate action to address ethical dilemmas and conflicts of interest.

Integrity

Psychologists value honesty, accuracy, clarity, and fairness in all their interactions, and seek to promote integrity in all facets of their professional endeavours. They take steps to maintain their own mental health and ensure their work is professionally supervised. They are required to be honest and open about their qualifications and the effectiveness of the services they provide. They take action against harmful or unethical behaviour in colleagues.

The HCPC (2012) sets out 10 standards of conduct, performance and ethics, which are covered in the above information from the BPS code, with the addition of:

Standard 9: the practitioner psychologist must provide the HCPC with any important information about his/her competence or conduct and co-operate with any investigation into his/her professional conduct.

Standard 8: the practitioner psychologist must effectively supervise tasks s/he has asked other people to carry out. S/he is responsible for ensuring that the same standards are met through the delegated work as would have been met by him/herself.

The HCPC describes someone who is 'fit to practise' as someone who has the skills, knowledge, character and health to practise their profession safely and effectively.

Furthermore, all professionals have a duty to ensure they are fully informed of relevant safeguarding policies and procedures and to make all their clients aware that if any concerns are shared which suggest there is or may be a risk of harm then the practitioner will not be able to maintain confidentiality and will follow appropriate safeguarding procedures.

Summarising the ethical considerations set out above, there are questions against which to evaluate professional practice.

How does the therapeutic practice:

- Respect the client as a person with expertise and power over the choices they make in their own lives?
- Benefit the client or be judged by the client to be worthwhile?
- Guard against bringing any harm to the client?
- Ensure trust is maintained between the professional and the client?
- Ensure that disclosure of information is restricted to agreed professional purposes?
- Ensure that services and resources are distributed fairly?
- Avoid bringing the profession into disrepute?
- Take care of the practising professional?

In considering the ethical basis for psychological therapies the above questions would inform therapeutic practice with particular attention to working with children and young people, and asking:

- What consent has the child or young person given to the involvement of the practitioner?
- How does the child or young person withdraw consent?
- What knowledge and understanding does the child or young person have about the therapeutic approach offered?
- What has been discussed and agreed about the information shared through therapy?

- How does the therapeutic practice acknowledge and respect the culture, community and context of the child or young person?
- How is the therapeutic practice supported and supervised?

These considerations have been highlighted in relation to children and young people as it is unusual for a child or young person to refer themselves for therapy, however, the questions would apply equally to adult clients.

Furthermore, all professional practice is supported by appropriate supervision. Therapeutic practice requires that a supervisor, who has close knowledge and understanding of the chosen therapeutic approach, provides supervision (this may involve peer supervision). A decision-making model that can be used when considering ethical dilemmas is provided in Appendix B. In addition, some examples from practice are offered to support thinking about ethical dilemmas.

2.2 Multi-agency and multi-disciplinary practice

Ethical practice as it applies to a single profession or across agencies means that each member of that network should honour the beliefs, morals and values of their own profession, and work proactively to help others through unbiased decision making. There are a number of key requirements and standards. Within a given agency each individual as well as the collective should ensure that professional standards are maintained at the highest level and that core competencies ensure fairness, equality and respect for others. Within multi-disciplinary teams and across agencies a clear distinction should be made between different roles and responsibilities, acknowledgment of positive contributions made but also support and challenge to address areas of under-performance.

There should be clear communication between all those working in support of a child or young person and their carers. The requirement to consult is highlighted in professional frameworks and guidance produced by bodies such as the BPS and HCPC and legislation such as the Children Act (1989) and the Education Act (1996). Information provided should detail activities supporting the child or young person and their carers and give recommendations for further progress that are clear, evidence-informed and timely. The communication should also make clear any professional limitations or other constraints that would preclude responsible judgment or successful performance of a duty in support of the child or young person. Multi-disciplinary practice is fundamental to effective safeguarding practices, with the team around the child being crucial in the prevention of harm.

Ethical practice within and across teams should include close co-operation and collaboration. In wider society but especially within a mental health context, where demands always seem to out-strip provision, professionals must work together within and across services. In order to meet new and increasing challenges facing public health there is the need for new collaborations.

Working relations must be free of professional rivalry and undue conflict. Any conflict of interest should be declared and negative competition avoided. The best interest of the child or young person should be paramount.

3. The evidence base

3.1 What is an evidence-based psychological therapy?

An evidence-based psychological therapy is one whose effectiveness is supported by a published and peer-reviewed research base and where the effectiveness of the intervention and quality of supporting research has been judged to be of good quality. Evidence should include outcomes research, including but not limited to randomised controlled designs and meta-analyses, as well as research supporting the feasibility of approach in terms of the child or young person's engagement and experience. Reported outcomes should demonstrate the application of a well-developed theory to understand the child or young person's presenting problems and illustrate the way theory has been applied to target a specific population, with good validity, which might include effect sizes and statistical and clinical significance, in order to scaffold the intervention and consistency of outcomes.

Carr (2009) argues that evidence-based practice in therapy 'involves the judicious and compassionate use of the best available scientific evidence to make decisions about patient care', which requires us to take into account available scientific evidence about 'what works', whilst also taking account of 'clients' unique problems, needs, rights and preference... and making balanced, compassionate judgements' (p.9).

Evidence-based practice, therefore, requires professional judgements and decision making to be guided by:

1. Prior empirical knowledge that indicates actions and intervention approaches most likely to be associated with effective outcomes.
2. Use of methods of evaluation that will enable determination of the extent to which outcomes are associated with practitioner action (Cournoyer & Powers, 2003).

This approach assumes optimal use of resources and transparency in relation to decision-making processes (Fonagy et al., 2002). The benefits of evidence-based interventions are thus framed in terms of economic efficiency, as well as in relation to the quality of care and/or professional efficacy; there is general agreement that to commit resources without reference to the evidence-base, or to offer a course of treatment to a service user without first considering and discussing the evidence that exists to support different options, would be professionally negligent and unethical.

There are many difficulties with the appraisal and interpretation of research evidence; for example, unlike participants selected for research studies (e.g. with diagnostic classification, such as anxiety), children and young people referred to services rarely have neat, unifying presenting problems. Interventions that are researched follow standardised protocols, yet for therapists working in community settings, fidelity of implementation may not be feasible; the intervention may need to be modified so that it better accommodates the particular service user's needs and preferences, and/or significant life events.

In measuring outcomes, most research studies use standardised instruments, which do not record qualitative aspects of the therapeutic experience, such as personally significant events or subjective happiness. To consider these subjective experiences with more readily quantifiable measures of wellbeing requires the use of mixed methods, and sometimes

different stakeholder perspectives too, since mental health and wellbeing may be viewed as an inter-personal as well as an intra-personal phenomenon.

Wolpert et al. (2006) add a further dimension in their definition of evidence-based practice, describing it as *'the integration of individual practitioner expertise with the best available evidence from systematic research in order to reach decisions about client care'* (p.5). This recognition of the practitioner's expertise is important, considering the complexity of therapy as a personal-professional transaction more than an applied science; skilled therapy depends upon interpersonal and therapeutic competencies and transcends applied research.

There are different reasons for considering evidence when engaging with psychotherapeutic work. These include:

- using evidence generated with the client to help with problem formulation;
- screening for inclusion in particular services or referral routes;
- establishing baselines and monitoring client progress;
- evaluating service provision;
- helping the therapist to contribute to the practice-based evidence research; and
- conducting and participating in research so that therapists can contribute to the evidence-base.

These different aims require slightly different considerations, based on the definition of what is good evidence. A tool that is good for one purpose may not be suitable for another and there needs to be clarity about the reasons for generating and evaluating evidence. If a measure is used, how do we know it is an appropriate measure that is fit for purpose? How can we notice patterns across groups that receive the same intervention? How do we detect more subtle change that is idiographic, personal, and meaningful to the child or young person?

Ramachandi et al. (2001) detailed the professional competencies required for evidence-based practice, which include:

- being able to formulate an answerable question(s);
- having access to bibliographic databases and knowing how to effectively search for relevant studies;
- conducting a critical appraisal of diverse research findings;
- having knowledge and skill in interpretation of results and application to practice; and
- being able to conduct routine evaluation of one's own practice.

These ideas form the basis for a set of competencies required for carrying out therapeutic interventions, published by the Centre for Outcomes Research and Effectiveness (CORE) and available on the website

(http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm)

For more information about criteria used to evaluate study quality and outcomes see Appendix C.

3.2 Practice-based evidence and relationship with evidence-based practice

As reported in 3.1, one of the problems in using research evidence for informing clinical practice is that the research evidence is collected under ideal conditions using manualised approaches, with a homogenous participant group using a high degree of fidelity in the way the intervention is carried out. Therapeutic practice tends to be more individualised, community-based and used with a varied participant group (Mychailyszyn et al., 2011). There is recognition that research evidence alone is insufficient to determine best practice; professional experience in communities is also needed (APA, 2005). This leads to a difference between the established efficacy of a researched therapeutic approach and its effectiveness in community use.

The experience of the therapist is important in making decisions about the way research evidence is translated into evidence-based (or research-informed) practice. In evidence-based practice decisions about individuals are based on a mixture of therapeutic expertise from professional practice, and research evidence from systematic research (Sacket et al., 1996). Useful resources that pull together research evidence to support therapeutic expertise are being developed, such as the Evidence Based Practice Unit at the Anna Freud Centre (<http://www.annafreud.org/pages/resources-aimed-at-children-and-young-people.html>).

Practice-based evidence is generated in a different way. This starts with the assumption that the real world is messy and there are many things that cannot be controlled. What matters in an individual case is whether change takes place or not as a result of intervention. In practice-based evidence, the therapist determines the best measures to track progress on matters important to the individual child or young person. The intervention itself is not controlled, but allowed to be flexible, responsive, and personalised to the individual's circumstances (Swisher, 2010).

In contrast to randomised controlled trials (RCTs) which have high internal validity that is traded off against generalisability and which give an indication of efficacy, practice-based evidence has high generalisability, because it is located in existing professional practice and gives an indication of effectiveness, but it has low internal validity and rigour. One approach to systematically collecting practice-based evidence is to have common outcome measures, but these measures may not always reflect the difficulties with which the child or young person wants help.

An approach has been suggested (Margison et al., 2000) to deal with the advantages of both evidence-based practice and practice-based evidence:

- Generate a theoretical model of how the intended therapeutic plan should work.
- Test the efficacy of the model using techniques such as RCTs that look at intention to treat.
- Replicate studies to check the findings.
- Disseminate the findings so that the evidence can be used to inform practice. EPs are likely to modify the approach in their professional practice.
- Collect data from actual practice, including information about how the approach is implemented to generate practice-based evidence. Information is needed about therapeutic integrity; this includes the therapist's adherence to the theoretical model underpinning the therapeutic approach, their competence and level of knowledge, and differentiation of the approach to specific individuals.

3.3 Review groups

In the UK, the Child Outcome Research Consortium (CORC) and the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) constitute two organisations which play a central role in collating and analysing data from multiple sources, in order to maintain and develop the evidence base which can inform practitioner decision-making, ‘consumer’ choice and overall treatment efficacy.

CORC describes itself as a ‘world-leading, grassroots collaboration of mental health specialists from over 70 Child and Adolescent Mental Health Services (CAMHS) across the UK and beyond’. It is a ‘not for profit learning collaboration whose members come together to find the best way of routinely evaluating outcomes across the full range of CAMHS’. Collaborating services pay an annual membership fee for all staff within their service to be part of the CORC network (<http://www.corc.uk.net/about/>).

Members collect responses to an agreed set of questionnaires from the children and families with whom they work as part of the service’s internal evaluation of the positive outcomes for service users, in response to the therapy provided, and of the experience of children/young people and their carers.

There is an expectation for CORC organisations to use this data to support service improvements and strengthen the evidence-base which informs their own practice. Additionally, CORC member services’ data are submitted centrally for analysis, which contributes to a cumulative, cross-service synthesis of practice-based evidence which can inform the thinking of all practitioners nationally, whilst also offering members access to data from other services, allowing them to compare the outcomes they achieved, with comparable services elsewhere.

Services which offer therapy may elect to seek CORC membership and so contribute to the development of practice-based evidence regarding effectiveness of therapeutic intervention. Whether or not they do so, the evidence-base published by CORC should be a helpful reference point.

While CORC is concerned centrally with child and adolescent mental health, the EPPI-Centre has a wider remit, concerned with two main areas: systematic reviews and research use across a number of domains, including:

- education and social policy;
- health promotion and public health;
- international health systems and development; and
- participative research and policy.

It is in contributions to the evidence base through systematic reviews within the ‘health promotion’ (including mental health) and public health domain that the work of the EPPI-Centre is of greatest relevance in contributing to evidence-based decision-making for therapists, service users and carers.

The EPPI-Centre (<http://eppi.ioe.ac.uk/cms/>) is based within the Social Science Research Unit at the University College London (UCL) Institute of Education. Its work is funded by the Economic and Social Research Council (ESRC), the Medical Research Council, the National Institute for Health and Care Excellence (NICE), the European Commission, several UK government departments and charities, and other national and international

partners. The EPPI-Centre is a partner of two international collaborations concerned with policy-relevant reviews of research evidence: the Cochrane Collaboration (<http://www.cochrane.org/>) in health care and the Campbell Collaboration (<http://www.campbellcollaboration.org/>) for social interventions in Crime and Justice, Education, International Development, and Social Welfare.

The last few decades have seen a big expansion of studies that evaluated a wide range of psychological and educational interventions. Glass (1976) proposed the meta-analysis as a way of comparing studies, recommending the conversion of results into a common measure (an effect size) to estimate the impact of findings and provide a standardised measure of magnitude (Field, 2013) so that the practical significance of outcomes can be determined and compared across studies (Thompson et al., 2005). To evaluate the evidence supporting a particular psychological therapy, consideration of effect sizes reported in systematic reviews and meta-analyses are important and should be taken into account. To read more about the calculation and interpretation of effect sizes, see Appendix C.

3.4 The therapeutic relationship

There are a large number of studies that highlight the benefits of establishing a strong therapeutic alliance to ensure the child and young person's engagement and good outcomes (e.g. Kazdin et al., 2006; Kendall et al., 2009; Shirk, 2008).

A central component of 'practitioner expertise' lies in the therapist's authenticity and skills in developing a trusting working relationship with children and young people. The contemporary relevance of the seminal work of Traux and Carkhuff in 1976, with its empirical evidence of the centrality of the therapeutic relationship in determining outcomes remains undiminished. They proposed that warmth, empathy and genuine positive regard are key therapist qualities, arguing that 'the beneficial effects of any human interchange are enhanced by such qualities as the other person's feelings, deep concern for her/his welfare without attempts to dominate her/him, and openness about one's own reactions' (Traux & Carkhuff, 1976).

So as well as taking account of leading edge research into the efficacy of different approaches to treating particular experiences of mental distress shown by children, young people, and/or their carers, therapists need to attend to the 'evidence' concerning the development of an effective working relationship or therapeutic alliance (Lambert, 2010) avoiding criticism and blame. The therapeutic alliance will be enhanced if therapy centres on the child or young person's interests, is engaging and includes the possibility of fun.

3.5 Responsibilities in contributing to, interpreting and disseminating evidence

Psychologists working in schools and communities have responsibility for continually building on the evidence-base about the effectiveness of therapeutic approaches. This includes Doctoral level research, as well as other research studies into the impact of psychological therapies as an intrinsic part of their work. EPs also have many opportunities within local authorities, schools and other settings, to contribute to and interpret research findings. Action research, in collaboration with schools, children, young people and their parents, is an invaluable way of assessing, reflecting on and sharing the evidence-base. Research studies published in publications such as *Education & Child Psychology* and

Educational Psychology in Practice are one way to communicate new findings to an audience of EPs. To disseminate findings to a broader academic audience, there are a wide range of specialist journals that invite articles for publication. Conferences are another means of disseminating research. However, in order to have impact and lead to policy or systems change, key stakeholders need to appreciate the benefits of an intervention. Professional benefits for psychologists involved in disseminating research include:

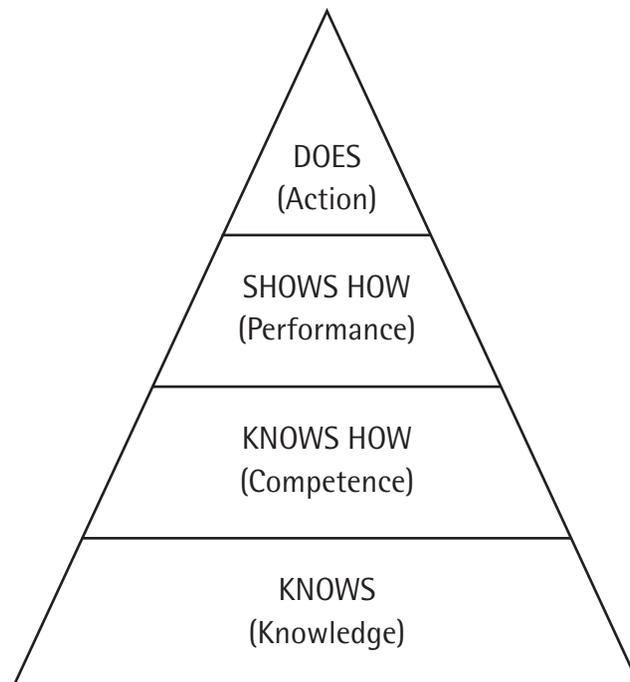
- informing practice;
- informing future research; and
- enabling others to learn about the evidence base.

4. Training and supervision

4.1 Defining competencies

There has been increasing interest in the definition and assessment of professional competence (Fouad et al., 2009; Kaslow et al., 2009). Foundational competencies are necessary to perform the core functions of psychological practice, such as application of ethical frameworks, knowledge of scientific principles and awareness of cultural diversity issues. Functional competencies can be observed in a psychologist's professional performance in terms of sets of behaviours. Competency assessment strategies are necessary to determine what an individual knows, to establish if they know how, if they can show how, and to evaluate what the individual does in practice (see Figure 2).

Figure 2: Miller's (1990) Model of Knowledge and Skill Development



Effective appraisal of competence is important to ensure that individuals are fit to practice and can provide effective and useful services. There have been various attempts to identify specific sets of therapist competencies. For example, Roth and Pilling (2008) published an empirically derived competency framework identifying explicit behaviours and knowledge required for delivery of Cognitive Behaviour Therapy (CBT). Different therapies involve some generic therapeutic competencies, but also some competencies specific to that therapeutic approach.

4.2 Training routes, qualifications and standards

Psychologists may engage in the more specialist activity of directly delivering recognised therapies, in which case professional standards set out in the BPS *Code of Ethics and Conduct* (2009) make formal training and supervision essential in order to practice within the boundaries of competence. Essential elements of ethical and appropriate therapeutic practice require an individual to:

- have successfully undertaken additional training;
- be actively working in therapeutic practice;
- undertake regular supervision from an appropriately qualified supervisor;
- be committed to developing the evidence base of the therapeutic practice; and
- be actively engaged in gaining further training and development in therapeutic practice.

This set of requirements can be conceived as a cycle with initial training-practice-supervision-reflection and review which may lead to the next cycle of further training.

In Appendix D, a tiered framework for development of therapeutic competencies is presented. This example proposes four distinct phases of the learning cycle in the development of therapeutic competencies: key elements should be addressed at each phase.

4.3 Minimum requirements for giving and receiving appropriate supervision delivered by skilled, experienced supervisors

Implementing psychological therapies as a routine aspect of psychological practice has many implications, ethical and practical, for models of service-delivery and supervision. Therapeutic skills and principles can be incorporated into generic casework, and supervision relating to this could form part of the usual supervision within the service. Professional supervision may be generic, specialist or a mixture of both. The possibilities are conceptualised and represented in Figure 3.

Figure 3: Supervision competencies



The direct delivery of psychological therapies should be accompanied by detailed supervision by practitioners experienced in the therapeutic approach (which may involve peer supervision), where required. The DECP guidelines on professional supervision highlight the need to access specialist supervision in order to:

‘...cover work in a specific area or using a particular approach... it will also involve specialist knowledge, competence and experience on the part of the supervisor. Hence if an EP were using a specific technique, such as Cognitive Behaviour Therapy (CBT), managing organisational change or Video Interaction Guidance (VIG), they should access specialist supervision. It is important that EPs have access to specialist supervision and this may need to be negotiated, commissioned or bought in from specialist sources. In such cases the supervision should be provided by someone with the requisite competencies who also has a current knowledge of the role and working context of the Educational Psychologist, but who may or may not be an EP’ (DECP, 2010, p.9).

It is important that supervision is documented and reflected upon: to support this it is recommended that a reflective log is kept (see Appendix E).

There may be difficulties with accessing appropriate specialist supervision because of a shortage of experienced or accredited supervisors, in particular those who have training and experience with children and young people. Within some Educational Psychology Services (EPSs), there is also the problem of limited resources to fund an adequate level of training and supervision. One solution would be for EPSs to arrange training and supervision for one (or a small number of) EPs, who would then become competent to offer training and supervision to others.

5. Delivering psychological therapies: The practicalities

5.1 Procedures to assist decision-making about whether, when, and for whom a particular therapeutic approach is appropriate

Where indicated, targeted provision of evidence-informed psychological therapies in schools and communities should form part of a range of multi-level, multi-modal preventative interventions spanning universal to specialist.

Where individual or group therapy is judged to be an appropriate intervention, consideration should be given to the conditions of acceptance (see Figure 4 below).

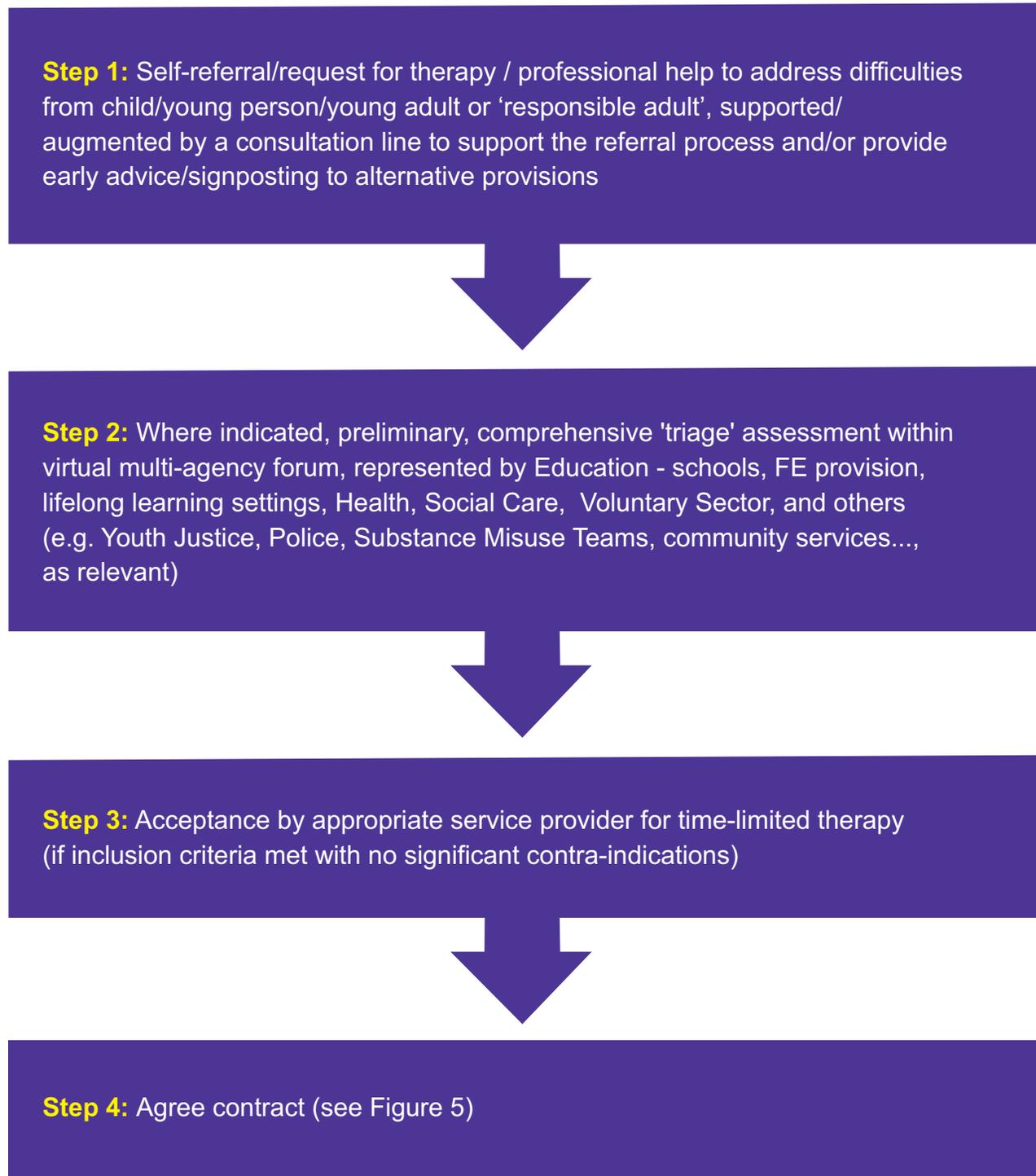
These should include the following:

- Expression of need or request for help by the child, young person, or adult(s) with parental responsibility.
- Evidence of mental distress and adverse effects on the child's or young person's overall level of functioning.
- Evidence (from research and the initial assessment of the child or young person and family circumstances) to suggest that therapy might achieve worthwhile and durable change/improvement.
- Multi-agency assessment through which parallel/alternative needs are identified, with firm plans made to address them, note taken of any contra-indications to therapy, and with firm step-up and step-down plans (Step 2 of Figure 4). The multi-agency assessment should also ensure that, whether or not therapy is offered, a team around the child, family and/or school approach can be implemented to complement therapy and/or to offer appropriate support in cases where therapy is not considered appropriate. The assessment should also check for complex needs requiring more comprehensive assessment and long-term, multi-agency intervention.
- Freely-given, informed consent to therapy from the child or young person and, in the case of children or young people who may not have attained 'Gillick competence' from their parent or carer (see Appendix F);
- The individual should have sufficient mental capacity (see Appendix G) to make independent decisions and engage in assisted decisions (in relation to their treatment plan/therapy/consent and confidentiality) where there are concerns about suicide risk.

Threshold levels for these broad criteria should be agreed locally between agencies, with acceptance of the need for dynamic calibration of thresholds to accommodate fluctuating levels of demand within communities, variations in service capacity, and developments in the evidence base.

At locality level the range of services available to address and respond to mental health distress would need to be clearly charted within a provision map, as part of the local offer, available to service providers, professional groups and children, young people and parents or carers. The range of therapeutic services offered within schools and other community settings would be represented on this map, together with information about referral routes, care pathways and acceptance criteria.

Figure 4. Procedures for Acceptance for Therapy



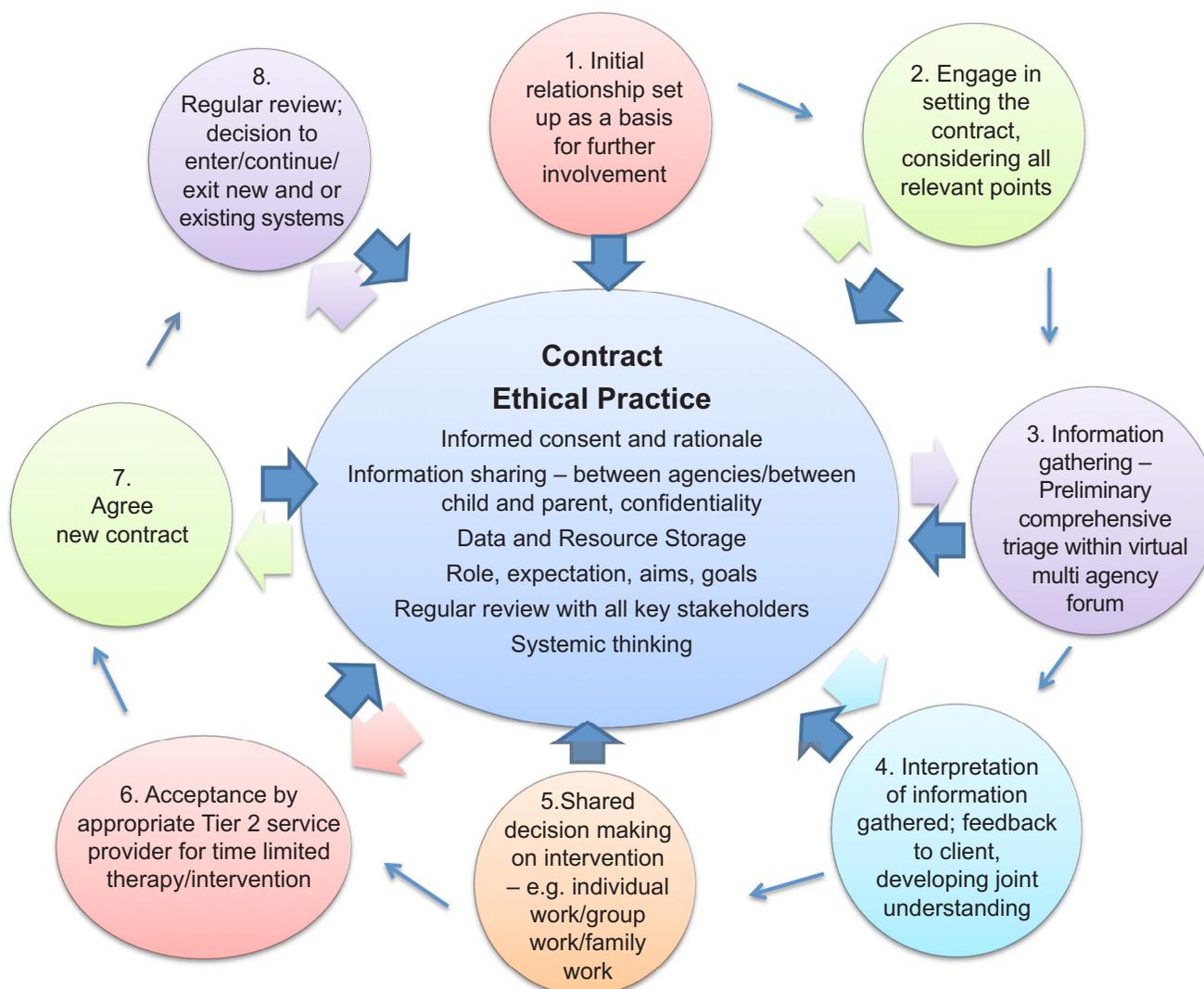
Steps in the therapeutic process are represented in Figure 5. A central concept here is the notion of 'triage': derived from the French word trier, meaning 'separate out'. This is now used in the UK to signal early sorting of referrals (including self-referrals) of a large number of children, and young people potentially in need of some form of intervention, to differentiate those for whom therapy would, on the basis of initial, rigorous, criterion-referenced assessment, afford the intervention of choice and those for whom other forms of intervention are judged more appropriate or those for whom therapy is contraindicated.

Figure 5: Core principles for delivery of psychological therapies

Outer circles – key procedures/process for acceptance for therapy

Inner circle – some core principals to be revisited throughout process.

Arrows – flexible movement, feeding in and out of process and procedures

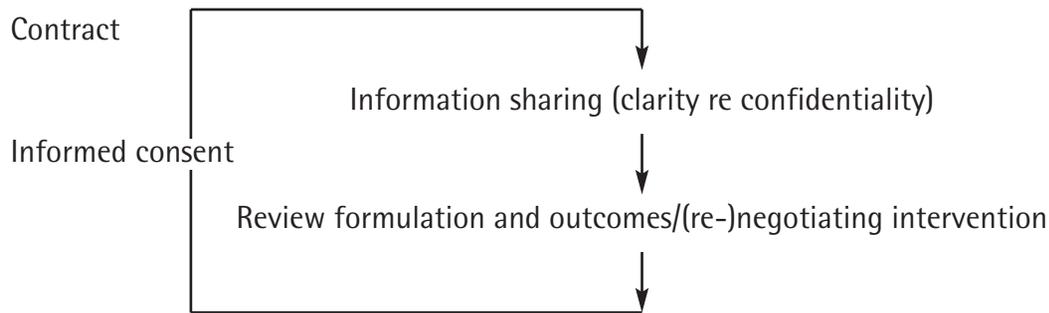


Following Step 3, there may be differential outcomes of an early ‘triage’ assessment in the form of:

- referral/sign-posting to other necessary/suitable provisions; or
- no further action, where measures of wellbeing and available support indicate no current need for intervention.

The therapeutic contract negotiated at Step 4 above would be dynamic, requiring renegotiation through the therapeutic process in light of the continuing monitoring of session-by-session outcomes and contingent revision in the formulation and overall intervention plan, alongside renegotiation of consent at each stage of the therapeutic process. Features of the therapeutic contracting process are represented in Figure 6.

Figure 6: The Therapeutic Contract



5.2 Criteria/conditions for discontinuation of therapy

It is important that the criteria for ending therapy are made clear to the child or young person and their family. A range of reasons may trigger the decision to discontinue, including:

1. completion of the agreed course of therapy;
2. measures of change and wellbeing indicating the acceptability of discontinuation in light of strengthened child or young person self-efficacy and an acceptable balance of risk and protective influences within her/his immediate environment;
3. conditions under which the child's or young person's continuing participation in therapy is no longer feasible or appropriate (e.g. change of residence, health needs, court proceedings, response to therapy evidenced through outcome monitoring or evaluation of the positive or negative impact of the particular therapeutic approach used), dissipation of risk factors;
4. safeguarding concerns which need to be addressed before therapy can safely be resumed;
5. deterioration in mental health which requires urgent or specialised assessment; or
6. consent is withdrawn.

A clearly specified, robust after-care plan should be agreed to ensure maintenance of progress and support relapse prevention. This might include referral or signposting to other services judged more appropriate in light of the changed circumstances, and/or work to strengthen the supportive and protective influences within the home, school or other key systems in which the child or young person lives and works. Such ecological interventions might include supporting staff skill development, mediating the social dynamics in the peer group or other forms of social system-analysis and change.

5.3 Information sharing – Caldicott Principles (1997)

The Caldicott Committee developed a set of six general principles for the safe handling of personal-identifiable information, and these are the guidelines which govern information-sharing within the NHS, together with the Data Protection Act (1998). Both cover information held in a variety of formats – electronic, paper, verbal, or visual. The six Caldicott Principles must be adhered to when collecting, transferring, or generally working with personal-identifiable information.

For non-NHS community-based providers of therapy, arrangements will need to be developed on a regional basis, taking account of the range of regional providers of therapeutic services for children, young people and young adults, and of agency protocols for information-sharing. However, within any such procedures, expectations for child or young person confidentiality should be prioritised, with criteria informing decisions re: information-sharing congruent with the Caldicott and Data Protection Act Principles, and also informed by:

- consideration of other agencies' 'need to know'; and
- evaluation of risk (a paramount consideration).

The six Caldicott Principles require staff to:

1. justify the purpose of recording/using confidential information;
2. use/record personal information only when absolutely necessary;
3. use the minimum that is required;
4. enable access only on a strict 'need to know' basis;
5. understand his or her responsibilities – this is universal responsibility;
6. understand and comply with the law.

In order to address these requirements, it is suggested that service providers (e.g. EPSs) should:

- include information about the ways in which child or young people's records will be used, who can access it and how it will be stored;
- have clear data protection policies that include password protection systems, regulations about storage and access to files and clear procedures for anonymity when sending information electronically;
- have, and communicate, a clear file and record disposal policy; and
- ensure regular, effectively evaluated training for staff on confidentiality, data protection and IT security.

5.4 Minimum expectations of settings where therapy is delivered

There is considerable evidence that for many children and young people access to therapy may be compromised by factors such as the social stigma which continues to attach to mental health (e.g. Hinshaw, 2011; Mental Health Foundation, 2014) and therapy (e.g. Corrigan et al., 2011; Vogel et al., 2008) as well as to practical difficulties associated with travelling to centres which may be situated outside the child or young person's immediate neighbourhood (Young Minds, 2014).

There is evidence that there are many benefits associated with provision of therapy within more familiar community-based settings, and in schools in particular (e.g. Mayer et al., 2009; Mennuti et al., 2012), with the Department for Education (2011) evaluation of the Targeted Mental Health in Schools (TaMHS) initiative providing particularly striking evidence from a large sample of schools in England of the widespread benefits to children, school ethos and staff of the development of schools' role as settings in which services were delivered.

However, if 'non-traditional' settings such as schools, colleges and other community settings are to be used as the locations for provision of therapy to children and young people, it is axiomatic that care must be taken to ensure the suitability of sites for this purpose.

Such considerations also apply to practitioners working independently of established public and third sector organisations, offering therapy on premises which are not regulated nor subject to organisational health and safety policy and procedures.

Here, reference to the fundamental values, codes of conduct and ethics published by established bodies such as the British Psychological Society (BPS), Health and Care Professions Council (HCPC) (2012), British Association for Counselling & Psychotherapy (BACP) (2009), and British Association for Behavioural and Cognitive Psychotherapies (BABCP) (2009) should inform decisions about acceptable standards which need to be ensured if children and young people are to be assured safety and dignity.

Considerations of the above require that therapy be provided in settings:

- which are culturally acceptable to children, young people and their families;
- which ensure privacy both during therapy, and in waiting areas;
- which ensure comfort in terms of lighting, heating, acoustics and seating;
- where reasonable adjustments can be made to support effects of special educational needs and disability;
- where arrangements are made to ensure children and young people are safe from risks of harm, including exploitation; and
- where routes of access to a practitioner's manager and supervisor are clearly communicated, to ensure that children and young people and their families have information, and access to support, through which they can communicate concerns or complaints to a third party, without risk of coercion.

5.5 Communication protocols for feeding back and reporting to children and young people and parents/carers

Procedures will need to be agreed between children and young people and their parent or carer about the documentation of and feedback from the therapy sessions. These would take place as part of the initial discussion and agreement to therapy. Such documentation and feedback may be similar to general reporting frameworks used by practitioners for example letters, reports, summaries of work.

Therapeutic documents

Therapeutic documents are a therapeutic tool intended to strengthen sessional work with children and young people. The intended functions of therapeutic documents are varied and include the following aims:

- Strengthening the therapeutic alliance, which plays a significant role in the success of therapy, by inviting and promoting rapport and engagement with the therapeutic process.
- Conveying that the children and young people views and perceptions are taken seriously and have value. Therapeutic documents offer the opportunity to give children and young people a voice. Payne (2006) suggests that the client centred open and social nature of therapeutic documents can provide a 'counterbalance' to other forms of documents the content of which may be less in the control of the person about whom they are written. This is especially pertinent to children and young people where decision making power most often rests with parents, carers and professionals.
- Providing a permanent record of progress, discoveries, new perspectives that affirm the children's and young people's views and efforts and celebrate change and achievement.

- Extending the ‘therapeutic’ discourse to the child’s or young person’s real life so that new discoveries and insights are reinforced in context. This can help to counter the potential for new learning to be lost as ‘habits of thinking and self-story telling attempt to reassert their previous dominance’ (Payne, 2006).

Therapeutic documents may be used to:

1. Summarise emerging stories by providing an account of session discussions, conveying to the child or young person a sense of being ‘held in mind.’ They can reinforce and emphasise key points of sessional discussions (as they allow re-engagement with ideas through self-reflection).
2. Recognise/acknowledge particular skills, qualities or attributes on the part of the child or young person or aspects of identity. They can be used to name and thus highlight strengths and positive changes emerging in the course of therapeutic sessions and to affirm and celebrate commitment to the therapeutic process.
3. Reinforce activities to be undertaken in between session ‘homework’ tasks.
4. Support psycho-education and skill consolidation by naming strategies and actions the child or young person has agreed to try.
5. Communicate alternative stories to others in the family/system around the child or young person.

The format of therapeutic documents is varied and can include:

- pictures and drawings;
- photographs;
- diagrams;
- letters;
- cards;
- certificates;
- emails;
- books; or
- sound and video recordings.

Therapeutic documents can be created by the practitioner for the child or young person, but documents may also be co-produced or independently produced by the children and young people themselves (Payne, 2006).

Points for consideration when writing therapeutic documents to children and young people

The use of therapeutic documents should be the outcome of a careful consideration by the practitioner of where the child or young person ‘is at’ in the process of therapeutically supported change. The introduction of therapeutic documents should be the outcome of negotiation between the practitioner and the child or young person. Questions to ask to establish their purpose include:

1. Consideration of the purpose of the document(s) in the context of the therapeutic intervention is important. Are the documents being used to establish and sustain the therapeutic alliance, to summarise or to challenge thinking and offer something new? Is the child or young person ready to be affirmed in this way; how will they respond to ideas related to change? For example, an overly positive description may be a contrast to the way the child or young person is thinking or feeling and it may be difficult for them to receive the message, as it may feel unreal or suggest that the practitioner does

not fully accept the child or young person's 'reality'. For therapeutic documents to be successful they need to keep pace with the person.

2. To establish whether the young person wishes to receive such documents? The child or young person should agree to receive therapeutic documents. Careful thought needs to be paid to where the document is sent and the decision made in consultation with the child or young person (who may fear breaches of confidentiality).
3. To agree the most appropriate format, style and content for the document(s). Consideration needs to be given to the child or young person's age, developmental stage and associated skills and competencies, especially literacy and handwriting skills. The documents should be differentiated so that they can be independently accessible for the child or young person. Reading can cause anxiety and distress for some children and young people with literacy difficulties. Alternative means of providing feedback should be considered.

Pare (2016) advocates the use of an informal communicative style and supplementary pictures to illustrate points in a playful way. Style would, however, need to be appropriate for the children and young people, informed by knowledge of them and what is likely to be most effective. Documents should use the child or young person's own terminology and language, with the inclusion, where appropriate, of direct quotes to demonstrate active listening. Reports of discussions during therapy should be accurate, as any deviation could be invalidating for the child or young person (Craven, 2013). Whilst not negating the life experiences of a child or young person, traumatic and very difficult experiences should be considered very sensitively to avoid evoking aversive memories (Courtois et al., 2009). It is important to check out, with ongoing monitoring, how therapeutic documents have been received by the child or young person, to ensure they are accurate in their account and remain an appropriate and valid part of the therapeutic process.

Therapeutic documents may be written at different points in the therapeutic process, prior to the start of a therapeutic intervention, at the start of the intervention, between sessions and/or at the conclusion of the intervention. See Appendix H for examples. Please note that these reflect the type of therapy used and different approaches will generate documents that vary in style.

Pre-therapeutic intervention letters are a good way for the practitioner to introduce themselves, set a friendly inviting tone and explain what the intervention will and will not involve (allowing the child or young person to conceptualise the intervention).

Documents written at the conclusion of a therapeutic intervention may serve the purpose of affirming and celebrating with the child or young person the outcomes of the therapy; they may also involve disseminating information on outcomes to others. If this is the case it is important that the content and form of feedback is agreed with the child or young person (Fuggle et al., 2013). It is important that the parents and school are aware of personnel to contact in the event of future distress.

Young people would need the opportunity to discuss their response to the document during the following session, or if at the end of an intervention, before the last session. End of therapy documents would ideally be drafted before the final sessions.

6. Commissioning and service delivery

6.1 Range of models

Until recently EPSs in England and Wales have been managed almost exclusively within Local Authorities (LAs), with service delivery arrangements made in consultation with schools and other partners. Changes in local government funding and responsibilities have led to these services rapidly extending their reach beyond the traditional offer to schools, which is in part due to changes in the ways in which EPSs are commissioned. A recent educational psychology workforce survey (2013) found that although most services continue to be funded by local authorities for statutory and early intervention activities, there was an increase in the number of services receiving direct commissions from schools both individually and in clusters. Future changes in commissioning were anticipated by respondents with a trend towards greater trading and outsourcing through new organisational models, including co-operatives, joint ventures, involvement of private or not for profit companies. More than half of the LA EPSs reported that there were non-local authority providers working in competition in their areas, including lone traders, independent consortia and private companies.

Strategic commissioning is at the heart of public sector reform and is seen by central government as a key mechanism to deliver modernisation through transformation, increased cost-effectiveness, value for money and improving quality. However, commissioning processes are evolving from a one-dimensional transaction, procuring a service at the lowest cost, to ongoing interactions between commissioner, service provider and stakeholders. This development is exemplified by a new approach to planning and delivering public services described as co-operative commissioning.

‘Co-operative commissioning is an approach that puts citizens and outcomes at the centre of commissioning and creates stronger relationships between key stakeholders. It looks beyond cost and “value for money” to put greater emphasis on the social costs and benefits of different ways to run services’ (RSA, 2020, 2013, p.9).

In one local authority, co-operative commissioning is based on the following principles:

- To place citizens and communities at the heart of all commissioning activity.
- To commission for sustainability by prioritising early intervention and prevention.
- To commission for quality and outcomes.
- To focus on delivering value for money and promoting social value.
- To be needs and evidence based.
- To commission with a range of partners regardless of organisational form.
- To work collaboratively and co-produce public services.

These principles align with key legislative changes in the 2012 Public Services (Social Value) Act (2012) and Children and Families Act (2014) which aim at greater community engagement in designing public services that enable citizens to build independence and focus on ‘social value’ not simply cost. The principles resonate with debates about models of psychological therapy, in particular the extent to which methodologies are empowering and outcome focused.

One other matter that managers have to consider when running services that deliver psychological therapies is clinical governance. This is about focusing on the child or young person and their family's experience and improving intervention outcomes through learning, improving service delivery, the working environment, anticipating risk and taking action to reduce or eliminate risk or harm. Therefore, the aim of a clinical governance strategy would be to address the following:

- Define the roles and responsibilities across the organisation for clinical governance.
- Describe the framework of internal controls to assure standards are met and an environment of high quality child and young person safety and care is provided.
- Describe the implementation process of the systems designed to continuously improve and monitor performance of clinical governance issues.
- Define the communication and escalation processes for clinical governance across the organisation to reduce or eliminate risk.

6.2 Commissioners of therapies in schools and communities (schools, parents, CAMHS)

Schools as commissioners

School funding through local authority school forum structures and direct funding of academies and free schools from the Department for Education (DfE) have enabled schools to have greater autonomy over determining which services they commission to meet the needs of children and young people for whom they are responsible. Some schools make decisions as institutions and approach individual professionals, such as counsellors or therapists, to commission delivery of therapeutic interventions. Others buy services from organisations providing a range of options, such as the educational psychology service or a voluntary organisation. As yet there is no research on the impact of this broadening of the commissioning base. It is argued that increased autonomy will bring about a better match of provision to need, as schools make the necessary decisions to the benefit of their pupils. On the other hand the limited options available, with reducing budgets and potential lack of expertise and experience in commissioning may lead to poor decision making. There are concerns that the cost of evidence-informed therapy will be prohibitive to individual schools whose priorities may not be focused on the most vulnerable children and young people.

Models of schools combining resources in collaborative networks or consortia offer new ways of achieving economies of scale that may not be achieved by individual schools alone. Cooperative models with local authority providers of early intervention services (through reformed commissioning models such as that described above) also offer opportunities for pooling resources and co-construction of services to achieve agreed outcomes.

7. Evaluation

7.1 Evaluation of outcomes

With the growing emphasis on accountability and evidence-informed practice, evaluation has become increasingly important in the contexts in which EPs work. Evidence-informed practice implies that decisions about approaches and methods adopted should be based on systematic knowledge of intervention outcomes rather than on unsubstantiated judgement (Cottrell, 2002; Larney, 2003). This approach necessitates both drawing on evidence as the basis for practice, and developing a focus on demonstrable outcomes of interventions, which bring clear benefits to children, young people and their families, EPs and services.

The purposes of evaluation range from issues of whole service effectiveness, effectiveness of group and individual interventions, to child and young person satisfaction with interventions, as well as informing the evidence base on a case study level. From both research and practitioner perspectives, central questions about an intervention are ‘Does it work?’, ‘When does it work?’, ‘For whom does it work?’ and ‘How does it work?’ and additionally ‘Is it appropriate, acceptable and cost-effective?’ In order to answer these questions, evaluative data need to be collected.

Evidence-informed therapies do not work in all circumstances (e.g. Cartwright-Hatton et al., 2004). Therefore, evaluation of outcomes for individual children and young people should be an integral component of therapeutic practice, so that lack of improvement in therapy is picked up without delay. Evaluation of outcomes is also important for the practitioner as it helps to identify those areas of the problem that are improving and those that are not. This feedback may improve the focus of therapy and is consistent with the current approach within ‘Improving Access to Psychological Therapies’ (IAPT). In the context of therapeutic interventions, the types of evaluation suitable for answering these questions about casework outcomes usually include both quantitative and qualitative ones.

7.2 Framework to evaluate therapy with children and young people

Evaluation is a crucial part of therapeutic interventions. The choice of methods and tools depends on the theoretical basis of the therapeutic approach and on the presenting difficulties and concerns. The chosen methods and tools used can contribute to formulation and monitoring of progress as well as to evaluation of overall effectiveness.

Evaluation should include multiple sources of information which might include goal-based measures, standardised measures and/or qualitative information from children, young people, parents and teachers. Systematic feedback to children and young people is an important part of evaluation and should be routine.

There are a range of published standardised measures that are feasible to use with children and young people to gain a standardised evaluation of change over time, such as the ‘Strengths and Difficulties Questionnaire’ (SDQ; Goodman, 1997), and the ‘Beck Youth Inventory’ (Beck et al., 2005). ‘Rapid Assessment Instruments’ (RAIs) are short questionnaires (usually self-report) that are completed by the child or young person. More detail about RAIs can be found in Appendix I. More subjective measures such as scaling and self-report procedures feature strongly in many therapeutic interventions and are a useful means of assessing changes in cognitive processes which underpin reduced

distress. Affective change can be measured through ratings of feelings. Behavioural change can be measured by direct structured observation, and hypotheses about associated cognitive shifts can be checked directly.

The 'Target Monitoring and Evaluation system' (TME; Dunsmuir et al., 2009), which is a variant of 'Goal Attainment Scaling' (GAS) can be used to define targets, monitor progress towards them and evaluate effectiveness post-intervention. TME retains many of the key advantages of GAS such as the provision of data on whether progress following intervention is *as expected*, *better than expected* or *worse than expected*. Furthermore, as with GAS, three targets or goals can be set that link directly to intervention plans. The system is sufficiently flexible to allow definition of cognitive targets as well as behavioural and affective ones, and school staff, parents children and young people can be involved in TME completion (see Appendix J). TME data can also be collected and collated across cases and used for practitioner, project and service level evaluation. TME will not provide standardised data but can augment standardised and qualitative outcome indicators.

The current IAPT measures for use in work with children and young people include measures of global progress, session by session measures regarding 'symptoms' and impact of therapy, and measures of the family's experience of the service (see <http://www.iapt.nhs.uk/cyp-iapt/>).

7.3 Pre-intervention, post-intervention and follow-up measures

There are many standardised instruments available, measuring varied aspects of functioning, and it can, therefore, be difficult to make decisions about the most appropriate to evaluate therapy. Outcome evaluation should utilise measures which assess the area of functioning targeted for change through the intervention, which are acceptable to both children and young people and practitioners and are easy to complete, minimising the burden on the child, young person or parent.

Many available measures elicit the child or young person's perspective on their distress, usually through self-report. A child or young person can provide valuable information about their distress. It is important to seek information from a range of sources before reaching any firm conclusions (Logan & King, 2002). Some children or young people measures also have parent and teacher scales, which can provide an important perspective on the child or young person's problems but may be subject to inherent bias (Beitchman & Corradini, 1988). The instrument selected should have demonstrated reliability and validity and be sensitive to change over time (see test manuals, technical documents and published articles). It should be noted that many self-report scales lack validity data.

Goodman's Strengths and Difficulties Questionnaire (1997) can be completed by the parents and teachers of children and young people age range 4 to 16 years, and by the young person age range 11 to 16 years. It provides ratings of Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems and Pro-social Behaviour.

Achenbach's Child Behaviour Checklist (2000) includes parental ratings of both internalising and externalising behaviours and is suitable for children and young people from 6 to 18 years old.

The Beck Youth Inventory (2005) gives self-ratings of Self Concept, Anxiety, Depression, Anger and Disruptive Behaviour. It is suitable for children and young people aged 7 to 14 years (and can be read to children who are not yet able to read the questions fully). For those aged 15 years and over the Beck Depression Inventory (1996) and Beck Anxiety Inventory (1993) can be used.

There are a number of other disorder specific questionnaires such as the Spence Children's Anxiety Scale (1998), the Revised Child Anxiety and Depression Scale (RCADS; Weiss & Chorpita, 2011), the Children's Revised Impact of Event Scale (CRIES, 1998) and the Trauma Symptoms Checklist for Children (TSCC; Briere, 1996). Many widely used instruments that can be used for the evaluation of CBT outcomes are freely available on the internet. The CAMHS Outcome Research Consortium (CORC: www.corc.uk.net) is a web-based resource that provides helpful information on appropriate mental health/behavioural outcome measures for children and young people. In addition, a range of useful instruments to assess children's mental health and psychological wellbeing can be found in the portfolio of measures edited by Frederickson and Dunsmuir (2009). Standardised checklists for a wide range of specific problems can also be found (e.g. Carr, 2006).

The TME (Appendix J) includes up to three goals. Ratings are made of baseline level, expected post-intervention level, and actual post-intervention level. The targets set are flexible and can include observable behaviours as well as targets related to thoughts and feelings, and ratings of frequency, intensity, duration and so on.

The task of ascertaining the value of therapy should be supplemented with qualitative data to ensure that key participants' views are taken into account. Qualitative information can be obtained through pre and post interviews with the child, young person, parent and school staff and also from the completion of a Relapse Prevention Plan (Gearing et al., 2013) by the child or young person, which can include ratings of strategies tried during the therapy and plans for booster sessions.

7.4 Session-by session measures

Session by session measures track progress towards goals over time. They also serve the purpose of maintaining focus on the goals, which in itself can contribute to positive outcomes. They give opportunities to consider the effectiveness of particular strategies within the therapeutic process and focus on those which appear most helpful. The Beck Inventories can be used on a session-by-session basis, as can a range of non-standardised tools, for example, the checklists for various types of anxiety disorder (Wells, 1997).

Further types of session-by-session measures can include ratings of frequency (e.g. how many panic attacks this week), duration (e.g. length of time spent doing ritual at night), intensity (e.g. of feelings) and believability (e.g. of thoughts). These can be presented as scaling-questions, thought-diaries, records of feelings, frequency charts, plotted on graphs, etc., and can be completed within session or as part of home assignments. Parents can also participate by keeping relevant logs and diaries. The Outcome Rating Scale (ORS; Miller & Duncan, 2000) is another example of a brief and easy-to-use scale which can measure the progress of therapy and is also a measure of distress.

Finally, session-by-session measures can be used to gather data on the process of therapy, particularly in relation to aspects of the therapeutic alliance.

7.5 The completion of measures: Self-report, parent, teacher

In work with children and young people, it is important to gain information wherever possible from the child, parents and school staff. There are potential sources of bias in self-report measures (e.g. children have more limited memory, particularly autobiographical memory, and show a greater tendency to give socially desirable responses) so that they may either over or under-represent changes which are apparent to others. In addition, different informants may produce different responses to 'symptom severity', frequency of behaviours or level of difficulty. For example, when Wren et al. (2004) looked at the correlation of child and parent scores on the anxiety inventory the Screen for Childhood Anxiety Related Disorders (SCARED; Muris et al., 1998), they found that children tended to report greater levels of somatic problems and more separation anxiety than their parents. Similarly, primary school teachers are poorer at identifying fear of harm from the Spence Children's Anxiety Scale (1998) than in identifying Separation Anxiety and Social Anxiety (Layne et al., 2006).

There are sometimes issues over who made the referral and whether their hoped-for changes are aligned with those of the child or young person, especially in relation to behavioural issues. Using a measure such as the ORS within a therapy session with key stakeholders (child/parent/referrer) can bring these different perspectives into focus. This can be very useful in negotiating helpful shared goals, especially when differences in perspective are problematic.

Other ways of evaluating interventions

Qualitative approaches include asking the child or young person to keep diaries that record what is going on in the session and in between the sessions. Examples include:

- Dysfunctional Thought Records (see Greig, 2007; Squires, 2002; Wells, 1997; for examples);
- using Recent Events Analysis to note change (Young & Brown, 1996);
- positive data logs (Stewart, 2007);
- problem formulation templates;
- safety behaviour logs (see Fennel, 1999); and
- homework bridging sheets (see Beck, 1995; Williams & Squires, 2014).

Simple rating scales offer a way of taking something that is individual to the client and presenting it in a quantifiable way so that progress can be mapped.

7.6 Beyond a problem focus: Building and measuring resilience and positive change

There has been a recent shift in emphasis towards positive mental health and wellbeing, in part informed by positive psychology (see Carr, 2004) and reflected in recent government initiatives and reports (e.g. Office for National Statistics Measuring National Wellbeing programme, New Horizons: A shared vision for mental health, DoH, 2009).

A range of interventions and measures based on building on strengths and increasing resilience and optimism have been developed, for instance, the Optimistic Child programme (Seligman, 2007). Measures based on wellbeing include Values in Action Inventory of Strengths (Peterson & Seligman, 2004), and resilience measures including scales such as those found in Frederickson and Dunsmuir (2009) or the recently developed Stirling Children's Wellbeing Scale (Liddle & Carter 2010).

7.7 When not to use measures

There are times when an over-emphasis on outcomes and goal directed action may hinder progress. Mindfulness-based interventions are an excellent example of focusing on 'being' rather than doing, but even in more generic counselling the creation of an open space where the child or young person feels comfortable, able to be themselves and perhaps to play and be creative, may require placing less immediate emphasis on goal-directed activities and correspondent measures. This is likely to occur if excessive goal focus is part of the problem (as in perfectionism, over-working and test stress).

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List of Appendices

- A** **Definitions**
- B** **A decision making model for ethical dilemmas**
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(DECP Working Group Representatives)**

Appendix A: Definitions

Therapist

Within this report, the various professional backgrounds of those delivering therapy, such as educational psychologist or counsellor, are identified, unless the comment relates to all trained, applied psychology therapists, in which case they are described as ‘therapist’.

Therapy and counselling

Counselling and psychotherapy aim to alleviate ‘psychological distress through talking rather than drugs’ (BPS, 2014). Counselling and psychotherapy are umbrella terms that cover a range of different models and approaches in the talking therapies. There have been various attempts to distinguish between them; but there is no general agreement about the differences. They can be long- or short-term and aim to bring about an improvement in the client’s wellbeing and daily function, and a decrease in psychological distress. In this document, therapy is used as an overarching term, which may overlap with definitions of counselling and psychotherapy.

Psychologists who offer therapy to children and their families bring not only their understanding and experience of different psychotherapeutic approaches but also their skills and knowledge as practitioner psychologists, which include:

‘family processes, the social psychology of childhood and parenting, child and life-span development, research on attachment, resilience and coping styles, multiple memory systems and learning theory, attribution and positioning theory, motivational systems including peer influence, etc.’ (Davy & Hutchinson, 2010)

The application of these skills and knowledge inform the delivery of psychological therapies for children and their families and are crucial in shaping and evaluating the approach to therapy. The choice of therapy should, therefore, be driven by an initial assessment and formulation informed by significant personal history, the desire for change and well-grounded psychological research evidence.

Appendix B: A decision making model for ethical dilemmas

1. Identify the problem.
2. Apply one's professional code of ethics.
3. Determine the nature and dimensions of the dilemma.
4. Generate potential courses of action.
5. Consider the potential consequences of all options and choose a course of action.
6. Evaluate the selected course of action.
7. Implement the course of action.

The following examples are derived from practice but do not relate to any specific case. They are offered to support thinking about ethical dilemmas.

1. You have worked therapeutically with J for three sessions. Before you began the sessions you explained that the information would be confidential unless J or someone else may be at risk of harm. J said that he understood this. At the fourth session, J asks you about a friend who is harming himself. J says he would like to help his friend and thinks you might be able to give good advice.

The problem: *there is a risk of serious harm to a 'friend' or possibly to J, but there is no informed consent from J's friend and there is no direct access to J's friend.*

Possible action: *Ask J about the responsibility J is taking for the friend. Offer information on self-harming and possible support services. Suggest J encourages his friend to seek support from a trusted adult.*

2. M has been for one session of counselling. Your involvement has been agreed with M's parents and M and you have explained that the information will be confidential unless anyone is at risk of harm. M's mother rings you and says M has been upset. M's mother can't get M to say what's upsetting her except it's something to do with the session with you. M's mother wants to know what happened.

The problem: *There is an agreement of confidentiality with M. M's mother is reporting distress and does this suggest possible harm?*

Possible action: *Clarify level of distress with M's mother. Remind mother of confidentiality agreement. Talk generally about possible emotional impact of talking about thoughts and feelings that are important. Let mother know that you will talk with M about the telephone call and ask M whether it would be helpful to involve mother in some way whilst she is attending sessions. Ask M what might be a helpful way for her to be supported outside therapy sessions.*

3. K has been referred to you because of anger issues. He is at risk of being thrown out of school. He meets with you for the first session and says he's only here because he was told to come and he doesn't want to talk to anyone especially people who think he's mental.

The problem: *there is no informed consent from K. K might be excluded and no longer able to access your support.*

Possible action: Explain what you are offering including saying that this requires his informed consent and the sessions are confidential unless there is a risk of harm. Suggest that K thinks about this and decides what happens next.

4. P has been having difficulties getting along with other pupils in his class. School have attempted to sort this out but feel they are getting nowhere. P meets with you and makes racist comments about the other pupils and says staff can't help because 'they are on their side'.

The problem: Racist comments are unacceptable.

Possible action: Ask where P's views have come from, what experience he has had and explore ideas about what leads P to the judgement about staff. State how racist language makes me feel and why and say that you're not able to have a conversation which includes this language. Offer a conversation without racist language.

5. You have had one session with S. S contacted you afterwards and said the session was really helpful and she is looking forward to the next one. At the next session she starts to record the conversation on her telephone. You ask her about this. She says she had recorded the last session as well. It was really helpful to listen to it again.

The problem: Lack of agreement to recording and possible use of recording outside the session.

Possible action: Suggest that recording is not a problem but the therapist would talk with the young person about permission. Discuss an agreement about the best way to record, how this is shared with each other and how it is used. Discuss the limits of sharing the recording.

6. T wants to have some therapy sessions but hasn't been in school for weeks. She suggests you come to her house instead. Her mother will be at work and her siblings at school.

The problem: Concern for safety of therapist and client.

Possible action: Explain that this isn't possible but offer to find a time when parent is present or agree a neutral meeting place.

7. R is nearing exam time and can't really afford the time out of lessons to come for sessions. He suggests that rather than doing face-to-face conversations, the session could be done by email, then it would be easier to fit into his exam schedule.

The problem: Uncertainty about the management and efficacy of this.

Possible action: Suggest times outside school hours for face-to-face meetings. Suggest suspending therapy until exams end. Suggest a trial period for emails and a date for a face-to-face meeting for review. State that there needs to be an agreement about when emailing happens and who has access to email.

Appendix C: Evaluation of the evidence

A model taken from medicine and from epidemiological studies to evaluate research considers three dimensions: effectiveness; appropriateness; and feasibility (Evans, 2003).

In this model, the concern is:

- with effectiveness of an intervention: does it work as intended for example, did CBT lead to a lowering of anxiety?
- with the psychosocial aspects, for example, is it acceptable to take clients into situations that increase anxiety so that they can learn techniques to moderate anxiety?
- with the feasibility of carrying out the intervention for example, how many sessions are needed; can a school or organisation accommodate it?
- the cost of the intervention and the potential benefits.

The best methodologies across all three dimensions are systematic reviews (such as Cochrane reviews see <http://www.cochrane.org/cochrane-reviews>) and multi-centre studies that involve meta-analyses across a number of peer reviewed studies. At the other end of the evidence-scale are expert opinion and case studies.

Quality	Effectiveness	Appropriateness	Feasibility
Excellent	Systematic reviews and multi-centre studies	Systematic reviews and multi-centre studies	Systematic reviews and multi-centre studies
Good	Randomised control trials (RCTs)	Randomised control trials (RCTs)	Randomised control trials (RCTs)
Fair	Uncontrolled trials with large effect sizes Pre-post quasi-experimental designs Non-randomised control trials	Descriptive studies Focus groups	Descriptive studies Action research Pre-post quasi-experimental designs Focus groups
Poor	Descriptive studies Case studies Expert opinion	Expert opinion Case studies	Expert opinion Case studies

Source: Evans (2003). Hierarchy of evidence: A framework for ranking evidence in evaluating health care interventions. *Journal of Clinical Nursing*, 12, 77-84.

Having identified RCTs as the 'gold standard' in epidemiological research there is a need to be cautious about the contribution to evidence-based practice for therapeutic interventions. There are concerns that the kind of evidence provided by RCTs is not good at predicting outcomes for individual clients (Margison et al., 2000). Some difficulties of using RCTs to evaluate the efficacy of therapeutic interventions have been highlighted (Morrison et al., 2003; Westen et al., 2004a, 2004b). These points are useful in evaluating published research and in thinking about how this translates to clinical work.

Selection of participants: In order to carry out a study that allows a particular treatment to be evaluated for a particular condition, researchers have to reduce variability in the patient group. They want the patients to be as similar to each other as possible (high homogeneity) and to reduce the influence of confounding variables such as co-existing conditions. This means that patients are screened and 35 per cent to 70 per cent of them are rejected. In the real world, children are referred to therapists with overlapping conditions and sometimes with more than one diagnosed condition. How do we know that the results of the RCT can be generalised to this group?

Manualised treatment plans: In order to be sure that the study is comparing the same interventions for all participants the researcher has to be sure of programme fidelity. The easiest way to do this is to ask the therapists to follow a manual so that everyone gets the same treatment. This might be okay for group work but individual therapy tends to be more variable and responsive to the needs of the individual. The therapeutic intervention is based on a broad model but the path for any two individuals is likely to be different as different strategies and learning experiences are selected. Programme fidelity is replaced with person-centred work where the client is considered as a co-therapist and empowered to make decisions.

The design of the treatment used in RCTs needs to be very specific, but with some therapies such as Cognitive Behaviour Therapy (CBT) there are many variant interventions to choose from. This variety can lead to global statements being made about CBT which only apply to the few strategies included in the manualised treatment plan.

Length of intervention: Interventions used in RCTs tend to be short and of fixed duration (e.g. six sessions, each lasting 45 minutes). The effect size of short treatment interventions is likely to be less than that of the longer interventions that may be needed in the real world. Naturalistic studies suggest that the more complex patients who are excluded from RCTs tend to fare worse, and require longer treatments. Therapists need to take into account the length of intervention likely to be given in school settings, to consider the selection criteria. Also, it is important to plan through to post-intervention delivery of strategies to support maintenance and generalisation that can be provided by other adults.

Single condition versus multiple conditions: The assumption in selecting single conditions for RCTs is that co-morbidities are additive problems. This perspective would require each condition to be treated sequentially using variations of the treatment approach. However, this view is not shared by many therapists. A cognitive distortion for anxiety may not be very different from a cognitive distortion for depression. A patient with both symptoms could be helped using the same strategies and does not need to learn two different coping skills.

There is also a difficulty about the definition of a diagnosed condition: sometimes the same behavioural characteristics contribute to more than one diagnostic category in *DSM-5* or *ICD-10*. The labels that a child gets may depend on nuances in the story told by parents to the clinician, who then makes an interpretation based on judgement and experience of similar children

Outcome measures are focussed on the symptom: At first sight this makes perfect sense, since the study needs to establish that the therapeutic intervention can lead to a reduction of disabling symptoms (effectiveness). However, person-specific CBT may have many outcomes. It may indeed reduce symptoms but equally it could strengthen coping strategies (e.g. a pupil may still feel angry but they learn to take themselves off to cool down, or learn relaxation techniques).

The use of treatment as usual (TAU) as a comparison: TAU is used in many RCT studies as being an equivalent to an intervention. However, the odds are nearly always stacked in favour of the therapeutic intervention. TAU often involves patients continuing to see other specialists who may have less time than those involved in the study. In school-based therapy this is similar to considering TAU to be school interventions supported by a busy SENCo being compared with individualised interventions run by the therapist.

Allowing for the individual and cumulative contributions which different methods of evaluation can offer in developing the composite evidence base, the use of a range of methods, both qualitative and quantitative, is accepted as good practice. However, the confidence in evidence derived from different methods ranges from excellent to poor.

The framework most widely used by therapists working in community settings is that commended by Wolpert et al. (2006), outlined in Table 1 below. This framework for ‘drawing on the evidence’ was developed by the Child and Adolescent Mental Health Services Evidence-Based Practice Unit (EBPU) at University College London, in collaborations with the Faculty for Children and Young People (CPU) of the Division of Clinical Psychology of the British Psychological Society (BPS) and the BPS Centre for Outcomes Research and Evaluation (CORE), with support from the Care Services Improvement Partnership (CSIP).

Table 1: Categories of evidence

Category 1a	Evidence from meta-analysis of randomised controlled trials (RCTs)
Category 1b	Evidence from at least one RCT
Category 2a	Evidence from at least one study without randomisation
Category 2b	Evidence from at least one other type of quasi-experimental study
Category 3	Evidence from descriptive studies such as comparative studies, correlational studies and case-control studies
Category 4	Evidence from expert committee reports of opinions, or from clinical experience of a respected authority, or both

(Wolpert et al., 2006, p.5)

In turn, four levels of ‘strength of evidence’ are attributed to therapeutic methods, according to the highest categories of evidence currently available. These are summarised in Table 2.

Table 2: Strength of practice implications

A	Directly based on Category 1 evidence
B	Directly based on Category 2 evidence or extrapolated from Category 1 evidence
C	Directly based on Category 3 evidence or extrapolated from Category 2 evidence
D	Directly based on Category 4 evidence or extrapolated from Category 3 evidence

(Wolpert et al., 2006, p.5)

In reporting the evidence supporting particular approaches to intervention for particular conditions (e.g. ‘disturbances of conduct’), ‘scores’ give an indication of known treatment efficacy. So, for example, at the time of its publication, in relation to ‘disturbances of conduct’, the Wolpert et al. (2006) publication ascribed a score ‘1a’ to parent training, ‘2b’ to ‘stand-alone CBT’, problem-solving approaches and anger-management programmes for adolescents, noting that, for psychodynamic therapies, ‘there is insufficient evidence to draw conclusions about the effectiveness of child psychodynamic therapy’ (p.9). It is worth noting that this publication and many other available reviews exclude consideration of school-based and/or whole community therapeutic interventions.

Effect sizes

To evaluate the evidence to support a particular psychological therapy, consideration of effect sizes reported in systematic reviews and meta-analyses are important and should be taken into account.

An effect size gives an indication of the clinical significance of an intervention by providing a measure of how much change has occurred. Thompson et al. (2005) argue that effect sizes should always be reported, even if small or non-significant. There are numerous ways of calculating effect size depending on the methodological design. A common statistic for looking at the difference between two groups is Cohen d which looks at the difference in the means divided by the pooled standard deviations (see Cohen, 1988; Rosnow & Rosenthal, 1989, 1996). A rule of thumb for Cohen d is that the effect is small if the value calculated is around 0.2, medium if it is around 0.5, and large if it is 0.8 or larger. Ferguson (2009) criticised Cohen’s (1992) interpretations of effect sizes for failing to anchor qualitative interpretations across effect sizes, proposing an alternative, more conservative rubric for interpretation of results. Hattie (2009) argues for $d=0.2$ (small effect), $d=0.4$ (medium effect), and $d=0.6$ and above (large effect) on the grounds that interventions delivered in real world settings are much more vulnerable to experimental ‘noise’ than controlled experimental studies, and that outcomes should be evaluated against typical effects, that is, normative expectations of change. Hill et al. (2008) recommend comparison of effect sizes relative to those reported in the literature for the same kind of study.

Appendix D: Learning cycle in the development of therapeutic competencies

Phase 1

A	Training Days	Two initial training days or equivalent addressing basic competencies; curriculum to include generic competencies in psychological therapy: <ul style="list-style-type: none"> ● Ethical practice. ● Therapeutic alliance including, empathy, and child centred. ● Active listening. ● Structure – Pacing and time management. ● Prepared for session. Knowledge of a model of therapy and ability to understand and employ the model in practice.
B	Case Selection	Appropriate case selection (to include liaison with team around the child) that has regard to evidence base supporting the therapeutic approach.
C	Assessment and Formulation	A minimum of one case involving assessment and formulation.
D	Intervention	Direct intervention – with same case.
E	Supervision	The case should have undergone supervision of at least five hours, with a supervisor at Phase 4, delivered in individual or group format. Groups should be no more than four people. Completion of reflective log for supervision.
F	Evaluation	Evaluation of casework outcomes, using quantitative and qualitative criteria.

Phase 2

A	Training Days	Three to four training days or equivalent building on both generic and basic competencies as in level 1. Curriculum to include development of specific competencies relevant to the therapeutic approach engaged in, focusing on specific techniques used in most interventions related to that approach.
B	Case Selection	Appropriate case selection (to include liaison with team around the child) that has regard to evidence base supporting the therapeutic approach. Articulation of how evidence base has informed case selection, formulation, assessment and selection of therapeutic methods.
C	Assessment and Formulation	An additional three cases (four in total) involving assessment and formulation.
D	Intervention	Direct intervention – with same cases.
E	Supervision	At least one case (in addition to supervised case from Phase 1) should have undergone supervision of at least five hours (close supervision) with a supervisor at Phase 4, delivered in individual or group format. Groups should be no more than four. DVR clips of some cases required at this stage for supervision. Completion of reflective log for supervision.
F	Evaluation	Evaluation of casework outcomes, using quantitative and qualitative criteria.

Phase 3

A	Training Days	Training to postgraduate diploma level or equivalent in relevant therapeutic approach. Curriculum to include competencies specific to the particular therapeutic approach as well as problem specific competencies.
B	Case Selection	Appropriate case selection (to include liaison with team around the child) that has regard to evidence base supporting the therapeutic approach. Articulation of how evidence base has informed case selection, formulation, assessment and selection of therapeutic methods.
C	Assessment and Formulation	An additional four cases (eight in total) involving assessment and formulation.
D	Intervention	Direct intervention – with same cases.
E	Supervision	Five hours supervision across eight cases necessary with at least three cases having undergone supervision of at least five hours per case (close supervision), with a supervisor at Phase 4, delivered in individual or group format. Groups should be no more than four. DVR clips of some cases required at this stage for supervision. Completion of reflective log for supervision.
F	Evaluation	Evaluation of casework outcomes, using quantitative and qualitative criteria.

Phase 4

A	Training Days	In addition to Phase 1 to 3, practitioners at Phase 4 will be trained and experienced practitioners able to offer high quality supervision, consultation and training. They will have developed meta-competencies and be able to engage with competencies used by therapists to work across all levels and to adapt the therapeutic approach to meet the needs of individual clients.
B	Case Selection	
C	Assessment and Formulation	
D	Intervention	
E	Supervision	Practitioners at this phase will have conducted 200 hours of supervised assessment and therapy during training in addition to having engaged in a substantial amount of both structured teaching and self-directed study as is required for Phases 1 to 3 inclusive.
F	Evaluation	Evaluation of casework outcomes, using quantitative and qualitative criteria.

Appendix E: Reflective log

Session Number	Things that helped or went well	Things that hindered or seemed to be difficult	Issues to take to supervision	Action points from supervision

Appendix F: Gillick competency

When deciding whether a child is mature enough to make decisions, reference can be made to whether a child is ‘Gillick competent’.

Gillick competency is defined in this way:

‘...whether or not a child is capable of giving the necessary consent will depend on the child’s maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.’

Lord Scarman’s comments in his judgement of the Gillick case in the House of Lords (1985) are often referred to as the test of ‘Gillick competency’:

‘...it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved.’

He also commented more generally on parents’ versus children’s rights:

‘Parental right yields to the child’s right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.’

Since the Gillick case, legal, health and social work professionals continue to debate the issues of a child’s rights to consent or refuse treatment, and how to balance children’s rights with the duty of child protection professionals to act in the best interests of the child. Further court rulings, new legislation and revised guidance continue to amend the legal position (De Cruz, 1987; Taylor, 2007; Wheeler, 2006).

Appendix G: Mental Capacity (as defined by the Mental Capacity Act, 2005)

A person who has ‘mental capacity’ is able to make a particular decision for her/himself.

The relevance of the definition to this guidance document may focus on a young person’s ability to make decisions in relation to: continuing to engage in therapy; changing to a different therapeutic approach; beginning or ending medication; consent; and confidentiality, where concern exists. It is also concerned with everyday decisions, health, education and social care decisions.

Aims of the Act

Protection of individuals’ rights to make their own decisions.

Protection of the rights and freedoms of individuals having decisions made for them, including involving them as much as possible in decisions made on their behalf.

Assumption of capacity – everyone is deemed to have capacity to make decisions.

To take decisions on behalf of someone, you must prove that they lack capacity.

Time and decision-specific – the Act is very clear that capacity is time- and decision-specific. This allows for the possibility that the person may regain an impaired decision-making capacity.

Decisions made on behalf of the adult lacking capacity must always be made in the person’s best interests.

Within the legal definition, a person who lacks capacity cannot, due to an illness or disability such as a mental health problem, dementia or a learning disability, do the following:

- Understand information given to them to make a particular decision.
- Retain that information long enough to be able to make the decision.
- Use or weigh up the information to make the decision.
- Communicate their decision.

Note that some people have conditions which mean that their decision-making capacity can fluctuate: for example, bipolar affective disorder.

The Mental Capacity Act can apply to:

- major decisions such as those relating to personal finance, social care or medical treatment; and/or
- everyday decisions such as those concerning what to wear or eat.

The law works on the principle that everyone is assumed to have capacity to make decisions for themselves if they are given sufficient information, support and time.

The law protects people’s right to make their own decisions and to be involved in any decisions that affect them. Even if a person’s decision appears unwise or eccentric, the Act makes clear that the person should not be treated as lacking capacity for that reason.

You must have taken all practical steps to enable the person to demonstrate capacity. This could include a variety of things that are specific to the individual concerned. If a person fails on any one of the above four areas, the Act says that they lack the capacity to make the decision.

Any intervention made with a person lacking capacity must be proportionate and must be the option that is least restrictive of their basic rights and freedoms.

You should never make a decision in isolation, and if in doubt, involve other relevant professionals in any assisted decision making.

Appendix H: Therapeutic documents

Below is general guidance for CBT practitioners to summarise the intervention at case closure and includes information about what to do in the event of future relapse.

1. Agree the feedback with the young person that will go to their parents, school and/or the referrer (e.g. GP). This will usually take the form of a letter that will include the following information.
2. Include information about the number of sessions attended and dates.
3. List any missed appointments and dates.
4. Provide a summary of what happened (e.g. 'In the CBT sessions we focused on....') and what strategies were effective ('X foundto be particularly helpful').
5. Include information about progress that was made, making reference to pre- and post-intervention data ('In the reassessment, we found improvement in the following areas.... [or not]).
6. Arrangements for future contact ('I have advised X that if she has any concerns in the future, she should contact...').
7. It is important that the parents and school are made aware of personnel to contact in the event of future relapse.

Below are some examples of therapeutic documents that vary in style, function, audience and therapeutic approach.

1. Examples of therapeutic letters sent at end of therapeutic intervention to involved adults from therapist and child/young person"

Dear XX.

Now that XXXXX and I have finished our sessions together we thought it might be useful to write you all a letter to tell you about what we did in our sessions and what XXXXX has managed to achieve. XXXXX and I decided together what to put in this letter, but she asked me to write it from us both.

We have had ... sessions together over the last term. Each session had a slightly different aim.

1. Planning and deciding what our focus would be.
2. Thinking about different thoughts and feelings.
3. Thinking about how different situations affect what we think and how we feel.
4. Thinking about how situations make XXXXX feel and noticing any warning signs. We also practiced some relaxation techniques and talked about events that had happened during the week.
5. Talking about times when XXXXX has managed to make things better by trying.
6. Going over all the things we had talked about, planning the letter and deciding what might help XXXXX in the future.

The main area that we focussed on was the thought, 'If I try I can make things better'. This was not something that XXXXX felt was very true at the start of our sessions. In our last session XXXXX told me that although sometimes trying does not mean you will always do better, she feels it is a true comment most of the time. XXXXX was also able to give examples of times when she had tried and then things had improved.

Each week we talked about how Xxxix week had been. It was nice to talk about some positive changes that Ms Z had noticed, for example, how XXXXX was trying harder in class.

XXXXX has worked hard during the sessions that we have had together and was able to talk about different emotions and feelings. XXXXX was often able to describe the best ways of reacting to situations, other ways of reacting and the consequences of both of these. XXXXX was able to use a template (see attached) to think about thoughts, emotions, how her body was feeling and what might happen next.

XXXXX feels that she has worked hard during the sessions. She is going to keep trying in school, and will keep asking for help when she needs it. XXXXX said that she would like to try using the template to think about other situations at school. XXXXX and I also talked about the possibility of Ms Z or another member of school staff using this with her. XXXXX said that she would also try having a bookmark with the symbols from the template on it; as she said, this might help her to be aware of what she is feeling or thinking.

I have really enjoyed working with XXXXX over the sessions and I have been very impressed with how she has worked during them. I really hope that XXXXX continues to build on the positive changes that she has been making.

Dear XX.

Many thanks for attending the CBT group we held in school. I enjoyed working with you and really valued the contributions that you made. When we first met you told me that your aim for attending the group was to be able to talk about how you are feeling and to feel less worried about your forthcoming exams. Throughout the group you noticed that you developed your confidence in talking about how you were feeling (I noticed this as well) and that the worries you had about exams had dropped in strength from 9/10 to 4/10.

I was impressed with how well you recognised the influence your thoughts can have on your feelings and behaviours. We all have negative thoughts about ourselves and these thoughts are often inaccurate. You recognised that you sometimes have negative thoughts about your exams and that these contribute to the feelings of worry that you can experience in school. When we looked at the thoughts more carefully, you could see that these were 'thinking errors' that had minimal evidence.

The thinking error that worried you the most was 'I'm going to fail all my exams and everyone is going to be disappointed with me'. We took a step back from this and challenged it with more balanced thoughts:

- I've revised for my exam and have worked hard, so whatever the outcome is I have tried my best.
- My parents are proud of the effort and care I put into my work and want me to do my best.
- I have good predicted grades based on my classwork and mock exams.
- Even if I don't do as well in my exam as I would like, it's okay, it is only one module and I can retake it if I need to.

Having challenged the thinking error you were able to reframe it in a more balanced way: 'I have revised and worked hard for my exam and all I can do is my best. My parents are proud of the hard work I have put in to revising'.

Spotting thinking errors and reframing them in this way helped you to feel less anxious about your exams and I hope that noticing and balancing your thoughts in this way continues to be helpful. You told me that hearing other people's similar experiences was helpful and I would like to invite you to our drop in follow-up session on xx/xx/xx.

2. Examples of between session letters to young people

Dear XX.

I'm writing to let you know the outcomes of the ratings we completed yesterday.

On the Beck Youth Inventory which you completed, your anxiety was mildly raised in April at a score of 57 (where 50 is average), but has now dropped to the low side of normal at a score of 46. Your mum's ratings on the Goodman's Strengths and Difficulties Questionnaire, have dropped from 5 for Emotional Symptoms in April (elevated) to 1 yesterday, which is well within the normal range.

Based on what you told me yesterday, the length of time doing night-time rituals has decreased greatly, even allowing for the minor relapse, and you are no longer troubled by obsessive thoughts at all, so the rituals are more of a long-term habit without purpose.

I know you are a very courageous person, and I'm confident that you can manage to cut the rituals completely, although I know it will be a tough challenge. Don't be disheartened by the re-emergence of some rituals recently. You've done it once and you can do it again. I hope you find the book helpful in conjunction with re-visiting the strategies we have developed together.

I look forward to hearing from you by email about our arranging our next session.

Well done!

Dear XX.

It was a pleasure to talk with you again today. Once again I thought you worked really hard. I hope that you found the session useful. I feel that together we learned three things today that link together into an important life story for you.

1. You want to make your parents proud of you. You do not want them to hear more of the story of bad behaviour from school.
2. The stories of good behaviour and of being a learner are in your life at the moment, but they come and go. The story of good behaviour has lots to it, it involves not arguing, doing your best, staying calm, being quiet, showing respect for others by not dominating them, thinking about whether it is the right time to say something and talking nicely. When 'being a learner' approach is with you, you do your work and you listen. This means that you are going to school, you look at the teacher, you are quiet because you are paying attention. You think, you ask questions and you make a

contribution. You also told me that being a learner means going to all classes. When these two stories are part of your life you feel like you've achieved something that you are proud of yourself because you can prove to others that you can be good. These stories also affect other people, because you have more fun with others and get on better with them because you are a nicer person to be with.

3. There are good teachers at school. In fact you named a lot more good teachers than bad teachers. The story of good teachers includes a number of important things. These teachers can teach well, they keep the class under control, they talk to you on a level, recognise and praise you and send letters home. Also you feel that you can talk to some of these teachers as a friend as well as a teacher.

I was wondering what would happen if you took this opportunity and tried to increase the amount of time the stories of good behaviour and being a learner are in your life? If you could achieve this then the good teachers might recognise you more, they might praise you more. If this was happening your parents might hear less of the story of bad behaviour and might make your parents proud of you.

I hope you find this letter helpful and look forward to seeing you again next Friday.

3. Example of therapeutic letter used to reinforce engagement in sessions

Dear XX.

I enjoyed meeting you for our first talking session this morning. I thought you worked really hard and put a lot of thought into what you told me about school and I was really interested in what you had to say, so I thought I would write a short letter to you about some of the things that interested me most.

You told me that you want to learn but you feel that you are falling behind because at the moment you are not attending lessons but working in the learning support centre and at the PRU, this is a worry for you. It was good to hear that you want to get back to lessons as soon as you can.

What was clear from what you said is that although things are difficult for you at the moment, you still have your interest in learning and feel that although you are not in lessons you are still a learner. We talked about the fact that our lives are made up of different stories and that during the day the stories can change.

We talked about the story of being a learner means to you. You told me that when you are being a learner you do your work and you listen. This means that you are going to school, you look at the teacher, you are quiet because you are paying attention. You think, you ask questions and you make a contribution. You also told me that being a learner means going to all classes. I agree that going to all classes is important to making progress, but I was wondering if being a learner can only take place in classes or can it happen elsewhere? I want to suggest that your story of being a learner might also be with you when you are in the learning support centre. Why not try showing more of you 'Being the Learner' and see how this affects your relationships with teachers?

We also spent some time talking about another story. You called this the story of good behaviour. This story has lots to it, it involves not arguing, doing your best, staying calm, being quiet, showing respect for others by not dominating them, thinking about whether it is the right time to say something and talking nicely. You explained to me that when this story is happening you feel like you've achieved something that you are proud of yourself because you can prove to others that you can be good. You also feel that this story affects other people, that you have more fun with others and get on better with them because you are a nicer person to be with. I was wondering who else at school would know about this Good Behaviour story? Who would not be surprised to hear you tell this story? Who would know that this story is part of your life?

I hope you find this letter helpful and look forward to seeing you again next Friday.

4. Example letter to parent on completion of therapy

Dear Mrs. XX.

We have now had a total of 12 sessions of CBT. XXXXX has done really well in overcoming her fear of dogs (as shown by our recent visit to Battersea Dogs Home!). She told me she can now approach and stroke familiar or friendly dogs, such as her Aunt's Jack Russell, and stand still if an unknown dog runs towards her off the lead.

We have also worked together on other anxieties and worries which XXXXX has, and developed some ways of coping which she can use in future.

As we discussed at the last session, the goals we had initially set were achieved, and there was no need for further sessions at present. XXXXX has completed a 'relapse prevention sheet' which I expect she showed you last week.

XXXXX has worked really hard throughout the sessions and with the home assignments, and I know this has taken a lot of courage for her.

Thanks too for all the support you have given with the walks in the park and visits to friends and relatives with dogs. Please don't hesitate to get in touch if you have any further concerns or feel that XXXXX would benefit from a booster session.

Appendix I: Rapid Assessment Instruments (RAIs)

A RAI is a short questionnaire, such as a self-rating questionnaire completed by the client. This is sometimes used with every therapeutic session but sometimes just as a baseline and post-intervention measure. In selecting a RAI there are some key issues to consider (Corcoran & Fischer, 2013).

Utility. What is the purpose of the measure? What is the practical advantage in clinical practice? Does it help you plan or improve your service? How long does it take to administer? How long does it take to score and interpret? Is it cost-effective when you have considered the costs of materials, copyrights, manuals, training, and staff time?

Reliability. Reliability is the extent to which the outcome of a test remains unaffected by irrelevant variation in the conditions or procedures of testing (BPS Psychological Testing Guide). In short, is the measure stable? For example, if you are equally anxious when tested on two separate occasions then you should get the same score. In practice, there is always some variation and error in the measurement process so we can only look for a high correlation in scores such as test re-test reliability.

We also need to consider the internal consistency of the measure. If certain items are meant to measure the same thing, then it should score the same on each of these items. This can be estimated using Cronbach's alpha.

The other thing we need to consider is the conditions in which the test is being completed. Are they similar to the conditions in which the instrument was designed? Is a standardised procedure needed? Are the conditions for completing the instrument(s) ideal? What other things would affect this: for example, a client being flustered after missing a bus and arriving late?

Validity. Does the instrument measure what it sets out to measure? Does it have face validity and at least look as if the items are a good measure of the relevant construct? Does it have construct validity? This means that the measures on one test of a construct gives similar measures to another established test of the same construct. It could also mean that there is a clear theoretical basis for the instrument or that it is related to alternative methods of diagnosis of the same construct. The instrument should also have good discriminant validity and be able to differentiate one condition from another.

Specificity. Does the test only measure the condition that we want or is the score affected by other conditions? What about related constructs such as depression? What happens if a client has more than one condition? How does co-morbidity affect results? How is differential diagnosis undertaken?

Suitability and Acceptability. You need to consider the suitability of the instrument to the client's culture, intellectual ability, language skills, literacy skills and emotional state.

Sensitivity. Changes in the client need to be detected by the instrument. The test also needs to be able to discriminate sufficiently well between non-clinical and clinical populations. The instrument needs to be most sensitive in measuring change where it matters and the test has more opportunity for variation in scores in the clinical range than in the non-clinical range.

Directness. The instrument needs to reflect directly the actual thoughts, feelings or behaviours of the clients. To what extent do a limited number of items on the test restrict the richness of the patients' experience that is reportable? Why use a test instead of asking them?

Non-Reactivity. The very act of measuring a phenomenon changes it. The more the items on the test change feelings by evoking thoughts or changing behaviours by directing attention to them, the more reactive the test is. Ideally, tests should measure without interfering with thoughts, feelings or behaviours. They should be as non-reactive as possible.

Appropriateness. Therapists need to make judgements about how appropriate an instrument is when selecting it, using a combination of the constructs above. It is an evaluation of how useful the test is for a given context and system of assessment.

Examples of RAIs used for Improving Access to Psychological Therapies (IAPT) include:

- Patient Health Questionnaire (PHQ-9) for depression;
- Generalised Anxiety Disorder Assessment (GAD7);
- IAPT phobia scales;
- Work and Social Adjustment Scale (WSAS);
- IAPT employment status questions;
- a range of relevant anxiety disorder specific measures (ADSMs); and
- IAPT patient choice and experience questionnaire.

Source: *The IAPT Data Handbook Guidance on recording and monitoring outcomes to support local evidence-based practice. Version 2.0.1 June 2011.*

Examples of RAIs used for the Children and young People IAPT are available from the Child Outcome Research Centre (CORC) website:

<http://www.corc.uk.net/resources/measures/>

Appendix J: Target Monitoring and Evaluation (TME) guidance

1. The evaluation form should be completed at the initial consultation. Ideally this should be done with the child/young person. However, it can also be used effectively to set and agree targets with parents/carers and/or teachers.
2. A date for review should be agreed, following the programme of intervention.
3. Up to three targets or goals can be agreed. These should link directly to intervention plans and activity.
4. The descriptor of baseline level should be defined first. This should be a framed in clear, unambiguous terms and can relate to cognitive, emotional or behavioural targets.
5. The baseline descriptor is allocated a rating on a scale from 1 to 10, circled and marked with a **B**. This will normally be at the lower end of the scale (around 2 or 3).
6. The level of achievement expected by the review date is defined as a target and written in the space above the shaded box. The consultee (child/parent/ teacher) is asked to allocate a rating on the scale to indicate the expected level. This should be circled and marked with an **E**. This will normally be between 6 and 8.
7. At the review, a score is allocated for the level achieved, circled and marked with an **A**. A score above the expected level (**E**) indicates more progress than expected, below this, less than expected.
8. A statement linked to the baseline and target descriptors, detailing the actual outcome following the intervention is recorded under 'descriptor of level achieved'.
9. Copies of forms should be made available for all involved parties and placed on file as evidence of outcome.
10. Following the intervention, data can be derived from the completed form and entered into a database. For details about potential analyses and application, please see Dunsmuir et al. (2009).

Target Monitoring and Evaluation (TME) Form

Child:	School:
Consultee:	Date of consultation:
Therapist:	Date of review:

Target 1:

Rating:	1	2	3	4	5	6	7	8	9	10
Descriptor of baseline level:										
Descriptor of level achieved:										

Target 2:

Rating:	1	2	3	4	5	6	7	8	9	10
Descriptor of baseline level:										
Descriptor of level achieved:										

Target 3:

Rating:	1	2	3	4	5	6	7	8	9	10
Descriptor of baseline level:										
Descriptor of level achieved:										

Any comments?

Target Monitoring and Evaluation (TME) Form

Child: <i>Kiran</i>	School: <i>New Primary</i>
Consultee: <i>Kiran</i>	Date of consultation: <i>9 April 2015</i>
Therapist: <i>Claire</i>	Date of review: <i>31 May 2015</i>

Target 1: *To speak in class twice a day.*

Rating: 1 ② ^B 3 4 5 6 ⑦ ^E 8 9 ⑩ ^A
Descriptor of baseline level: <i>Does not speak in class.</i>
Descriptor of level achieved: <i>Speaks in class several times a day.</i>

Target 2: *To not worry about speaking out in class.*

Rating: 1 2 ③ ^B 4 5 ⑥ ^A ⑦ ^E 8 9 10
Descriptor of baseline level: <i>Worries a lot about speaking out in class.</i>
Descriptor of level achieved: <i>Only sometimes worries about speaking out in class.</i>

Target 3: *To think that people will be interested about what I say in class.*

Rating: 1 ② ^B 3 4 5 ⑥ ^A ⑦ ^E 8 9 10
Descriptor of baseline level: <i>I think that people will get cross if I say wrong things.</i>
Descriptor of level achieved: <i>People think that what I say is OK.</i>

Appendix K: Delivering Psychological Therapies in Schools and Communities (DECP Working Group representatives)

Representation	Name
2 DECP Leads	Sandra Dunsmuir Julia Hardy
2 EPs involved in specialist training	Garry Squires Helen Upton
2 EPs involved in specialist research	Jez Morris Tommy MacKay
2 Specialist EPs involved in delivering an evidence-based therapy in schools	Rebecca Williamson Olivia Kenneally
2 Specialist EPs involved in delivering an evidence-based therapy in CAMHS	Amy Clinch Simon Rowe
1 Specialist EP involved in delivering an evidence-based therapy in private practice	Suzi Iyadurai
1 EP Service Manager	Alan Fuller
1 CAMHS Service Manager	Denny Grant
1 Training Programme Director	Sue Morris
1 DECP Training committee representative	Frances Lee
1 DECP committee representative	Charmian Hobbs
1 Division of Counselling Psychology representative	Julia Hutchinson

The British Psychological Society

St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK

Tel: 0116 254 9568 Fax 0116 227 1314 Email: mail@bps.org.uk Website: www.bps.org.uk