

EVALUATION OF THE WELSH SCHOOL- BASED COUNSELLING PRIMARY PILOT: FINAL REPORT

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Commissioned by Wrexham Local Authority on behalf of the Welsh Government.

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CONTENTS

	Page no.
Evaluation team	2
Acknowledgements	2
Executive summary	6
1. Introduction and background	13
1.1 The evaluation	13
1.2 Aims and evaluation strands	14
2. Methods	16
2.1. Data collection methods	16
2.2. The sample: centres/contexts and participants	16
2.2.1 Qualitative data sets	17
2.2.2 Quantitative data sets	17
2.2.3 The TIPs instrument	17
2.3 Qualitative data analysis	19
2.4 Quantitative data analysis	19
3. Findings	19
3.1 Qualitative findings	19
3.2 Quantitative findings	27
4. Discussion	31
4.1 Discussion of qualitative research findings	31
4.2 Discussion of quantitative research findings	34

5. Recommendations	36
6. Conclusion	37
References	39
Bibliography	40
Appendices	42
Appendix 1: Ethical Statement	43
Appendix 2: Interview questions	44
• Heads of settings	
• LA Coordinator of Foundation Phase	
• Wrexham LA	
• Therapists	
• Focus Group	
Appendix 3: TIPS	48
Appendix 4: TIPS Outcome Results	60/61

List of Tables:	Page no.
Table 1: What were the expectations of the intervention?	20
Table 2: What information was offered from participants on the actual service delivery?	20
Table 3: What were the perceived benefits and effectiveness of the intervention?	22
Table 4: What were the perceived examples of good practice?	23
Table 5: What were the perceived identified problems	25
Table 6: What could be changed?	25
Table 7: What should stay the same?	25

List of Figures:	
Figure 1: Improvement in all domains	28
Figure 2: Domain 1: Psycho-social and emotional well-being	28
Figure 3: Domain 2: Somatic well-being	29
Figure 4: Domain 3: Involvement	29
Figure 5: Domain 4: Subjective respondent well-being and involvement assessment	30

Executive Summary

Overview

This evaluation forms part of the development of counselling in schools in Wales. In April 2008, the Welsh Government produced an information document which outlined their national strategy for the implementation of a comprehensive, school-based counselling programme throughout Wales ¹(National Strategy for School-based Counselling Services, WAG, 2008) based on the report evaluating school-based counselling across the UK ²(Pattison et al., 2007). In it, they outlined the execution of Phase 1 - the introduction of school based counselling in secondary schools in Wales, and committed themselves to pilot schemes to evaluate the provision for primary schools. The Primary Pilots were based in primary schools in four Local Authorities, Wrexham, Cardiff, Bridgend and Pembrokeshire. Each pilot developed service delivery in different ways and adopted play-based interventions based on children's needs, the school environment, available staff and other resources.

Aims of the evaluation

The aims were to assess the implementation of therapeutic counselling interventions across the four primary pilot centres in relation to five main strands:

Strand 1: Therapeutic Processes and Outcomes

- Is the therapeutic intervention effective in terms of outcomes?
- What are the processes involved in the intervention and how well do they work?

Strand 2: Developmental Process

- Is there evidence that the process of introducing, training workers and implementing the therapeutic intervention is effective and working well?
- What works and what needs to be changed?
- Is the information gained from the therapeutic instrument supporting the therapeutic process of the interventions?
- How can the above processes be further developed?

Strand 3: Systems

- What works well in relation to systems around the training and implementation of the intervention?
- What needs to be further developed?

Strand 4: General Process

- Is there evidence from the data to support the therapeutic intervention chosen?
- What are the strengths and difficulties of the therapeutic interventions in place?
- Are the most vulnerable children being effectively identified for individual therapeutic interventions as part of a whole setting approach to increasing support for children?

Strand 5: Strategy/policy

- How does the intervention address the ¹Welsh Government's Ten Recommendations of the 'Counselling in Schools' Agenda ?

Methods

These aims were achieved by the Evaluation Team through the implementation of a series of data collection methods over a two year period 2010-2011.

- **Focus groups** to capture the views and experiences of key centre staff in daily contact with the children (Appendix 2)
- **Interviews** at the start and end of the pilots with therapists, senior centre managers, Foundation Phase head teachers and coordinators, Local Authority Leads (Appendix 2)
- **Therapy outcome data** using the ³Therapeutic Intervention Process Instrument (TIPS v2, Hunt and Robson, 2009; see Appendix 3) to assess the effectiveness of the interventions for individual children

Key findings

Major themes identified from the focus groups and interviews and from TIPS suggest that:

- Overall levels of satisfaction with the pilots amongst head teachers and LA Leads were found to be high, and the services were seen as being good value for money
- The strengths of the pilots were seen as the investment in children's wellbeing, the

- use of a 'whole school' approach, and the use of age-appropriate interventions
- Specific areas of low satisfaction were: limited resources, lack of integration with other initiatives, limited monitoring and evaluation, problems with meeting the needs of Welsh-speaking pupils, lack of availability of counsellor training, and limited publicising of services within the schools
 - Not all of the counsellors in the primary pilots were professionally qualified
 - Stakeholder recommendations included the provision of adequate resources to meet the demand for school-based counselling in the primary sector; ensuring equality of access across the sector; and an assessment of the costs of various service models before a wider roll-out of services across the sector.
 - Outcome evidence indicated that that the counselling was associated improvements in psycho-social and emotional well-being, somatic well-being, and involvement/engagement. It was also reported by stakeholders that counselling was associated with improvements in pupils' behaviour, educational attainment and school attendance

Discussion

Strand 1: Therapeutic Processes and Outcomes

When assessed across all data sets, the therapeutic interventions were found to be effective in terms of outcomes. The small scale of this pilot in terms of numbers of children assessed using the TIPs instrument, and the lack of complete data sets in some cases, means that the results are not statistically valid, and therefore cannot be generalised. However, the results do provide useful information pointing to the benefits of therapeutic play-based interventions in school at the Foundation Phase. The child-centred play-based nature of the interventions and the support for staff are key issues in the beneficial therapeutic processes.

Strand 2: Developmental Process

The focus group and interview data indicates that the process of introducing, training workers and implementing the therapeutic intervention has been effective and worked well within resource limitations and parameters of parental consent and engagement. One of the strengths was the careful and well thought out preparation for setting up the services in terms of assessing the school environment and training staff in relation to a child-centred play-based approach. The information gained from TIPS suggests that every child measured showed improvement in at least one of the four domains of the questionnaire - 'psycho-social/

emotional well-being', 'somatic well-being', 'involvement' and 'subjective respondent well-being'.

Strand 3: Systems

The systems around setting up services and providing interventions to children were put in place following clear and careful assessment of individual centre needs and requirements. This represents a holistic, full school approach to the unique circumstances of the individual school environment and the school population. Therefore, the decisions made in each school to deliver specific therapeutic interventions were based on assessed need. This led to a diverse range of systems and delivery of interventions leading to more successful implementation. This is an important finding, indicating that 'one size will not fit all'. On the other hand, limited resources, lack of integration with other initiatives, limited monitoring and evaluation, problems with meeting the needs of Welsh-speaking pupils, lack of availability of counsellor training, and limited publicising of services within the schools were highlighted as problematic. In order to further develop these systems there needs to be assured funding and resources.

Strand 4: General Process

The TIPs outcome data supports the range of the therapeutic intervention chosen. All children for whom data was available showed improvements. Individual therapeutic interventions were not assessed, nor were comparisons made. However, the findings indicate that school staff in the pilots developed insights that they described as enabling and empowering in relation to vulnerable children in their care. They also observed shifts around parental self-worth and increased awareness of parental knowledge and understanding of their child's behaviours in relation to their age and emotional development. An important finding was that vulnerable children whose parents did not engage with services could be involved in play underpinned by play therapy principles. As not all interventions were 'therapy' the child was neither stigmatised nor made a scapegoat. Vulnerable children were identified through observation of play in the naturalistic school context, for example, the playground or classroom.

Strand 5: Strategy/policy

The intervention addresses the Welsh Government's In-school Counselling Strategy in the following ways. The links are made here to each of the Strategy's 10 Recommendations (Pattison et al. 2007):

1. *Have sustainable funding* - funding did not form part of this evaluation and this is dependent upon the funding available through the Welsh Government's Strategy for In-school Counselling.
2. *Employ professionally qualified counsellors who have experience of working with young people; who access appropriate clinical supervision with experienced supervisors; who take part in regular, relevant continuing professional development (CPD)* – Counsellors providing play therapy for the pilot study interventions were trained. However, there is a shortage of qualified play therapists and data from focus groups and interviews indicates that the lack of available child-centred therapeutic play training for therapists working with young children is of concern as is the lack of supervisors with experience in this field.
3. *Deliver accessible counselling in an appropriately private but safe setting within the school vicinity* - the provision of in-school counselling for primary school children has been useful and effective in the pilots, making therapeutic approaches available to the most vulnerable children in ways that ensure respect and privacy.
4. *Be seen as non-stigmatising by the school community and a normal part of school provision which is integrated into the school community* – the interventions forming part of the Primary Pilots were all integrated into the whole school approach. This was a strength of the pilots and provided a non-stigmatising approach. Vulnerable children could access a therapeutic play approach, which could be viewed as 'non-therapy' and therefore non-stigmatising.
5. *Be monitored and evaluated by individuals or an agency (in or out of the school) with experience in this specialised area of work* – the qualified play therapists were provided by an outside agency and they provided training, supervision and support to in-school staff involved in the pilots. Interviews with Centre Head Teachers, coordinators, school staff and Local Authority Leads indicated that the support provided by the qualified

therapists was excellent, and this contributed greatly to the therapeutic outcomes for the children.

6. *Pay due regard to current legislation and guidance, and offer confidentiality within usual ethical and safeguarding limits* – this recommendation was addressed directly by all four pilot centres and staff working within the schools/pilots. Training was provided by the qualified play therapists for the in-school staff.

7. *Respond flexibly to local needs in respect of diversity (e.g. language) and practicality (e.g. available during holiday periods)* – the provision of a service that met the needs of diversity in language was an issue. There is a lack of qualified Welsh-speaking play therapists, for example. However, this is addressed in part through the child-centred therapeutic play approach, rather than a linguistically based therapy.

8. *Work with and alongside other services and agencies in a collegial manner, whilst maintaining appropriate levels of confidentiality* – the boundaries of confidentiality whilst working with other agencies were maintained in the four pilot studies. Multi-agency working did not form an integral part of the approach used, however, professional links were made where appropriate and did not pose problems. The child-centred approach lends itself well to a collegiate way of working with other professionals.

9. *Employ counsellors who are members of a professional body and as such have an established ethical framework and complaints procedure* – The lead play therapists were professionally qualified and were members of established professional bodies. However, the lack of qualified play therapists generally means that the employment of staff will need to be carefully considered and training provided.

9. *Employ counsellors whose personal qualities will mean that they are approachable, have good listening skills and a manner that encourages a climate for safe and trusting relationships* – Interview data clearly indicates that the therapists were experienced by school staff as being very warm and approachable, often going the 'extra mile' to support staff in their work with vulnerable children. The relationships between therapists and children and school staff were fostered within a child-centred approach and based upon building strong trusting relationships.

Recommendations

The Evaluation Team recommend that:

- The Welsh Government includes a secure funding stream to ensure sustainability of age-appropriate therapeutic interventions in the Foundation Phase.
- Training programmes for counsellors working with young children are further developed, particularly in the area of therapeutic play and courses for clinical supervisors, along with training for school staff in therapeutic play approaches.
- Service managers, schools and counsellors ensure that all school staff, parents and children have information about the therapeutic approaches and services available.
- Service providers adopt monitoring and evaluation systems in order to evidence their practice
- Service providers, schools and counsellors adopt strategies to identify and target the most vulnerable children and provide interventions that children can access in spite of lack of parental engagement
- The Welsh Government provide funding to train Welsh-speaking counsellors and play therapists

School-based counselling in Wales (the Strategy) was developed to provide all children with opportunities to access a trusting adult to talk to in response to the recommendations of the ⁴Clywch Inquiry (2004) and the Children's Commissioner for Wales. In 2007 the Welsh Government commissioned a research team led by the British Association for Counselling & Psychotherapy (BACP) and the Newcastle University to evaluate counselling in schools across the UK ²(Pattison et al. 2007). This report made ten recommendations for developing high quality school-based counselling in Wales. A year later (2008), informed by the 2007 evaluation, the Welsh Government published the ¹National Strategy for School-based Counselling Services. The Strategy aimed to ensure that counselling services were available in all Welsh secondary schools, along with the piloting of primary school services in four local authorities. Initial funding of £1m was made available in 2008–09, with additional sums of £2.5m in 2009–10 and £3m in 2010–11 to take the Strategy forward. An additional £1.5m was agreed for 2010–11 to expand services and a further £14.25 million has been committed for the years 2011–14. In 2010 the Welsh Government commissioned a research consortium led by the British Association for Counselling & Psychotherapy and the University of Strathclyde to evaluate the Strategy over the first three years of its implementation (April 2008 to July 2011). The Final Report was published in November 2011 ⁵(Hill et al., Welsh Government Social Research 23/2011).

1.1 The evaluation

The Welsh Government have a commitment through their In-school Counselling Strategy to provide counselling service in primary schools in addition to secondary schools, including those pupils who are in Year 6 and in transition to secondary schools. Therefore, the Strategy funded four Primary school pilot projects, in four Local Authorities. Each of the pilots has approached service delivery differently, based on identified need and available resources, including staff. This evaluation examines one of the Primary pilots based at four centres in Wrexham Local Authority. The other the Primary pilots were based in primary schools in Cardiff, Bridgend and Pembrokeshire Local Authorities. Each pilot developed service delivery in different ways and adopted play-based interventions based on children's needs, the school environment, available staff and other resources. The Wrexham pilot took a broad whole setting approach to therapeutic work with younger children, focussing on cohorts of children to complement the play ethos of the foundation phase of education in four foundation phase primary settings.

The interventions included:

- Reflective Practice through Observation: Staff taught to observe children through play in order to understand their emotional well-being.
- Mindful enquiry: Staff given opportunities to reflect on their own professional practice and well-being.
- Better play training: Where staff involved with the children (lunchtime supervisors and classroom staff were taught play theory and practice)
- Better play with Individuals: Staff trained to provide child led play sessions.
- Better play in groups: Where children are free (within a boundaried space) to tell their stories to their peers in order to enhance relationship building and self - esteem.
- Therapeutic Service: If, after assessment, it was decided that the child, family or both needed professional interventions, these were arranged.

Each of the four settings chose the interventions that they felt best suited their context and these were implemented by the project therapists (NSPCC). The project ran from April 2009 and ended in March 2011.

1.2 Aims and evaluation strands

The aims of this evaluation report are to address the following questions within five main strands:

The evaluation focused on the five strands using the data from an analysis of information collected from interviews with parents/carers, Early Years' staff offering the interventions, play therapists/counsellors, heads of settings, key staff working at a strategic level within the Local Authority and the TIPS questionnaire. Each strand used this analysis to answer specific research questions:

Strand 1: Therapeutic Process and Outcomes

- Is the therapeutic intervention effective in terms of outcomes?
- What are the processes involved in the intervention and how well do they work?

Strand 2: Developmental Process

- Is there evidence that the process of introducing, training workers and implementing the therapeutic intervention is effective and working well?
- What works and what needs to be changed?
- Is the information gained from the therapeutic instrument supporting the therapeutic process of the interventions?
- How can the above processes be further developed?

Strand 3: Systems

- What works well in relation to systems around the training and implementation of the intervention?
- What needs to be further developed?

Strand 4: General Process

- Is there evidence from the data to support the therapeutic intervention chosen?
- What are the strengths and difficulties of the therapeutic interventions in place?
- Are the most vulnerable children being effectively identified for individual therapeutic interventions as part of a whole setting approach to increasing support for children?

Strand 5: Strategy/policy

- How does the intervention address the Welsh Government's 'Counselling in Schools' agenda?

2. Methods

This section presents information on the three main data collection methods used by the Evaluation Team to achieve the aims. A series of data collection methods over a two year period 2010-2011 were implemented.

2.1 Data collection methods

- **Focus groups** to capture the views and experiences of key centre staff in daily contact with the children (Appendix 2)
- **Interviews** at the start and end of the pilots with therapists, senior centre managers, Foundation Phase head teachers and coordinators, Local Authority Leads (Appendix 2)
- **Therapy outcome data** using the Therapeutic Intervention Process Instrument (TIPS v2, Hunt and Robson, 2009; see Appendix 3) to assess the effectiveness of the interventions for individual children

2.2 The sample: centres/contexts and participants

Field work was carried out in the four educational settings offering the counselling play-based interventions with their Foundation Phase staff and pupils (3-7 years) Interviews (semi-structured) and focus groups were conducted in the settings with key staff at senior management level in addition to staff offering education and care to the children. The service provider, local authority leads and therapists were interviewed.

The quantitative aspect of the project was aimed at gathering pre- and post-test data from the individually selected children for more intensive work using the Therapeutic Intervention Process Instrument (TIPS v 2, Hunt and Robson, 2009). In addition to providing the research team with outcome data the TIPS instrument also provided therapists with process information to enable monitoring of the therapy for individual children over the time of the intervention.

2.2.1 Qualitative data sets

A series of three point interviews were carried out (beginning, middle & end) with the following number of participants:

Beginning n=10

Middle n=10

End n=10

A series of two point interviews (beginning & end) were carried out with the following number of participants:

Beginning n=2

End n=2

All interviews and focus groups were recorded and later transcribed or notes were taken that were written up in detail shortly following the interaction.

2. **Quantitative data set**

The sample consisted of number 27 children in total from the four settings. The sample was purposeful as it comprised of identified children receiving both individual and group therapeutic support from the NSPCC therapists and supervised setting staff. All data was collected using the TIPS questionnaire.

2. **The TIPS instrument**

The TIPS questionnaires were used by therapists, careers and classroom teachers with some of the children receiving direct interventions to serve as both a base line measure and a record of process. These questionnaires were then analysed using descriptive statistics. The TIPS Tool

TIPS aims to collect a snapshot parent/ teacher/ therapist participant perceived view of the current level of a child's well being, somatic expressions and involvement in life and is scored through a Likert Scale which is a type of ordinal scale. The questionnaire is based on the fundamental concepts of well-being and involvement described by Laevers (1999, 2000 and with Heylen, 2003) in his work on process monitoring and assessment in young children's educational experience. It also monitors children's physical well-being. Each dimension measured is described below.

Psycho-Social Emotional Well-Being: "Children (and adults) who are in a state of well-being, feel like 'fish in water'. They are obviously happy. A state of well -being results in a fair amount of self-confidence and self-esteem, as well as a big portion of fighting spirit. People with a high level of well -being have the courage to be and to stand up for themselves and they know how to handle life. They radiate vitality as well

as relaxation and inner peace. The prevailing mood in their life is pleasure. They have fun and enjoy each other's company and the things happening to them. They are aware of what they feel, think, wish for and need." (Laevers, 1999)

Somatic Well-Being: Children and young people will, from time to time will experience illness and distress. It has been observed that Children and young people who experience unusual levels of stress and distress often show distress through their bodies. Examples of this may be excessive crying, frequent bad-temper, sleep disturbance, not eating/over eating, chronic rashes, frequent headaches, stomach aches, nausea and bed wetting, clinging behaviour, extreme fear of separation, high levels of restlessness, fear, and anxiety, hyperactivity, withdrawal, anger, despair, guilt, tiredness, intrusive thoughts and feeling bad about themselves are all common responses. However, humans are unique so any unusual physical symptoms should be attended to.

Involvement: This refers to the intensity of the activity, the amount of concentration, the extent to which one is 'absorbed', and the ability to give oneself completely, to be enthusiastic, to find pleasure in exploration; all of which allow the child and young person to further his/her development. They are in a special state. They are concentrating and eager to continue with the activity. They feel intrinsically motivated to carry on, because the activity falls in what they want to learn and know their desire to understand and grasp things, to get a grip on reality, to experiment, to invent and make new things.

The raters are offered statements such as 'The child is able to concentrate appropriately' which is scored as either 'Not True', 'Rarely True', 'Somewhat True', 'Mostly True' or 'Always True'. These scores are then assigned a number e.g. 'Not True' = 1 - 'Always True' = 5 and an overall score can be calculated. Because this is an ordinal scale, the numbers offer descriptive statistics and can indicate a perceived movement in the child's level of well-being in four domains: 'psycho-social/emotional well-being', 'somatic well-being', 'involvement' and 'subjective respondent well-being'.

2.3 Qualitative data analysis

A thematic approach using the process of phenomenological reductionism was taken to data analysis for the interview and focus group data (McLeod, 2001). The analysis focussed on answering questions related to the five strands of the research.

2.4 Quantitative data analysis

This aspect of the project was aimed at gathering pre- and post-test data to establish outcomes of the individual interventions for identified children. The TIPS data was analysed by selecting full data sets of pre and post intervention data, noting the presenting problems, the type of intervention and the pre and post overall TIPS score in the four domains of 'psycho-social/emotional well-being', 'somatic well-being', 'involvement' and 'subjective respondent well-being and involvement assessment'. Not all of the children who were offered therapeutic interventions had TIPS completed for them; the completed TIPS comprise a small sample of the total of children involved in the whole project (27). Descriptive statistics were used to convert this data into graphical format.

3. Findings

The findings are presented under the heading of qualitative and quantitative findings.

3.1 Qualitative findings

The findings are presented in Tables 1-7 in the main categories. Generic thematic expectations of the project are listed in Table 1. Themes identified post-intervention are listed in Tables 2-7. Quotations are presented and linked specifically to an expressed expectation where it is considered necessary for purposes of clarity and emphasis.

Table 1: What were the expectations of the intervention?

Nine major issues were identified.

	<p>Expectations included: Learning how to understand and interpret the children’s play and provide guidance on this to staff Increasing the availability of staff to play with children Learning about children’s behaviour through play and be able to understand what it means Learning about interventions in play by using the extra tools of play Not sure of expectations. More inter-agency working and involvement. No specific expectations Something that teachers can take on as part of their tools and use in the classroom every day. Quote (a): ‘Not something that adds to their workload, something that empowers them as practitioner, to feel more confident with observing and managing children’s play. In particular, any disturbed, or what might be perceived by adults as disturbed, as quite unsettling play or disturbing play’. ’ Concerns around dealing with a small number of schools (b).</p>
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Table 2: What information was offered from participants on the actual service delivery?

Fifteen main issues around service delivery were identified

1	<p>Difficulty in delivering services to identified children when parents refuse permission. Quote from early interview with Foundation Phase Teacher: ‘We identify children that need help and it is offered and then parents refuse – so that’s really frustrating. Having to have parents’ permission is counterproductive.’</p>
2	<p>Frequency of meetings, monthly, between key school staff and therapists works well in keeping each other up to date, sharing information and planning for support for individual children.</p>
3	<p>School staff involvement at all levels, listening to their opinions, views and hearing what they say helps the services to function for the best interests of the child.</p>
4	<p>The use of play as a major part of the intervention is appropriate and essential. Emotional wellbeing was viewed through play. Quote from Foundation Phase Teacher: ‘...children don’t understand through talking. They understand their experience through play.’</p>
5	<p>Careful and well thought out preparation for setting up the service helped to ensure its success. For example, the therapists, school staff and Early Years Coordinator looked at the school environment in terms of play for children – indoor and outdoor. Observations of children’s play helped to guide the design and choice of interventions. In this way, the service was not only Child- centred, but school -centred.</p>
6	<p>Teaching assistants were trained to work therapeutically with children. This provided a useful resource and helped a greater number of children.</p>
7	<p>A form of therapeutic triage was used to determine the intervention required for individual children. Some children, the majority were involved in group work and circle time. The more vulnerable children were referred for 1:1 play therapy with a trained therapist.</p>

8	The early identification of vulnerable children was central to the delivery of the service. This worked well. Quote from Foundation Phase Teacher: ‘...identified vulnerable children – it’s not always the boisterous ones that are vulnerable.’
9	In-school ethos for play developed through training and service delivery. Quote from a key setting staff member: ‘Rather than say to a child “I’m fed up of seeing you here”, I would now say “and how do you feel now that you’ve been brought back to my office?” and this leads to a lot of restorative practice.’
10	Provision of Mindful Inquiry for staff proved to be supportive to the service provision for children.
11	The delivery of service felt embedded in Foundation Phase practice with Key Stage One. Quote from Foundation Phase Teacher: ‘...(it) doesn’t feel like an add-on to our Foundation Phase practice. It helps to clarify our thinking about where we started and where we are going.’ Another teacher said: ‘it complements the Foundation Phase completely – runs parallel with everything we do. It seemed even from the outset as something that would fit rather than be added on. It is helping the majority of children.’
12	The service delivery meets the objectives in responding to individual children’s needs and needs at a school wide level.
13	The key therapeutic staff provided support through telephone calls, emails, provision of resources to use with individual meetings and face to face meetings on a monthly basis. This facilitated the service provision.
14	“Play box sessions” have been a very useful part of the delivery of service. Children and staff have appreciated this part of the interventions. One of the advantages was the practical nature of the play boxes and not having to write copious notes after each session.
15	The need for service provider continuity was highlighted as important to a quality standard of service delivery.

Table 3: What were the perceived benefits and effectiveness of the intervention?

Fifteen benefits and effectiveness points were identified from the interview data, mainly from the NSPCC therapists.

1	Quote from Foundation Phase teacher: ‘Very effective in terms of staff expertise and skills and also identifying vulnerable pupils.’
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2	Has helped staff to apply boundaries around boisterous play and teach these boundaries to the children.
3	Has helped staff to observe children's play and identify vulnerable children through their play and social interactions
4	Children who find it difficult to open up, for example in groups, often do in play. Role play is very good for this.
5	Children's behaviour changed. (Therapist interview).
6	Children learned how to play and share. (Therapist interview).
7	Through work with children and teachers, boundary issues were addressed, for example, inappropriate closeness. (Therapist interview).
8	Children now engage in play, where previously they have been withdrawn. (Therapist interview).
9	There have been shifts around parental self-worth and increased awareness/ appreciation of their child's behaviours in relation to their age and emotional development. (Therapist interview).
10	Staff have developed insights which they perceive as enabling and empowering for vulnerable children in their care – for all children in their care. (Therapist interview).
11	Staff are able to engage with children in child- led rather than directed play. (Therapist interview). Staff have increased understanding of the emotional difficulties experienced by vulnerable children and have increased therapeutic play skills with which to respond. (Therapist interview).
12	Staff express enhanced self worth which may enhance the well- being of children in their care. (Therapist interview).
13	Children whose families could not/would not engage with services could engage with play that is underpinned by play therapy principles. As the intervention is not 'therapy' the child is neither stigmatized nor made a scapegoat. (Therapist interview).
14	A play rather than play therapy approach when parents do not engage provides a way of assessing children and referring to additional services, perhaps statutory, if found to be very vulnerable. (Therapist interview).
15	Mindful inquiry with school staff helps them to feel grounded, knowledgeable and affirmed. This creates the best climate for children.

2	<p>Quotes from staff in respect of whether the project met their expectations: 'Totally exceeded my expectations – it's the best thing I've been involved with.' 'Very positive feedback, especially from the Teaching Assistants.' 'Mindful Inquiry has made a big difference to staff. It is confidential and is combined with self-esteem building.' 'I've been to meetings and been involved with educational psychologists, social workers etc.' 'It's been brilliant, I am really sorry it has finished. It has been so useful for the children and staff. It was a huge crutch we were able to lean on. I am so sorry it has finished.' 'Yes, it has definitely met expectations. We knew (the therapeutic key staff) anyway and so I was quite confident to start with.' 'It has been very positive and I think it's made a real difference. It's helped the staff to have space to listen and understand children and that's been really excellent.'</p> <p>Linked to quote (a): 'For them it has exceeded their expectations in terms of getting them to look at it from a different perspective. It has perhaps changed a lot of people's minds and perceptions of those types of play.' It fits in with Foundation Phase pedagogy perfectly, with children's well being at the centre of everything we do. This project brings the clarity and focus and it empowers teachers to feel confident in their ability to keep children's well being at the centre of teaching and learning.' (b) 'I think with hindsight we did the right thing and I think we have done some quality work in those schools.'</p>
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Table 4: What were the perceived examples of good practice?

Fifteen examples of good practice were highlighted.

1	At the beginning of the project all members of staff were actively involved in playing with children to observe vulnerability. This was part of the initial training. (Start of project Focus Group with key setting staff)
2	The key therapeutic leads gave time to discuss children and provided support and guidance, as well as giving input in meetings with Social Services. (End of project Focus Group with key setting staff)
3	The opinions and views of school staff have been respected and talked through. They have been involved and feel they have had a role to play. They felt valued. (Focus Group Interim Response: Foundation Phase Teacher). Quote: 'Most of this type of help comes from outside and we are not part of it. But this approach has meant we are completely involved and understand what is going on...we can help the child even when (name- the therapist) is not there.' (Teacher in Focus Group at end of project).
4	The Therapeutic Leads provided support for teachers and a forum for them to 'let it all go'. (Focus Group Interim Response: Foundation Phase Teacher).
5	The Therapeutic Leads provided training for teaching assistants from each area of the school including a lunchtime assistant. (Interim Focus group with Foundation Phase Teacher and teaching assistants). Part of this support involved Mindful Inquiry to give reflective time and build confidence.

6	Most staff came on board with the interventions and they became a whole school approach. (Interim Focus group with Foundation Phase Teacher and teaching assistants). Quote: It is embedded now down at Key Stage One with Foundation.' (Teacher in Focus Group at end of project).
7	The Therapeutic Leads provided strong support to parents. (Interim Focus group with Foundation Phase Teacher and teaching assistants).
8	The interventions complimented the Foundation Phase, running parallel to it. Quote: It seemed from the onset as something that would fit rather than be added on. It is helping the majority of children'. (Interim Focus group with Foundation Phase Teacher and teaching assistants).
9	The centrality of play was totally appropriate for the age of the children. Emotional well-being was looked at through play; children were observed playing at a school wide level and vulnerability identified. Members of staff have been able to look at the different types of play provision in their school and the appropriateness of different types of play. Quote: 'Children are now being taught the boundaries to different types of play rather than staff stopping the play they deem to be 'inappropriate'.' (Foundation Phase Teacher, Focus Group at Interim point).
10	Therapeutic resource boxes were provided and made easily accessible to children in school and in the playground. (Interim Focus group with Foundation Phase Teacher and teaching assistants).
11	Children identified as being particularly vulnerable were referred for 1:1 work with the therapists in the project.
12	The Therapeutic Leads helped school staff with training and support for generic interventions, for example, Circle Time.
13	The initial training provided was rooted firmly in theory and the evidence-base. Members of staff in each school were presented with theory on attachment, which helped them to understand how children build trust. Staff became very enthusiastic about their learning. Quote: 'She (the Therapeutic Lead) has been fabulous, finding books and she brought us further reading and so on...'. (Foundation Phase teacher at end of the project).
14	The interventions were seen as Child-centred, infant based and specific to the needs of the children, (School key staff).
15	The interventions are responsive to the needs of children. School key staff member quote: 'You can just get on and do it rather than having to wait for a CAMHS appointment.'

Table 5: What were the perceived identified problems?

Nine problems were identified in the implementation of the strategy.

1	The use of the TIPs outcome tool was difficult at times, for example, if a parent had problems with literacy. The time involved could be lengthy. (School using Mindful Inquiry)
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2	Replicating the intervention across other schools may be difficult without money being invested in the service and a practitioner who is qualified to carry out the work to a high standard. Quote from post intervention interview with therapist: 'This is not the cheapest option.' (Mindful Inquiry)
3	The withdrawal of a therapeutic service provider part-way through the project caused confusion around what was happening with specific children. (End of project interview with Acting Head and Early Years Teacher).
4	Some parents would not consent to therapeutic intervention. This was problematic when vulnerable children were identified and could not be helped. (End of project interview with Acting Head and Early Years Teacher)(Play Therapy Intervention). Needing parental consent is problematic for some children. Quote from Focus Group with key setting staff: 'Need to find another way of accessing therapy within the school – along the lines of ChildLine.'

5	There is a lack of professional workers who could carry on the work in school now that the project has finished and without a play therapist the work is not sustainable. (End of project interview with Acting Head and Early Years Teacher)
6	It was difficult at times to get parents on board. Some families wouldn't engage. (Interview with school Head and teaching assistant) (Play Therapy, Play Box and Mindful Inquiry). Quote from Foundation Phase Teacher: Post project Focus Group: 'Without parental involvement things don't move on as well'.
7	Sustainability of good practice may be problematic without the project and the need to report. (End of project interview: L.A. Lead)
8	Uncertainty about the project and perceptions of it being a 'fixing service'. (Interim response from Focus Group-Foundation Phase Teacher).
9	Initial fears among staff that they would not have a role or be involved in the process. (Interim response from Focus Group-Foundation Phase Teacher) Quote: 'It's important to have a role – have to be involved. Need at least to be valued for being there.'

Table 6: What could be changed?

Seven areas for change were identified.

1	Extra CPD courses such as child development offered as multi agency. Quote from Foundation Phase Teacher: 'Currently there is no cohesion between services and we need to talk to each other.' More training on attachment required.
2	The use TIPs is a long process, it is a long document, and is difficult if parents have literacy problems. It proves time consuming for staff.

3	Would like to be able to plan for contact times staff and key therapeutic workers in advance.
4	There is a place for a part- time counsellor in this field.
5	Not sure but Laver's well being and involvement will be the basis for change.
6	Would like more feedback on aims and expectations for the child and what timescale to expect change. (Head of Setting interview).
7	Family involvement has been difficult. Perhaps working with parents in groups would be helpful.

Table 7: What should stay the same?

1	Continue training links with the key therapeutic staff. Continue transparency and openness among school staff Continue the high level of involvement in school and the whole school approach All of the project should stay the same. In terms of sustainability it works
2	Keep the project small and roll out over the Foundation Phase first.
3	The key therapeutic workers were excellent. It would be good to keep them.
4	The way school members of staff are trained needs to continue.
5	It's not rigid and has flexibility to fit in with school and child needs. This needs to continue.
6	It is valuable to work with experts in play.
7	The service and training should remain based on Laver's well being and involvement model.
8	Family liaison should be continued.

3.2 Quantitative findings

TIPS (Appendix 2) was offered to the NSPCC therapists by the research team to be used to collect both process and outcome therapeutic intervention data for this evaluation and also as a useful professional tool to record the therapeutic process and inform practice. This was to be administered every three months during the project (8 sets of data). Setting staff chose not to use it in this way. Possibly due to the length of time it took to administer the questionnaire and the administrative load of recording and collecting the information regularly, it was abandoned for the vast majority of children taking part in the intervention. Ideally, this should be filled in during an interview with parents of the child. Much of the information would not be available to a class teacher or other setting staff member. In this instance the questionnaires were filled in by setting staff and used by the NSPCC therapists for some of their clients, occasionally completed in collaboration with parents. In their usual work with children the NSPCC therapists would use the Goodman Strengths and Difficulties Questionnaire (date) and it was the understanding of the research team that this would also be in place as a regular monitoring of process and outcome measure for the intervention. However, it was not used. Consequently, as TIPS was the only measure used, descriptive statistics from this measure are presented here.

Of the 28 children who had TIPS questionnaires completed, 1 was not a complete data set so the results below confine themselves to the 27 children who had a base line measure at the start of the project and an end of project measure. (See Appendix 3 Table showing assessment, intervention & total well-being and involvement score)

The TIPS questionnaire was completed with identified vulnerable children receiving both group and individual interventions and setting staff and therapists completed the questionnaires pre and post intervention (between October 2009 & April 2011).

The pre and post scores in the four domains of the questionnaire - 'psycho-social/emotional well-being', 'somatic well-being', 'involvement' and 'subjective respondent well-being and involvement assessment' and are presented below:

Figure 1: Improvement in all domains

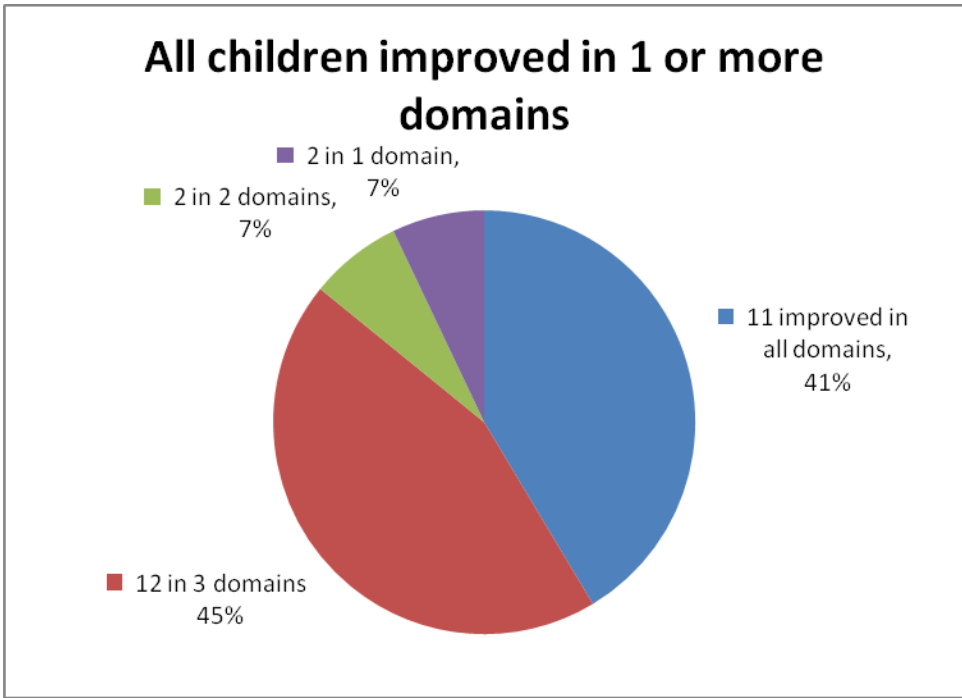


Figure 2: Domain 1: Psycho-social and emotional well-being

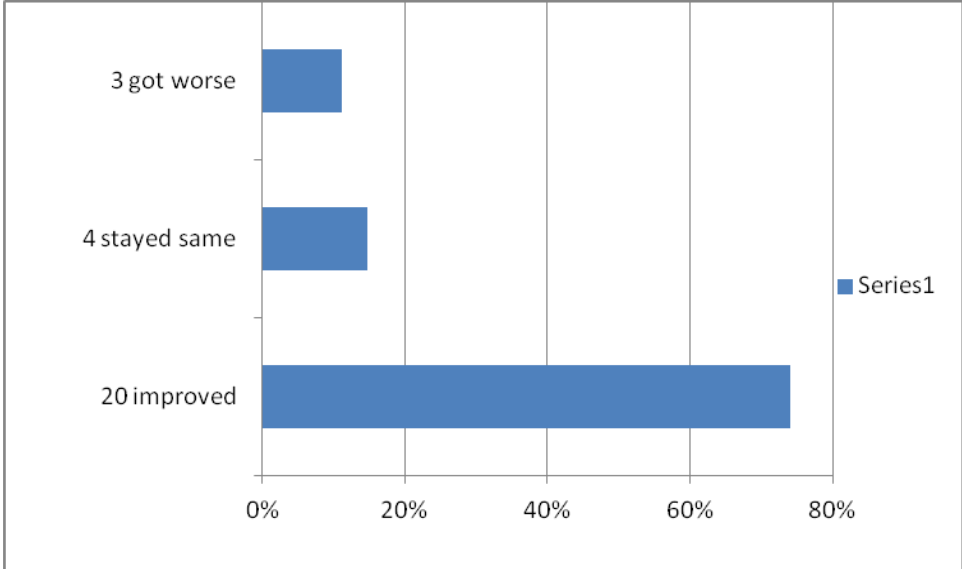


Figure 3: Domain 2: Somatic well-being

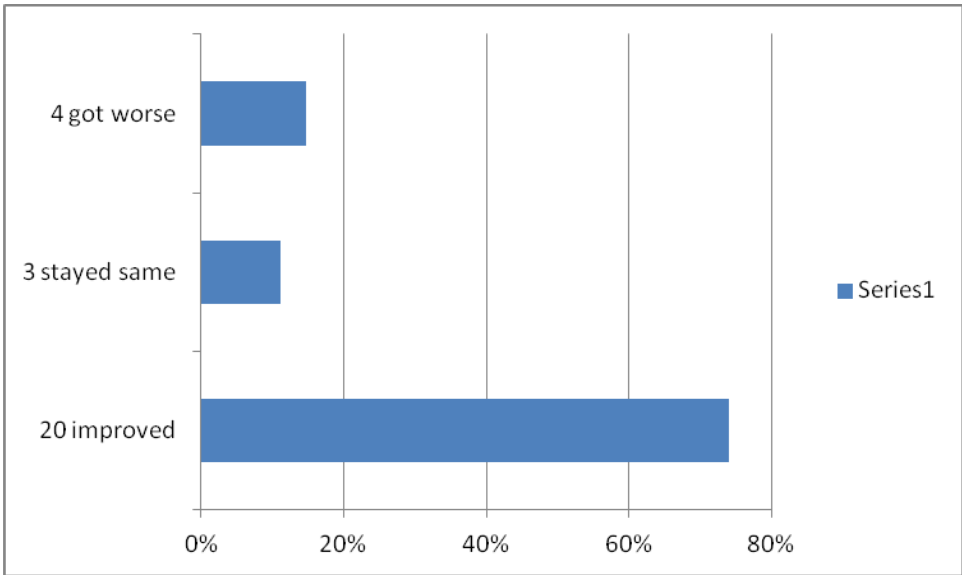


Figure 4: Domain 3: Involvement

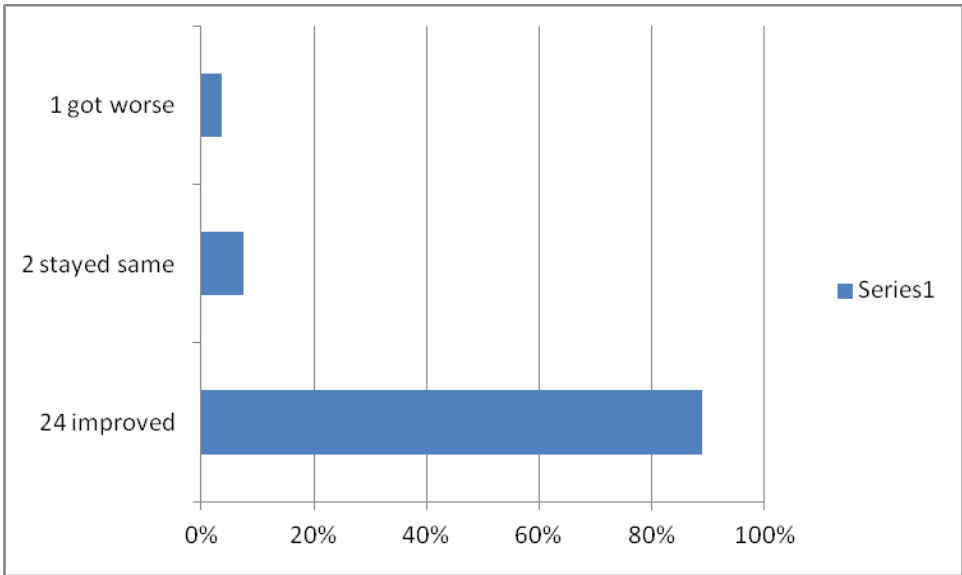
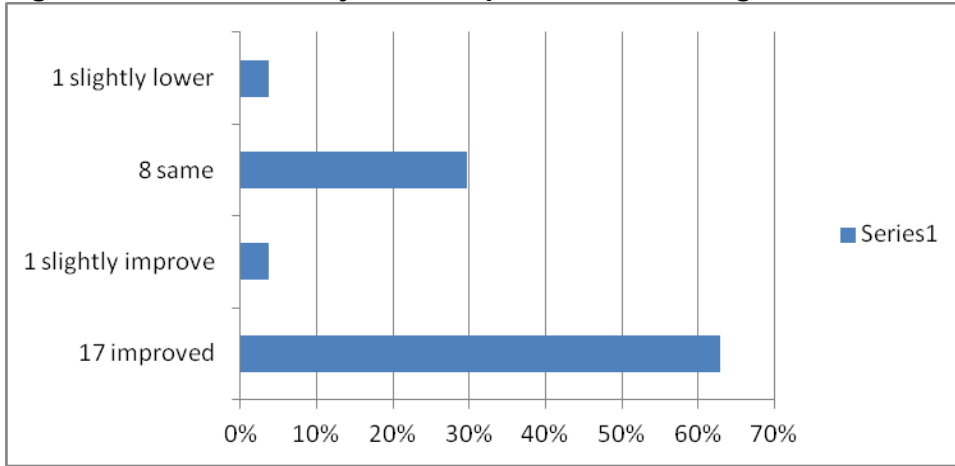


Figure 5: Domain 4: Subjective respondent well-being and involvement assessment



A Table showing presenting problems and pre and post scores in the four domains is in Appendix 4

1. Discussion

1. Discussion of Qualitative Research findings

What were the expectations of the intervention?

Highly motivated, educated, experienced and professional education staff indicated that they needed to learn more about play and to be able to understand more about a child through the observation of play and once this knowledge and understanding was in place to be able to provide guidance to other staff. In particular, to be able to know more about the links between play and the behaviour of a child. There was an expectation that they would learn how to intervene with a child using play to provide emotional and social support in addition to using play to offer educational input in the setting. It was hoped that they would be able to incorporate this new learning into their current workload rather than increases the workload. They wished for empowerment and increased confidence in identifying patterns in play that may indicate more serious underlying difficulties and the tools to intervene in unsettled or disturbing play to the benefit of the child. This indicates that there was awareness of the power of play in disclosing underlying issues for a child and knowledge that there is more to know about it and practical skills to learn in how to apply this knowledge for the benefit of the child. The recent emphasis on teaching and learning through play for the foundation phase in Wales had begun to influence the culture of the settings as play was now validated by the government as the best way for younger children to learn.

There were concerns about the availability of staff to be able to take the time to play with children in busy educational settings. This is indicative of the time pressure staff may be under to deliver the curriculum in school settings. Some had no particular expectations or were unsure and were just waiting to see what transpired. There were some concerns that only a small number of schools would benefit from the intervention.

What information was offered from participants on the actual service delivery?

In the first instance it was recognised that offering a therapeutic intervention necessitated the gaining of parental permission. This ethical practice is unfamiliar to school setting staff and caused some frustration when permission was refused. The sharing of information and careful team planning to meet the needs of children was valued. In particular, the inclusion of teaching assistants was seen as resourceful. School setting staff valued learning to closely observe children playing alongside the NSPCC therapists. Awareness of play being a language of

children was highlighted in all activities. Learning to identify children who may benefit from intervention and how best to offer this, either in a group or in individual therapy was part of the process for all concerned. In addition mindful inquiry enabled staff to reflect on practice and consider intrapersonal aspects of the expansion of the teaching role. The fit with foundation phase education was enlightening and comfortable for the trained staff. The special relationship and continued support between the key therapeutic staff and school based staff was appreciated as part of the new learning experience.

What were the perceived benefits and effectiveness of the intervention?

There were increased awareness of the acquisition of increased skills and expertise in both identifying and emotionally supporting vulnerable children from the setting staff. Learning how to apply boundaries and maintain them helped staff to feel more confident to allow boisterous play. This may have been a daunting experience and most likely this kind of play would have been stopped in the past.

The therapists observed changes in the behaviour of the children with increased ability to share and play together in the new atmosphere of valuing freely chosen child-led play. This included children who had been withdrawn and less able to socially communicate with their peers. Parents became empowered and more confident through increased knowledge of child development and how to appropriately manage their children's behaviour. Non-stigmatising activities enabled many children to participate with full parental support, thus enabling vulnerable children to be identified and offered further support if necessary. The increase in well-being, knowledge and in particular self-worth of the setting staff was seen to be associated with affirmed and grounded adults and well-being in the children in their care.

What were the perceived examples of good practice?

Learning to keenly observe children was highlighted and offered as part of the initial training for setting staff. Busy educators seldom take time to watch children closely and yet when they do they begin to see so much more than before. The setting staff appreciated being part of the discussions about the social and emotional needs of the children they know so well and commented on feeling excluded from much of this aspect in the past. Confidence to put useful interventions in place without the need for specialist mental health support, which can be slow to materialise was noted. Open discussion where all were equally heard was highly valued. Training in reflection as part of Mindful Inquiry was valued as a key continuing development activity for the staff. The holistic approach to the development of the staff and children put down a firm foundation and led to the therapeutic interventions later taught becoming

embedded in the educational experience for the children. Training in 'Circle Time' and the use of therapeutic support boxes gave the setting staff the tools to deliver support during the project and to be able to sustain delivery into the future.

What were the perceived identified problems?

Lack of agreed parental consent was highlighted as a problem. Even when parents did consent on some occasions they were less than enthusiastic and this hampered the children's progress at times.

The TIPS instrument was perceived of as time consuming and difficult for less literate parents. Some expressed concerns that the project was a 'fixing service'. Many of the problems the children were experiencing and the complex family circumstances may necessitate a more systemic approach as there would be no easy fix for many children.

Sustainability was a concern. Good practice maintenance could be difficult without the necessity to monitor and report to the LA in the future. There was also expressed concern about losing the key therapeutic workers from the school settings once the pilot project money had been spent.

What could be changed?

More interaction and further integration between all services involved with children would be welcomed. In addition staff have identified future education and training needs such as attachment theory (Bowlby 1969, 1973, 1980) and its applications to their work.

Monitoring instruments need to be practical and short enough to meet the needs. TIPS could be adapted and a shorter version offered for brief assessment purposes, alternatively Goodman's Strength and Difficulties questionnaire could be offered with training in how to use this for all setting staff. Furthermore, training on the possible therapeutic process to be expected in children is required to further extend and develop knowledge and practice. Lastly there is a need to bring more parents into the work and offering support in groups may be a way forward, once again with staff trained in therapeutic group facilitation.

What should stay the same?

In the first instance roll the project out to all foundation children in the local authority. Maintain the key therapeutic workers from NSPCC as lead staff in this process to continue to offer support from a distance for existing settings and to begin to introduce the work into new

settings. Keeping the work flexible and integrated into the daily life of the school is essential for sustainability. The work of Professor Ferre Laevers (1999, 2000 and with Heylen, 2003) and his developed concepts of well-being and involvement as key indicators of educational attainment should continue to underpin the development of emotional and therapeutic support for children in primary schools.

4.2 Discussion of Quantitative Research findings

The quantitative research findings, although from a small sample, suggest that children's well-being and involvement improved over the time of the project. As can be seen from the Figure 1 above, all children showed improvement in at least 1 domain with 41% (n. 11) demonstrating improvement in all domains, 44% (n. 12) in three domains, 7% (n. 2) in two domains and 7% (n. 2) in one domain. .

The majority of children also improved within each domain. Figure 2 shows results from Domain 1: 'psycho-social/emotional well-being'. 74% (n. 20) of the sample showed improvement, 15% (n. 4) stayed the same and 11% (n. 3) got worse. In domain 2: 'somatic well-being' 74% (n. 20) improved, 11% (n. 3) stayed the same and 15% (n. 4) got worse. In domain 3: 'involvement' 89% (n. 24) improved, 7% (n. 2) stayed the same and 4% (n. 1) got worse. In domain 4: 'subjective respondent well-being and involvement assessment' 67% (n. 18) improved or slightly improved 30% (n. 8) stayed the same and 4% (n. 1) got worse. This evidence, although not demonstrating a causal link, suggests very strongly that the interventions were successful and that children's well-being and involvement improved. These results offer evidence to answer questions posed in all five stands of the evaluation:

Is the therapeutic intervention effective in terms of outcomes?

Although no casual link can be shown, the above results strongly suggest that the therapeutic interventions are effective in terms of outcome. All children showed improvement.

Is there evidence that the process of introducing, training workers and implementing the therapeutic intervention is effective and working well?

The subjective data gathered from interviews and focus groups suggests that this training and implementation worked well and the TIPS data supports this. For children to show such improvement suggests that workers offering the therapeutic intervention were well trained and implemented the intervention successfully.

Is there evidence from the data to support the therapeutic intervention chosen?

As discussed in above, the data from TIPS suggests strongly that the intervention produced positive change in the children's well-being and involvement.

How does the intervention address the Welsh Assembly's 'Counselling in Schools' agenda?

The TIPS results support the Welsh Assembly's 'Counselling in Schools' agenda through promoting young people's welfare, supporting their learning and alleviating and preventing the escalation of mental health problems.

5. Recommendations

The Evaluation Team recommend that:

- The Welsh Government includes a secure funding stream to ensure sustainability of age-appropriate therapeutic interventions in the Foundation Phase.

- Training programmes for counsellors working with young children are further developed, particularly in the area of therapeutic play and courses for clinical supervisors, along with training for school staff in therapeutic play approaches.
- Service managers, schools and counsellors ensure that all school staff, parents and children have information about the therapeutic approaches and services available.
- Service providers adopt monitoring and evaluation systems in order to evidence their practice
- Service providers, schools and counsellors adopt strategies to identify and target the most vulnerable children and provide interventions that children can access in spite of lack of parental engagement
- The Welsh Government provide funding to train Welsh-speaking counsellors and play therapists.

5. Conclusion

In conclusion, the answers to the questions that this evaluations set were largely positive. The prevailing pre-interventions took a cultural approach to social and emotional difficulties in young children in the pilot settings and in turn, the prevailing

school culture in each case was positively influenced by the resulting intervention. School staff who based in the pilot centres developed a greater understanding of the purpose of play and were enabled, through this, to understand the children better and to be able to identify children in distress. In particular, there was a change in the perceptions, knowledge, skills and level of confidence within the staff in the settings to the social and emotional needs of the children in their care as a result of working alongside a qualified and experienced play therapist and child counsellor from the service providers. They felt empowered by these workers to use the medium of play, not only to identify vulnerable children but also to develop whole class, and in some cases, whole school interventions such as zoning playgrounds in order to benefit all of the children.

Through the use of classroom observation and circle time, vulnerable children were identified who could benefit from the therapeutic interventions using play. Staff members were trained to use the 'play box' with individual children and reported high success rates. Staff were trained within the school and supported by the therapeutic workers; therefore, the children did not have to wait for an appointment with a professional therapist but could be offered individual play space almost instantly. The most vulnerable children could be referred to a professional therapist for individual and family work.

Most of the expressed expectations of the project from the staff participants were met:

1. They learned how to understand and interpret the children's play and provide guidance on this to other staff
2. There was a move to increasing the availability of staff to play with children as the value of play and interventions were shown to bring positive outcomes.
3. The setting staff and some parents learned about children's behaviour through play and were able to understand its meaning.
4. There was practical experience of learning about interventions in play by using the extra tools of play as offered by the key therapists
5. The interventions certainly became something that teachers and other staff could take on as part of their tools and use in the classroom every day. Quote (a): 'Not something that adds to their workload, something that empowers them as practitioner, to feel more confident with observing and managing children's play. In particular, any disturbed, or what might be perceived by adults as disturbed, as

quite unsettling play or disturbing play'. Managing this kind of play with appropriate boundaries was one aspect of the learning process.

Two expectations remain unaddressed:

6. Concerns around dealing with a small number of schools
7. More inter-agency working and involvement with action to be taken at Local Authority and National level.

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Appendices:

Appendix 1: Ethical Statement

Appendix 2: Interview questions

- Heads of settings
- LA Coordinator of Foundation Phase
- Wrexham LA
- Therapists
- Focus Group

Appendix 3: TIPS

Appendix 4: TIPS Outcome Results

Appendix 1: Ethical Statement

The study was carried out with due regard to the following:

- Ethical research values and principles
- Child protection
- Data protection
- Equal opportunities
- Legal context of researching/counselling children and young people

Confidentiality applied to the research process, data protection prior, during and following this, including dissemination processes. The boundaries of confidentiality were clearly defined and limits on the guarantees of confidentiality were made clear to children's families and other research participants prior to the start of the project. Adults were not compromised by disclosure of their data and children also unless there was a child protection issue (none were identified in this study).

All members of the research team had Criminal Record Bureau enhanced checks carried out. Informed consent from parents/carers was obtained. More intensive interventions were made available for children and their families who have been identified as needing such follow-up help through the monitoring process. Several policies have informed this ethical statement and form the basis for an ethical research study with children and young people.

- GSR Ethics Protocol (GSR professional guidance: Ethical assurance for social research in Government, Government Social Research Unit, 2007)
- National Children's Bureau Guidelines www.ncb.org.uk
- ESRC Ethical Research Guidelines (Research Ethics Framework, 2005)
- BACP Ethical Guidelines and 'Counselling in Schools Guidelines for Good Practice' (2006)
- BACP Ethical Framework (2001)
- BACP Ethical Guidelines for Research (2004)

Ethical Approval was obtained from Glyndwr University for the research proposal.

Appendix 2: Interview questions

The schedule of questions for Heads of Settings

Questions before the start of the project

1. What do you expect that the project in your setting will provide?
2. How would you judge that this expectation had been met?
3. What do you understand by Play Therapy?
4. How would you describe a vulnerable child?
5. How would you describe a family in need of support?
6. How are vulnerable children identified and supported currently?
7. How are families with children experiencing difficulties supported?
8. What criteria will you use to screen the children for additional support from the project?
9. How do you think offering therapeutic support for children and families in the Foundation Phase addresses the WAG agenda for counselling in schools?
10. Is there anything else you would like to say about this project?

Questions during/at the end of the project

1. Has the project met your expectations?
2. What evidence would you offer to support your view?
3. Has your understanding of interventions changed?
4. Has your understanding of Play Therapy changed?
5. Are you satisfied that vulnerable children and families who need support have been correctly identified?
6. Have you changed or do you intend to change, the way you screen vulnerable children and families needing support?
7. What would you keep the same about the project?
8. What would you change about the project?
9. Are more boys referred to this project than girls? If so, do you have any explanations for this?
10. How do you think offering therapeutic support for children and families in the Foundation Phase addresses the WAG agenda for counselling in schools?
11. Is there anything else you would like to say about this project?

The schedule of questions for LA Wrexham Foundation Phase Co-ordinator

Questions before the start of the project

1. What do you expect that the project in your LA will provide?
2. How would you judge that this expectation had been met?
3. What do you understand the interventions will be?
4. What do you understand by Play Therapy?
5. How would you describe a vulnerable child?
6. How would you describe a family in need of support?
7. How are vulnerable children identified and supported currently?
8. How are families with children experiencing difficulties supported?
9. What criteria would you hope would be used to screen the children for additional support from the project?
10. How do you think offering therapeutic support for children and families in the Foundation Phase addresses the WAG agenda for counselling in schools?
11. Is there anything else you would like to say about this project?

Questions at the end of the project

1. Has the project met your expectations?
2. What evidence would you offer to support your view?
3. Has your understanding of the interventions changed?
4. Has your understanding of Play Therapy changed?
5. Are you satisfied that vulnerable children and families who need support have been correctly identified?
6. Have you changed or do you intend to change, the way you screen vulnerable children and families needing support?
7. What would you keep the same about the project?
8. What would you change about the project?
9. Are more boys referred to this project than girls? If so, do you have any explanations for this?

10. How do you think offering therapeutic support for children and families in the Foundation Phase addresses the WAG agenda for counselling in schools?
11. Is there anything else you would like to say about this project?

The schedule of questions for Local Authority

Questions at the end of the project

1. What is your understanding of the interventions offered in the schools?
2. Has the project met your expectations?
3. What evidence would you offer to support your view?
4. Are you satisfied that vulnerable children and families who need support have been correctly identified?
5. Have you changed or do you intend to change, the way you screen vulnerable children and families needing support?
6. What would you keep the same about the project?
7. What would you change about the project?
8. Is there anything else you would like to say about this project?

Interview Questions Therapists before, during or post- therapeutic intervention

1. What is project offering:
2. Can you describe your experience of being involved in the project overall?
3. Have you observed any changes in the children's behaviour, if so what?
4. Have you observed any changes in the parents/carers' behaviour, if so what?
5. Have you observed any changes in the relationship between the parents/carers and their children who have taken part in therapy, if so what?
6. Have you observed any changes in the children's behaviour for those vulnerable children in play therapy, if so what?
7. Can you give some examples from therapy which stand out for you?
8. What might you notice about your body's state and any changes in your body when working as a therapist with the children and their parents/ carers in therapy?
9. What might you notice about your feelings and any changes in your feelings when working as a therapist with the children and their parents/ carers in therapy?

10. What might you notice about your thoughts and any changes in your thoughts when working as a therapist with the children and their parents/ carers in therapy?
11. What might you notice about your body's state and any changes in your body when working as a therapist with the vulnerable children in play therapy?
12. What might you notice about your feelings and any changes in your feelings when working as a therapist with the vulnerable children in play therapy?
13. What might you notice about your thoughts and any changes in your thoughts when working as a therapist with the vulnerable children in play therapy?
14. How have you found the battery of assessments to monitor therapeutic movement in practice?
15. Is there anything else that you want to share about your experience of offering therapy to children and their families in the project?

Focus group key setting staff: Aide memoir

Before the project:

1. What support is currently offered to vulnerable children and families?
2. How effective do you think it is?
3. What would you keep the same about it and what would you change?
4. What is your understanding of the proposed project?
5. Do you feel you have a role in it?
6. Is having or not having a role appropriate?
7. What do you understand by play therapy?
8. Do you think the project is an appropriate intervention for children at this age?
9. Is there anything else you want to say?

During/after the project:

1. What support is currently offered to vulnerable children and families?
2. How effective do you think it is?
3. What would you keep the same about it and
4. What would you change?
5. What is your understanding of the project?

6. Do you feel you have a role in it?
7. Is having or not having a role appropriate?
8. Do you think the project is an appropriate intervention for children at this age?
9. Is there anything else you want to say?

Appendix 3: TIPS Questionnaire

Therapeutic Intervention Processes (TIPS) Questionnaire for Children and Young People



Authors:

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Use of TIPS:

This questionnaire is designed for completion in an interview with the therapist/ therapeutic interventionist and either parent, carer, or teacher of the child or young person (CYP ages 3 to 18). It allows for the rating of the child's well-being and involvement in three domains - Psycho-Social Emotional Well-Being, Somatic Well-Being and Involvement. It may be used as a base-line measure and to record process and outcomes in the three domains. TIPS CYP is available for CYP to self report from age 11 years upwards.

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Therapeutic Intervention Processes (TIPS) Questionnaire for Children and Young People

Background to the design and development of the questionnaire

This questionnaire was designed by Dr Kathryn Hunt and Dr Maggie Robson in February 2001 and revised in January 2009 after five years of use (2001-2006). It is based upon concepts articulated by Professor Dr. Ferre Laevers of Leuven University, Belgium and the knowledge and experience of the designers in working therapeutically with children and young people (CYP).

Definitions: Well-Being and Involvement

The questionnaire below is based on the fundamental concepts of well-being and involvement described by Laevers in his work on process monitoring and assessment in young children's educational experience. It also monitors children's physical well-being.

Psycho-Social Emotional Well-Being: "Children (and adults) who are in a state of well-being, feel like 'fish in water'. They are obviously happy. A state of well-being results in a fair amount of self-confidence and self-esteem, as well as a big portion of fighting spirit. People with a high level of well-being have the courage to be and to stand up for themselves and they know how to handle life. They radiate vitality as well as relaxation and inner peace. The prevailing mood in their life is pleasure. They have fun and enjoy each other's company and the things happening to them. They are aware of what they feel, think, wish for and need." (Laevers)

Somatic Well-Being:

CYP will, from time to time will experience illness and distress. It has been observed that CYP who experience unusual levels of stress and distress often show distress through their bodies. Examples of this may be excessive crying, frequent bad-temper, sleep disturbance, not eating/over eating, chronic rashes, frequent headaches, stomach aches, nausea and bed wetting, clinging behaviour, extreme fear of separation, high levels of restlessness, fear, and anxiety, hyperactivity, withdrawal, anger, despair, guilt, tiredness, intrusive thoughts and feeling bad about themselves are all common responses. However, humans are unique so any unusual physical symptoms should be attended to.

Involvement

This refers to the intensity of the activity, the amount of concentration, the extent to which one is 'absorbed', and the ability to give oneself completely, to be enthusiastic, to find pleasure in exploration; all of which allow the CYP to further his/her development. They are in a special state. They are concentrating and eager to continue with the activity. They feel intrinsically motivated to carry on, because the activity falls in what they want to learn and know their desire to understand and grasp things, to get a grip on reality, to experiment, to invent and make new things.

Instructions for completing the questionnaire:

There are three parts to this questionnaire. Part 1 asks for demographic information and Part 2 asks you to rate the child or young person (CYP) in three areas: Psycho-Social/Emotional Wellbeing, Somatic Emotion Well-Being and Involvement. Part 3 asks you to give the child an overall rating on well-being and involvement.

Part 1: Demographic Information:

The first time you fill in this questionnaire for a client, please fill in all boxes. Subsequently, please only complete boxes 1 to 5 inclusive.

Part 2: Rating

Please rate the child or young person (CYP) in the three sections on the following 5 point scale from:

Not true	R a r e l y True	Somewhat True	Mostly True	Always True
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by answering the following questions in a way you believe to be the nearest match to their general well-being and involvement. All children vary from day to day and moment to moment but we would like you to answer the questions more generally as to the current situation.

Part 3: Subjective Scores

Please give a subjective score for the child overall on well-being and involvement. 1 is low well being and 5 is excellent wellbeing.

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Scoring: For Office Use Only

Psycho-Social Emotional Well-Being (1=Negative, 5 = Positive)

P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	Total P SCORE

Somatic Well-Being: Being (1= Positive, 5 = Negative)

S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	Total line 1
S11	S12	S13	S14	S15	S16	S17	S18	S19	S20	Total line 2
S21	S22	S23	S24	S25				Total line 3		Total S SCORE

Involvement: (1=Negative, 5 = Positive)

I1	I2	I3	I4	I5	I6	I7	I8	I9	I10	Total I SCORE

Subjective Respondent Well-Being and Involvement Assessment: Part 3:

Extremely low =1	Low =2	Moderate =3	High =4	Extremely high =5

Total Well-Being and Involvement:

Psych-Social & Emotional Well-Being (P)	Psychosomatic/ Negative Emotion Well-Being (S)	Involvement (I)	Overall Total (P+S+I)

Therapeutic Intervention Processes (TIPS) Questionnaire for Children and Young People

Part 1: Demographic Information:

1. Date of completion of questionnaire:

2. Please complete the table below giving number of sessions completed so far and dates of the sessions:

Number of Session 1 2 3 4 5 6 7 8 9 10

Date of Session

Number of Session 11 12 13 14 15 16 17 18 19 20

Date of Session

Number of Session 21 22 23 24 25 26 27 28 29 30

Date of Session

3. Presenting Problems: We notice that the problem the CYP presents during therapy can change. Please note below, any problems that are presented, the date this happens and the session number

Problem Date Session Number

4. Name of CYP:

5. Date of Birth of CYP:

6. Age of CYP: (Yr. and Mths.)

7. Gender of CYP: Male Female

8. First language of CYP: English Welsh Other, please specify

9. Ethnicity of CYP: Please choose one section and then cross the appropriate box to indicate ethnic origin.

White Mixed Asian / Asian British

British

English
Scottish
Welsh
Other, please specify

Irish

Any other white
background, please specify
White & Black Caribbean

White and Black African

White and Asian

Any Other Mixed
background, please specify:

Indian

Pakistani

Bangladeshi

Any other Asian
background, please specify:

Black / Black British

Chinese / Other Ethnic

Caribbean

African

Any other Black
background, please specify:

Chinese

Any other background,
please specify:

10.. Language the therapeutic intervention is delivered in: :

English Welsh Other, please specify

11. Does the Child/Young Person have a special educational need:

Yes No

12. If yes, please describe:

13. Does the Child/Young Person have a disability:

Yes No

14. If yes, please describe:

15. Completed by (name):

16. Completed by (job description/role):

Part 2: Rating

1. Psycho-Social/Emotional Well-Being:

	Not true	Rarely True	Somewhat True	Mostly True	A l w a y s True
1. The CYP is appropriately happy					
2. The CYP does not worry about changes					
3. The CYP is self-confident					
4. The CYP demonstrates a fighting spirit					
5. The CYP is able to stand up for him/her self					
6. The CYP radiates vitality					
7. The CYP is able to relax					
8. The CYP can be peaceful					
9. The CYP is able to express emotional pain					
10. The CYP can have fun					

2. Somatic Well-Being:

	Not true	Rarely True	Somewhat True	Mostly True	A l w a y s True
1. The CYP c r i e s excessively					
2. The CYP loses his/her t e m p e r inappropriately					
3. The CYP experiences s l e e p disturbance					
4. The CYP experiences e a t i n g difficulties (under/over eating)					
4. The CYP suffers from recurring or long term rashes					
5. The CYP experiences f r e q u e n t headaches					
6. The child experiences f r e q u e n t stomach aches					
7. The CYP experiences f r e q u e n t feelings of nausea or vomiting					
8. The CYP wets his/her pants during the day					

	Not true	Rarely True	Somewhat True	Mostly True	A l w a y s True
9. The CYP wets his/her bed during the night					
10. The CYP soils his/her pants during the day					
11. The CYP soils his/her bed during the night					
12. The CYP is excessively clinging					
13. The CYP is excessively afraid of separation					
14. The CYP is excessively restless					
15. The CYP exhibits frequent inappropriate fear					
16. The CYP exhibits frequent inappropriate anxiety					
17. The CYP is hyperactive					
18. The CYP is inappropriately or excessively withdrawn					
19. The CYP is inappropriately or excessively angry					
20. The CYP shows despair					

	Not true	Rarely True	Somewhat True	Mostly True	Always True
21. The CYP inappropriately or excessively experiences guilt					
22. The CYP is inappropriately or excessively tired					
23. The CYP talk about intrusive thoughts					
24. The CYP feels bad about themselves					
25. The CYP is frequently ill					

Please add below any other symptoms not listed above that you have noticed

3. Involvement

	Not true	Rarely True	Somewhat True	Mostly True	A l w a y s True
1. The CYP is able to concentrate appropriately					
2. It is difficult to tear the CYP away from a task or activity					
3. The CYP is keen to explore or find out about things					
4. The CYP likes to try out new things					
5. The CYP is persistent in pursuing their aims					
6. The CYP does not display boredom					
7. The CYP has an expression of concentration					
8. The CYP tries to insist on doing things his/her way					
9. The CYP talks enthusiastically about their experiences					
10. The CYP is content					

Part 3: Please ask respondent to give a subjective assessment of the CYP's overall well-being and involvement.

Extremely low	Low	Moderate	High	Extremely high

Appendix 4 TIPS Outcome Results

Results of Therapeutic Intervention Processes (TIPS) Questionnaire

Participant Number	Presenting Prob	Psych WB-1st Score	Psych WB-2ndScore	Difference = + positive	Somatic WB 1st Score	Somatic WB							
2ndScore	Difference = + negative	Involvement 1st score	Involvement 2nd score	Difference = + positive	Sub Res WB & I 1st Score	Sub Res WB & I 2nd Score							
1	Not recorded	14	14	same	48	44	-4	12	16	4	Extream Low	Extream Low	same
2	Not recorded	14	22	8	30	26	-4	12	22	10	Extream Low	Moderate	improved
3	Not recorded	30	44	14	39	35	-4	20	47	27	Low/Mod	Moderate	improved
4	Not recorded	43	43	same	39	43	4	37	39	2	High	Mod/High	slightly lower
5	Not recorded	31	29	-2	45	46	1	31	36	5	Mod	High	improved
6	Wetting - night & day	16	33	17	60	45	-15	39	39	same	Low	Mod/High	improved
7	Concentration - v active	23	34	11	36	35	-1	33	34	1	Low	Modertate	improved
8	Difficulty sharing attention & issues around prox	38	45	7	43	34	-9	35	43	8	Moderate	High	improved
9	Lives with Nan who has Huntington's. Foster care being sought	31	31	same	41	41	same	27	31	4	Mod	Mod	same
10	Failing to make prog - lang & speech prob waiting to see ed psy	23	31	8	39	31	-8	21	29	8	Low	Moderate	improved
11	Looking to put on SEN reg sept 10 for assessment	27	33	6	34	33	-1	28	31	3	Moderate	Moderate	same
12	Failure to thrive, uncoordinated waiting to see Ed Psy	28	36	8	33	26	-7	21	28	7	Moderate	Moderate	same
13	Testing limits, being 'rescued' in play proximilty to peers	31	33	2	30	28	-2	29	35	6	Moderate	High	improved
14	Not recorded	25	31	6	42	39	-3	24	29	5	Moderate	Modertate	same
15	Parents relationship not always stable. Occasionally shows aggression. Making good academic progress & usually well behaved	30	30	same	37	36	-1	27	27	same	Moderate	Moderate	same
16	Reserved , isolated play	33	39	6	26	26	same	26	34	8	Moderate	High	improved
17	Angry behaviour	29	37	8	42	33	-9	38	44	6	High	High	same
18	Beh deteriorated - distracting others	22	41	19	47	34	-13	33	43	10	Moderate	High	improved
19	V bossy & unpop in peer grp	28	40	12	65	55	-10	34	45	11	Moderate	High	improved
21	Learning difficulties abs 40 sess Sept - Jan 19	34	15	33	26	-7	10	38	28	High	Extream low	improved	
22	Not recorded	38	36	-2	46	38	-8	37	43	6	Low	Moderate	improved
23	Disruption in home life	34	33	-1	28	41	13	34	28	-6	Moderate	Mod WB High	improved
24	Balance & control - gross motor skills	31	39	8	35	33	-2	35	40	5	High	High	same
25	Some moderate learning difficulties; frequent absence	29	39	10	29	31	2	13	23	10	Moderate	Low	improved
26	Speech	32	34	2	35	33	-2	28	43	15	Low	Moderate	improved
27	Not recorded	24	32	8	42	42	same	25	30	5	Low	Low/Moderate	slight improve

