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An investigation of the role of the Educational Psychologist in meeting social, emotional and mental health needs

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Abstract

Supporting children and young people's mental health has become a government priority, leading to a Green Paper seeking to enhance support in schools (Department of Health (DoH) and Department for Education (DfE), 2017). Literature suggests that the role of the educational psychologist (EP) is seldom recognised and underrepresented in governmental guidance around mental health (Andrews, 2017; Greig et al., 2019; Zafeiriou, 2017). The current study sought to extend previous research by exploring the EP role in supporting children and young people's social, emotional and mental health (SEMH) in light of recent governmental agendas. The study aimed to contribute to a stronger professional identity in this area and illuminate the factors supporting or hindering EP engagement with SEMH work. A mixed-methods web-based survey was conducted within England. Quantitative and qualitative data were triangulated and analysed using descriptive statistics and content analysis.

Findings demonstrated that EPs consider they are involved with a relatively high amount of SEMH work through the five core functions of the role (Scottish Executive, 2002), across multiple system levels, and age phases. Opportunities for involvement in Green Paper proposals were limited in the current sample, suggesting little involvement with policy initiatives. The findings both concur with and diverge from prior studies; and highlight a number of areas to extend future practice. The combination of EPs' psychological knowledge and knowledge of school systems, alongside the high level of consultation practice potentially suggest a unique contribution in this area. Barriers to current practice and concerns for future practice include both immediate and wider systemic barriers. Such factors, combined with a low understanding of the role outside of the profession, potentially account for the absence of professional representation. The findings here illuminate the valuable knowledge and skills EPs currently contribute within the context of SEMH work in educational settings, and argue that mental health policy should more fully include EPs as a professional group.

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I dedicate this thesis firstly to my Grandad who would have been so proud to see me achieve my ambitions, and secondly, to my nieces and nephews in the hope they recognise that they can achieve anything they set their mind to.

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Glossary of terms

AEP	Association of Educational Psychologists
ACE	Adverse Childhood Experiences
ACT	Acceptance and Commitment Therapy
ASC	Autism Spectrum Condition
ASD	Autism Spectrum Disorder
BESD	Behavioural, Emotional and Social Difficulties
BPS	British Psychological Society
CA	Content Analysis
CAMHS	Child and Adolescent Mental Health Service
CASP	Critical Appraisal Skills Programme
CBT	Cognitive Behavioural Therapy
CP	Clinical Psychologist
CPD	Continuing Professional Development
CYP	Children and Young People
DA	Dynamic Assessment
DCSF	Department for Children, Schools and Families
DDP	Dyadic Developmental Psychotherapy
DECP	Division of Educational and Child Psychology
DfE	Department for Education
DfEE	Department for Education and Employment
DfES	Department for Education and Skills
DHSC	Department of Health and Social Care
DoH	Department of Health
DSLMH	Designated Senior Lead for Mental Health
EBD	Emotional and Behavioural Difficulties
EBSA	Emotionally Based School Avoidance
EC	Emotion Coaching
EHC Plan	Education, Health and Care Plan
ELSA	Emotional Literacy Support Assistant
EMDR	Eye Movement Desensitisation Reprocessing
EMHP	Education Mental Health Practitioner
EP	Educational Psychologist
EPS	Educational Psychology Service
EYs	Early Years

FBA	Functional Behaviour Analysis
FE	Further Education
HCPC	Health and Care Professions Council
LA	Local Authority
LAC	Looked After Child
LEA	Local Education Authority
MAPs	Making Action Plans
MHST	Mental Health Support Team
MI	Motivational Interviewing
PATH	Planning Alternative Tomorrows with Hope
PCP	Personal Construct Psychology
PEP	Principal Educational Psychologist
PRU	Pupil Referral Unit
SDT	Self-determination Theory
SEAL	Social and Emotional Aspects of Learning
SEBD	Social, Emotional and Behavioural Development
SEMH	Social, Emotional and Mental Health
SEN	Special Educational Needs
SENCo	Special Educational Needs Coordinator
SEND	Special Educational Needs and Disability
SENDCo	Special Educational Needs and Disability Coordinator
SFBT	Solution Focused Brief Therapy
TaMHS	Targeted Mental Health in Schools
TEP	Trainee Educational Psychologist
VIG	Video Interaction Guidance
WOWW	Working on What Works

Chapter 1: Introduction

1.1 Personal interest

The researcher was privileged to undertake a stimulating undergraduate work experience placement providing behaviour and mental health support to children and young people within education. Supervised by an educational psychologist (EP), this kindled the researcher's interest in how EPs can contribute to supporting children and young people's social, emotional, and mental health (SEMH). Subsequently, her role as a school-based assistant psychologist highlighted the importance of early intervention and preventative work alongside school staff, young people and their families. Within this role the researcher experienced working with young people with various SEMH needs, resulting in the delivery of therapeutic interventions and consultation at an individual and group level. Working within a school setting afforded the researcher the opportunity to reflect upon the importance of working at multiple levels of the system. Seeing the positive impact of promoting children and young people's SEMH was a rewarding experience and reinforced the value of our role.

Doctoral training has furthered this interest and supported the researcher's views that EPs possess the skillset to support the SEMH of children and young people, school staff and systems. Thus, training has developed the researcher's understanding of support in this area, emphasising the importance of working at multiple levels of the system beyond therapeutic intervention.

1.2 Professional interest

Numerous peer-reviewed papers and professional statements have argued that EPs are in a good position to support children and young people's SEMH needs (Association of Educational Psychologists (AEP), 2017; British Psychological Society (BPS), 2017; Derby City Educational Psychology Service (EPS) 2017; Durbin, 2017; Fallon, 2017; Greig et al., 2019; Gulliford, 1999; Leadbetter, 2010; O'Hare, 2017). In December 2017, the government published *'Transforming children and young people's mental health provision: a green paper'* (Department of Health (DoH) and Department for Education (DfE), 2017) outlining plans to improve mental health provision for children and young people. Nevertheless, discourse

within the profession has suggested that the role of EPs within this is little acknowledged and potentially misunderstood (AEP, 2018; Durbin, 2017; Fallon, 2017; O'Hare, 2017). This suggests the need to develop clarity around EP practice in this area.

The researcher was undertaking their final year placement as part of doctoral training within a local authority (LA) EPS as a trainee educational psychologist (TEP). The LA also felt that the research was pertinent and timely given current governmental agendas and service priorities. Additionally, the LA was due to become a 'trailblazer site' during the second wave of the green paper proposals planned for 2019/20 (NHS, 2018). As such, the research aimed to explore current EP practice in light of recent governmental agendas.

Chapter 2: Literature Review

2.1 Introduction

This review will introduce definitions and prevalence rates of mental health before discussing the impact upon children and young people. Next, the role of the EP will be explored, considering practice in relation to SEMH, followed by a review of relevant government policy. Finally, a systematic literature review aims to explore recent EP practice within this area, setting the present research within its context.

2.2 Definitions of Mental Health

Definitions for mental health and psychological wellbeing vary, and terminology is subject to discussion. Significantly, the distinction between health terminology, linked to a 'medical model' view of mental health (Davies, 2013), and educational terminology, reflecting a socio-ecological construction of mental health. For clarity around terms adopted within this study, the discussion below highlights variations in defining mental health, their potential implications and more importantly, developments related to terms used within educational policy and context.

Mental health is often associated with 'mental health problems', thus focusing on diagnosable mental illness, disorders, assessment and treatment (Department of Health and Social Care (DHSC), 2011). 'Poor mental health', described as periods in which thinking, feeling, and reacting become difficult or impossible to cope with, is said to lead to various 'mental health problems' (Mind, 2017). A more positive definition of mental health has been defined as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2004, p.10). Mental health is often viewed as a continuum of common everyday worries to more serious or pervasive conditions (Mental Health Foundation, 2009), suggesting that mental health is dynamic.

Despite tension above, the movement from a negative narrative towards more neutral or positively phrased definitions is apparent. Linked to this, the terminology used to

conceptualise children and young people experiencing SEMH needs has developed over time; discussed below.

2.2.1 Conceptualisations of SEMH and developments in terminology

The term emotional and behavioural difficulties (EBD) first appeared in policy guidance in the early 1990s (Jones, 2003). Early approaches can be considered to have been based on medical and psychiatric models, in which the management of behavioural difficulties was largely of medical origin (Cooper et al., 1994). A further conceptualisation included "Behavioural, emotional and social difficulties" (BESD) reflecting a focus on schools in identifying and supporting children and young people experiencing mental health needs (Frederickson and Cline, 2009, p. 412).

Within educational policy, 'EBD' was replaced in the *Special Educational Needs (SEN) Code of Practice* (Department for Education and Skills (DfES), 2001) by the phrase 'social, emotional and behavioural development' (SEBD). The behavioural emphasis, potentially suggesting within-child deficits, evolved from 'difficulties' to 'development', arguably reflecting more positive phrasing. The *Special Educational Needs and Disability (SEND) Code of Practice* (DfE, 2015) outlined a change in terminology from SEBD to 'SEMH'. This is identified as a broad area of need, recognising that challenging or disruptive behaviour "may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained" (DfE, 2015, p.98). This definition suggests that behaviour can be seen to be underpinned by, rather than independent from, social and emotional needs. The notion that mental health is an area of need, rather than a 'difficulty', suggests an emphasis on identifying unmet needs.

It has been argued that mental health diagnoses may potentially lead to discrimination and stigma (Weare and Nind, 2011). Arguably, the negative connotations of terminology such as 'poor mental health' and 'mental health problems' could be seen to exacerbate this. Specifically, in relation to children and young people, research has demonstrated that young people attach a negative value to being labelled with BESD (Sheffield and Morgan, 2016).

Systemic thinking such as Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979) emerged as an alternative to the medical model in educational contexts (Jones, 2003). Interactionist models such as the biopsychosocial view (Cooper, 2005) allow a young person's needs to be understood as part of their environment. EPs, working within the context of education, have tended to adopt a psychosocial view of mental health and psychological wellbeing and are "reticent in engaging unconditionally with work that emphasised the medical-diagnostic approach" (Durbin, 2010, p. 293). Similarly, Fee (2011) found that EPs experienced a conflict between the different paradigms and constructs of mental health, and a reluctance to engage with the 'medical model' and 'within-child' stance.

In line with research aims, the phrases 'SEMH', 'mental health', 'SEMH needs' and 'mental health needs' will be adopted: reflecting the *SEND Code of Practice* (2015). Alternative use of terminology reflects the views and beliefs of others.

2.3 Rationale for SEMH as a topic of interest

Supporting children and young people's SEMH has become a government priority (DfE, 2016; DoH, 2014; House of Commons, 2017; O'Hare, 2017). Policies have discussed the benefits of addressing children and young people's SEMH within educational settings, with an increased expectation on school staff to promote wellbeing (DfE, 2014; DfE, 2016; DfE, 2018; DoH, 2014; DoH and DfE, 2017; Weare, 2015; Weare and Nind, 2011; Young Minds, 2017). In the last decade, several initiatives have focused on supporting children and young people's mental health and wellbeing: for example, the *Social and Emotional Aspects of Learning* curriculum (SEAL; DfES, 2007), and the *Targeting Mental Health in Schools* (TaMHS) project (DCSF, 2008).

The effectiveness of school-based interventions (Weare, 2015; Weare and Nind, 2011) provides evidence that schools can have a positive impact on children and young people's mental health and wellbeing. Research nevertheless exists which suggests that school staff do not always perceive supporting mental health to be part of their role, or feel confident in identifying and supporting young people's mental health needs (Kidger et al., 2010; Young Minds, 2017). Finney (2006) suggested that teachers are over-stretched in their educational role and have reduced capacity to meet the mental health needs of children and young people. School staff have also highlighted a lack of support for their own mental health,

which may impact on their ability to respond to young people's needs (Kidger et al., 2010). Such research highlights an important consideration for supporting staff wellbeing in schools. Recent guidance has suggested the need for "rebalancing the education system" whereby pupil wellbeing is considered as important as academic attainment (Young Minds, 2017, p. 5), positing the need for this to be reflected in the Ofsted inspection framework.

2.3.1 Prevalence

The most recent survey of the prevalence of mental health was undertaken in 2017 (Sadler et al., 2018), estimating that one in eight (12.8%) children and young people aged five to nineteen years old have at least one mental disorder, reflecting a slight increase over time. Reports that one in ten primary school children have a mental disorder (Sadler et al., 2018) coincide with estimates that three children in every class now have a mental health difficulty (Young Minds, 2017).

Sadler et al. (2018) found that one in eighteen (5.5%) preschool children aged two to four years old had at least one mental disorder, suggesting that mental health difficulties can occur from early childhood. Statistics indicated that rates of mental disorder were higher in older age groups, with young people aged seventeen to nineteen three times more likely to have a disorder than those preschool age (Sadler et al., 2018). Of these aged seventeen to nineteen years old, nearly half had self-harmed or made a suicide attempt (Sadler et al., 2018). If we assume that the prevalence of mental health difficulties begins at a young age and may increase with age over time, the importance of early intervention to prevent the development of mental health difficulties is paramount.

Access to timely and appropriate support has been identified as a concern. One in four (24.1%) young people had no contact with any professional services and were not accessing informal support (Sadler et al., 2018). Additionally, around one in five aged five to nineteen years old reported waiting over six months for contact with a mental health specialist or educational support services. Young Minds (2016) reported that less than half of children and young people receive treatment at the time of mental health difficulties emerging.

It is important to reflect that varying definitions influence prevalence estimates (Ford, 2018; Greig et al., 2019). Those not identified with 'clinical' levels of need, may nevertheless have functional needs and difficulties.

2.3.2 Impact of SEMH upon children and young people

The significance of mental health for children and young people's academic, social and physical outcomes has been recognised (DoH, 2014; Durlak et al., 2011; Greig et al., 2019; Meltzer et al., 2000; Weare, 2015; Young Minds, 2017). On average, young people with higher levels of emotional, behavioural, social, and school wellbeing, have higher levels of academic achievement and school engagement (DfE, 2012). Additionally, children with a mental health difficulty were five times more likely to have SEN in comparison to those without (Meltzer et al., 2000), and more likely to be excluded (Sadler et al., 2018). Thus, the long-term consequences of childhood mental health difficulties on the health, social and employment outcomes of young people are acknowledged (Young Minds, 2017).

In the context of the current CAMHS crisis (Care Quality Commission, 2017; House of Commons Health Committee, 2014) it appears that early intervention within school settings is necessary. Long waits for treatment are reported to have a detrimental impact, with only the most severely affected young people accessing CAMHS, contrasting an early intervention focus (House of Commons Health Committee, 2014). Young Minds (2016) reported that on average, CAMHS turn away nearly 25% of young people referred. Taken with the abovementioned prevalence rates, additional early intervention services that can offer support, advice, and guidance to prevent mental health concerns from escalating are necessary.

The above highlights the significance of promoting children and young people's positive mental health, emphasising the importance of adopting a biopsychosocial model, in order that all areas of a young person's life are considered. The DoH (2015) published *Future in Mind; Promoting, protecting and improving children and young people's mental health and wellbeing* which stated that "professionals who work with children and young people should be trained in child development and mental health, and understand what can be done to provide help and support for those who need it" (p.18). It could be seen that EPs fulfil this

description despite only being mentioned once in this report. To illustrate this the role of the EP will now be explored.

2.4 The role of the Educational Psychologist

Consideration of the unique contribution of the EP role has been present within the profession for many years (Ashton and Roberts, 2006; Boyle and Lauchlan, 2009; Cameron, 2006; Department for Education and Employment (DfEE), 2000; Fallon et al., 2010; Farrell, 2010; Farrell et al., 2006; Gillham, 1978; Leadbetter, 2010; Lee and Woods, 2017). The following section will consider conceptualisations of the EP role over time, the impact of the context in which EPs are working, before considering the EP role specifically within the area of SEMH.

2.4.1 Conceptualisation of the role

The first major government review examining the EP role, The Summerfield Report (Department of Education and Science, 1968) refocused the profession's attention towards a consideration of environmental and contextual factors. Further, the 'reconstruction of educational psychology' (Gillham, 1978) exemplified a shift from a 'within-child' deficit model, toward a more systemic model of enabling others to support children and young people. Arguably this could allow for more effective work at the systems level and collaborative problem-solving approaches within consultation (Farrell, 2010). However, SEN legislation in the 1980s and 1990s maintained an emphasis on psychological assessment within the EP role (Atkinson, Corban and Templeton, 2011).

A review known as the *Currie Report* outlined five core functions of EP work: assessment, intervention, consultation, training and research (Scottish Executive, 2002). The report posited that these occurred at three levels: the individual child or family, whole-school and LA level. EPs work within early years, primary, secondary and special schools to "promote child development and learning through the application of psychology by working with individual and groups of children, teachers and other adults in schools, families, other LEA (Local Education Authority) officers, health and social services and other agencies" (DfEE, 2000, p. 5). This further illustrates EP engagement in multi-agency work and work with

groups. Systemic level work, such as training and research, increase the capacity of schools and organisations, supporting whole-school policy and development (Farrell et al., 2006).

It has been noted that schools and other agencies may hold a different construction on the role of the EP (Ashton and Roberts 2006; Boyle and Lauchlan, 2009; Farrell et al., 2006). Furthermore, Durbin (2010) found that EPs working within a multi-disciplinary context were constrained by differential understandings and expectations of the EP role. The DfEE (2000) suggested conflicts between what schools were seeking and what EPs wanted to offer. Ten years later, Fallon et al. (2010) suggested it was possible that service users had a less well-developed understanding of the EP role. A desire to engage in a wider range of work has been expressed by the profession (DfEE, 2000; Farrell et al, 2006), however it has been suggested that some EPs feel they do not have the necessary skills or training to adopt a wider role or undertake specialist work (DfEE, 2000). The debate around EPs main functions can be seen to continue.

Some reviews of the profession have implicated the socio-political context with how services are operating (Fallon et al., 2010; Farrell et al., 2006). Following budget cuts, a number of LA EPSs adopted partially or fully traded models of service delivery (Lee and Woods, 2017), in which the organisation is required to generate income from customers, mainly schools, to meet some or all of its costs. The service model of delivery may influence the type of EP work and, linked to the difficulties articulating the contribution of the role, EPs' professional identity and development (Fallon et al., 2010). Nevertheless, it has been suggested that traded models may lead to opportunities to expand the range of service commissioners and types of services offered (Fallon et al., 2010). Research has since demonstrated that trading may facilitate an understanding of the EP role as EPSs promote the services on offer to stakeholders, therefore allowing EPs to offer a greater range of work (Lee and Woods, 2017).

Despite this wealth of literature, there appears to be a difficulty in clarifying the role and a potential lack of confidence around professional identity (Fallon et al., 2010). This could relate to practice evolving over time, as conceptualised in the reconstructing movement, and the different guiding policies and terminology discussed in section 2.2.1. Some research has suggested that schools most value individual assessment of children and young people, which may be the unique part of the EP role (Ashton and Roberts, 2006; Farrell, 2010; Lee

and Woods, 2017). As a result, EPs may not be seen to have a role wider than support for learning, and one that encapsulates children and young people's SEMH. Despite a number of professional reviews, the role of EPs within mental health is less than clear (Fee, 2011). The EP role within support for SEMH will now be considered.

2.4.2 EP practice in relation to SEMH

EPs have more recently been described as practitioners with knowledge and experience of mental health and child development in relation to educational settings (Squires, 2010; Weeks et al., 2017). The BPS (2019) Standards for the accreditation of educational psychology training programmes stipulate that one learning outcome is for trainees to "Incorporate appropriate therapeutic techniques and processes when working directly with children, young people and families, and identify and implement evidence-informed psychological interventions to promote mental and emotional wellbeing" (p. 18-19). This implies that qualified practitioners should be competent in therapeutic techniques and interventions to support mental health development.

As such, a wealth of published literature exists around EPs delivering therapeutic interventions for SEMH (AEP, 2017; AEP 2018; Atkinson, Corban and Templeton, 2011; Atkinson et al., 2013; Law and Woods, 2018). Atkinson, Bragg, et al. (2011) surveyed 455 EPs and found that 92% used therapeutic intervention as part of their practice, the most popular being solution-focused brief therapy (SFBT), cognitive-behavioural therapy (CBT), personal construct psychology (PCP) and motivational interviewing (MI). Furthermore, respondents reported using therapeutic interventions as part of assessment, consultation and systemic work such as training (Atkinson, Bragg, et al., 2011). This suggests that therapeutic approaches are threaded through various functions of EP practice and not restricted to discrete time-limited interventions for pupils. Interventions therefore occur with a number of stakeholders such as SENDCos, school staff, parents and pupils (Atkinson, Corban and Templeton, 2011).

Often research encapsulates the five core functions of the EP role across individual, group and systemic levels (AEP 2017; Fee, 2011; Greig et al., 2019; Law and Woods, 2018; O'Callaghan and Cunningham, 2015, Stobie et al., 2005; Weeks et al., 2017). Systemic level involvement includes: training in interventions (Green and Atkinson, 2016; Greig et al., 2019;

Law and Woods, 2018; O'Callaghan and Cunningham, 2015), whole-school approaches to supporting SEMH (Law and Woods, 2018; Sharpe et al., 2016), group consultation for teachers (Law and Woods, 2018), and supervision to support staff delivering interventions (Green and Atkinson, 2016; Law and Woods, 2018; O'Callaghan and Cunningham, 2015; Weeks et al., 2017). Nevertheless, it has been suggested that school staff may not be aware that EPs offer supervision but would welcome this (Rae et al., 2017). Additionally, research has focused on the evaluation of EP delivered interventions with primary and secondary aged pupils (Ardern, 2016; Cryer and Atkinson, 2014; O'Callaghan and Cunningham, 2015; Ruttledge et al., 2016; Squires, 2001; Weeks et al., 2017) demonstrating EPs' commitment to research and practice-based evidence.

Potential barriers to EPs engaging in work around SEMH include statutory assessment duties, time, staffing levels, and opportunities (Atkinson, Corban and Templeton, 2011; Cryer and Atkinson, 2014; Farrell et al., 2006; Greig et al., 2019). Furthermore, the possible impact of traded services has been recognised in that schools may prioritise the EP role for learning assessments and may be reluctant to prioritise limited time for one pupil (Atkinson, Corban and Templeton, 2011; Lee and Woods, 2017). Moreover, schools may not recognise therapy as something EPs can offer (Atkinson, Corban and Templeton, 2011). Interestingly, a survey conducted by clinical professionals (Sharpe et al., 2016) acknowledged that EPs are frequently accessed by schools for SEMH support at the systemic level through 'staff training' and 'whole-school approaches'. These findings may suggest that EPs are the preferred contact group for schools regarding SEMH. Atkinson, Corban and Templeton (2011) reported variation in joint work with CAMHS and anxieties around role definition. Thus, EPs' perceptions of their role, for example, feeling that other services are traditionally more associated with offering therapeutic intervention, may also be seen as a difficulty the profession has faced. Fee (2011) further noted variation in mental health and psychological wellbeing work by both individuals and services, suggesting that time, training, opportunities, supervision, and working with other professionals were key facilitators.

Recent reviews of pupils with SEMH needs neglect to discuss the EP role (Carroll and Hurry, 2018). Thus, despite the research above outlining a potential contribution, it may be viewed that mental health legislation appears to imply a limited role for EPs (DfE, 2014; DfE, 2016; DoH and DfE, 2017): guidance on *Mental Health and Behaviour in Schools* (DfE, 2016) references EPs once. A more recent, updated version of this policy makes further reference to EPs (DfE, 2018) however, the role and types of support EPs can offer remains to be

understood and reported. To explore this further, the most recent and pertinent government publication in relation to mental health and education will now be discussed.

2.5 Pertinent legislation

The *Every Child Matters* agenda (DfES, 2003) emphasised that children and young people's mental health was 'everyone's business'. *Future in Mind* (DoH, 2015) was published in response to reports of the difficulties children and young people faced in accessing mental health support. Arguably, this began the drive towards early intervention, suggesting the need for more timely and appropriate CAMHS referrals.

The subsequent Green Paper *'Transforming children and young people's mental health provision'* (DoH and DfE, 2017) was followed by a response jointly from the Education, Health and Social Care Select committees, asserting that it failed to underline the importance of early intervention and prevention (House of Commons, 2018). The government responded with an acknowledgement that EPs may play a role in this (DHSC and DfE, 2018a). However, despite professional submissions of evidence (AEP, 2018), EPs were only mentioned twice in the government response to the Green Paper proposal consultations, with little exploration of the nature or contribution of the EP role (DHSC and DfE, 2018b). The notion that mental health is not a key part of the EP role can be seen to continue.

A key proposal stipulated within the Green Paper is that schools should be encouraged to identify a Designated Senior Lead for Mental Health (DSLMH) (DoH and DfE, 2017, p. 19), responsible for the school's approach to mental health. The DSLMH should oversee the provision for pupils with mental health needs, support staff to identify pupils showing signs of mental health needs and refer to specialist services where necessary. It is also suggested that the DSLMH supports staff with their own wellbeing. This point is interesting given the suggestion that the proposals put additional pressure on the teaching workforce without sufficient resources (House of Commons, 2018) and school staff may find this difficult (Finney, 2006; Kidger et al., 2010). DSLMH training and who provides it does not appear clear in the proposal, a critique shared by the Education, Health and Social Care Select committees (House of Commons, 2018). Additionally, DSLMH supervision is not addressed explicitly within the next steps for implementing the Green Paper Proposals (DHSC and DfE,

2018b). Given EPs' relationships with schools and education providers, it may be seen that EPs could provide support in the training, continuing professional development (CPD), and supervision of such mental health leads.

A further proposal is the establishment of 'Mental Health Support Teams' (MHSTs), said to comprise of "trained staff" (DoH and DfE, 2017, p. 21) offering individual and group support to help young people with mild to moderate mental health issues including anxiety, low mood and behavioural difficulties. The BPS (2019) published a briefing paper suggesting that MHSTs would include a newly trained professional referred to as Education Mental Health Practitioners (EMHPs) to deliver the abovementioned role. The government have proposed that the MHSTs will work "alongside existing good practice and services" (DHSC and DfE, 2018b, p. 15) naming EPs, however the nature of this collaborative working is not clear (DoH and DfE, 2017, p. 22). MHSTs, supervised by NHS children and young people's mental health staff, will work with the DSLMH to bridge contact between schools and mental health services, however, it is unclear if they will provide supervision for such school staff.

The proposals include a focus on shorter waiting times and improving mental health services for young people aged 16-25. This has implications for EPs given that the *SEND Code of Practice* (2015) outlines that EPs work with young people up to the age of 25. At the time of writing, these proposals were being rolled out in a number of 'trailblazer areas' (DoH and DfE, 2017, p. 4; DHSC and DfE, 2018b). Information suggests that 25 areas were selected as trailblazer sites for 2018/19 (NHS England, 2018) and a further 57 areas have been identified to take part in 2019/20 (NHS England, 2018). The consultation period found that the top professional for MHSTs to engage with were EPs (DHSC and DfE, 2018b), however the extent to which this has occurred in practice within trailblazer sites is not yet known, given that MHSTs aimed to be operational from the end of 2019 (DHSC and DfE, 2018b).

Government guidance appears to promote the role of schools and other professionals in "treating" or responding to mental health difficulties (DfE, 2014; DfE, 2016; DoH, 2014), with little focus on mental health promotion and prevention, despite being a recent government aim (Prime Minister's Office, 2017). This is reflected in the wealth of government documents in which there are often ambiguities, and sometimes contradictions, in the way that mental health and emotional wellbeing is understood. For example, DfE (2014) suggest schools should assess pupils to ascertain whether they are suffering from diagnosable mental health

problems, indicative of a 'within-child', medical perspective. Guidance by Weare (2015) advocates for whole-school approaches and promotion of wellbeing for staff and pupils, reducing stigma in the area of mental health. Following the Green Paper proposal, it can be seen that policies and guidance are beginning to recognise the importance of early intervention and prevention, and the potential impact of a young person's experiences or environment on their mental health and wellbeing (DfE, 2018). The Green Paper proposals serve a promising way forward for the future of children and young people's mental health and wellbeing, however the role of EPs within this is yet to be established.

2.6 Conclusion

Given the significant impact of mental health and wellbeing for children and young people, the prevalence rates for mental health difficulties are concerning. Despite acknowledging that EPs are professionals who work with schools in relation to young peoples' learning, developmental, behavioural, emotional and mental health needs (DfE, 2011), little focus is given to implicating the role of EPs within current governmental agendas around mental health. Thus, the role of the EP is potentially underrepresented and unclear. Therefore, whilst research suggests there is a place for EPs within children and young peoples' SEMH, primarily through the delivery and evaluation of therapeutic interventions, the extent to which EPs are engaged in varied activities in their everyday practice appears to be little reported. This raises the question as to whether this contribution is unknown, or whether EPs are not as active in mental health within day to day practice as research would suggest. In the following section, a systematic literature review is conducted to explore EP practice within the area of SEMH in the context of policy development, reflecting the government initiative around the mental health reform.

2.7 Systematic Evidence Synthesis Review

2.7.1 Introduction to the review

A systematic literature review involves a structured and rigorous search for research literature pertaining to a particular topic (Gough & Elbourne, 2002). Consensus regarding the best methodology for critical appraisal and synthesis of qualitative findings is yet to be established (Petticrew and Roberts, 2006). A number of qualitative approaches to systematic

syntheses exist such as meta-narrative synthesis, critical interpretive synthesis, textual narrative synthesis and meta-ethnography (Barnett-Page and Thomas, 2009).

This systematic review aims to explore current EP practice within the area of SEMH to develop an understanding of what is known, and what may need to be further investigated. A qualitative review was implemented given the exploratory nature of the review question (Barnett-Page and Thomas, 2009) and the predominantly qualitative methodology of included studies. The review adopts a meta-ethnographic approach (Noblit and Hare, 1988): aiming to produce new interpretations that transcend the finding of individual studies rather than simply aggregating findings (France et al., 2015). This is achieved by comparing study concepts to identify new overarching concepts. This process of translation allows for a comparison and analysis of texts and can lead to a 'line of argument' (Noblit and Hare, 1988). The approach to synthesis therefore followed the seven phases proposed by Noblit and Hare (1988) described in Table 2.1.

1	**Getting started**
2	Deciding what is relevant to the initial interest
3	Reading the studies
4	Determining how the studies are related
5	Translating the studies into one another
6	Synthesising translations
7	Expressing the synthesis

Table 2.1: Table to show the seven phases of Noblit and Hare's (1988) meta-ethnography

2.7.2 Review question

In line with step 1, the opinions, attitudes and knowledge of authors regarding the EP role were deemed a valuable source of data in relation to the review question:

'What does contemporary research conclude about the EP role in relation to social, emotional and mental health?'

2.7.3 Search strategy

Step 2 involved locating relevant studies through the following search strategy. Inclusion was decided based upon criteria defining the focus of the synthesis (Table 2.4).

Studies were identified through systematic searches of three well-established databases: 'Web of Science', 'Scopus', and 'ERIC' in July 2019. Due to the conceptualisation of SEMH over time and the variation in terminology used, multiple search terms were adopted across the three databases:

((“education* psycholog*”) AND (“social emotional and mental health” OR “mental health” OR “social and emotional” OR “wellbeing” OR “behavioural emotional and social difficulties” OR “emotional and behavioural difficulties”))

Search results are illustrated in Table 2.2 below.

Database	Number of search results
Web of Science	90
Scopus	296
ERIC	347
Total	733

Table 2.2: Table to show results for search terms in various databases

The removal of duplicates left 612 papers initially screened at title and abstract against the eligibility criteria (Table 2.4).

The inclusion of unpublished theses were felt to be important given the slim contemporary peer-reviewed literature in this area. The following terms were therefore searched on the British Library EThOS:

Search Terms	Number of search results
"Mental health" AND "educational psychologist"	65
Total	65

Table 2.3: Table to show search terms and results from British Library EThOS

A total of 65 theses were screened at title and abstract: 57 were excluded, two of which were excluded due to the same set of data being published in peer-reviewed articles (included within database searches) and one paper which was embargoed until 2021. Eight theses were included in the full-text articles assessed against the eligibility criteria (Table 2.4).

2.7.4 Identification of studies for review

The inclusion and exclusion criteria are described in Table 2.4 below.

Inclusion Criteria	Exclusion Criteria
Both peer reviewed and grey literature including unpublished theses	Whole books or reviews of books
Papers only describing one study	Reviews of studies such as systematic reviews or meta-analyses
Participants to include: EPs, children and young people with SEMH needs, school staff supporting children, young people or families around SEMH	Children and young people without SEMH needs, adult populations with SEMH needs, or solely other professional groups such as CAMHS or clinical professionals

Studies with a main methodological focus (i.e. a research aim or research question) on exploring the current EP role and contribution in supporting children, young people, families and schools around SEMH	Studies without a main methodological focus (i.e. a research aim or research question) on exploring the current EP role and contribution in supporting children, young people, families and schools around SEMH, or studies which focus solely on other professional groups such as CAMHS or clinical professionals. Studies which focus on exploring a future role for EPs. Studies which only consider the EP role within 'implications for EP practice'.
Research conducted within the UK only	Research conducted outside of the UK
Papers must be available in English	Papers written in any other language than English
Quantitative and qualitative findings	
Papers written from 2015 onwards	Papers written prior to 2015

Table 2.4: Table to show Inclusion and Exclusion Criteria

As the review aims to report an optimal picture of the topic, both qualitative and quantitative studies were included. The inclusion of UK only studies ensured a focus on EP practice in the UK, given the current political context. A date range was introduced to ensure that current practice was explored, in line with the focus of the review question. The date was determined in relation to policy development, covering practice 2 years prior to the Green Paper proposal (DoH and DfE, 2017) and 2 years after its inception. This timeframe represented the focus upon the mental health of children and young people in recent governmental agendas.

A flow diagram depicting the search process (Figure 2.1) following PRISMA procedures (Moher, Liberati, Tetzlaff and Altman, 2009) illustrates the removal of duplicates and screening process initially by title and abstract in accordance with the eligibility criteria. Of 15 articles identified for full-text screening, nine were excluded reasons for which can be found in appendix 1. Six articles were included in the review (see Table 2.5).

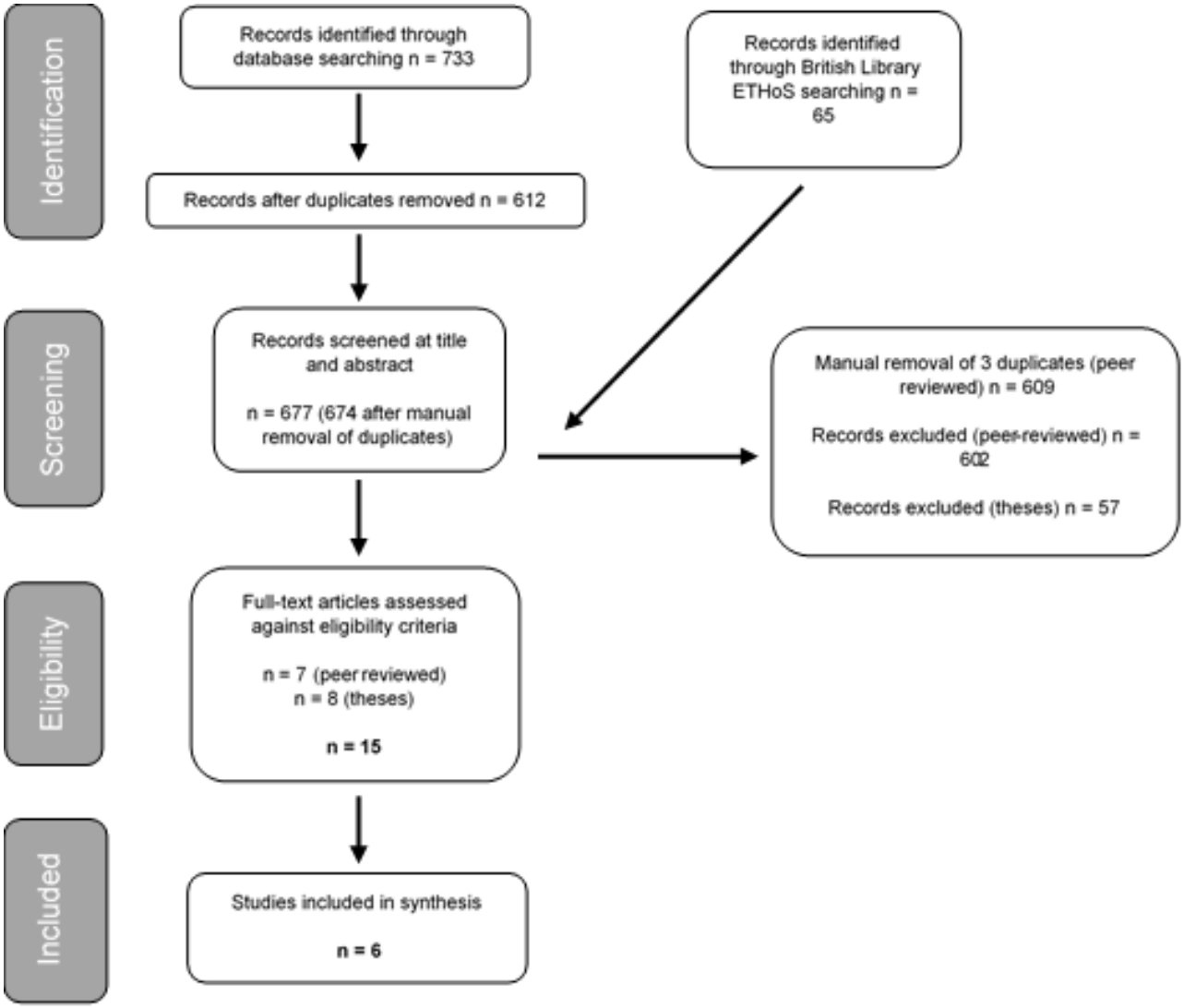


Figure 2.1: Flow chart illustrating the search and selection process

Title & Author	Participants	Type of study	Methodology/ approach	Key findings	Relevance
Reviewing and developing a psychological service's response to managing behavioural difficulties through action research. **Law and Woods (2019)**	6 EPs (1 Principal Educational Psychologist (PEP), 3 maingrade EPs and 2 associate EPs)	Peer reviewed	Action research model using RADIO[1] design: Focus group and interview	• Paradigmatic flexibility was regarded as distinctive to the EP role. EPs felt they adopted a holistic overview and avoided medicalised, within-child perspectives • Practice included individual casework, one-off assessments, and statutory work. EPs referred to the importance of consultation with adults to share expertise, 'give away psychological knowledge to empower others' (p. 105), explore interacting factors and joint problem-solving around challenging behaviours: enabling more solution-focused and holistic practice • Individual and group interventions such as resilience building, narrative therapy and developing classroom behaviour management practices were facilitated. Systems level practice included contributing to multi-agency processes within the LA • EPs felt there was a current focus on individual casework reporting less involvement in (individual and group) therapeutic work, or systems work such as training • Facilitators included changing perceptions of the EP role around behaviour • Barriers included traded model of service delivery, perceptions of the EP role amongst service commissioners, and time	Although focusing on 'managing behavioural difficulties' current policy indicates that behaviour and mental health are related needs, grouped under the category of SEMH (DfE, 2014) EPs conceptualised behavioural difficulties as including 'internalising behaviour' such as anxiety or self-harm
Supporting the mental health of children and young people: a survey of Scottish educational psychology services. **Greig, MacKay and Ginter (2019)**	21 survey returns from 19/ 32 LAs (59%) – sent to PEPs 19 PEPs and 2 additional participants (unspecified roles)	Peer reviewed	Quantitative Survey (dissemination unclear i.e. post or web-based)	• EPs most likely to undertake direct work with pupils/ schools and indirect work with parents/carers. EPs most unlikely to provide a mental health assessment or review a school's mental health policy • EPs least confident with mental health risk assessments and most confident delivering training to school staff. 60% confident in direct interventions with pupils and 85% confident in ability to provide intervention for parents/ carers and support policy development • EPs most likely action is referral to CAMHS, or specialist support in school, or for self-help, and least likely to provide specialist support from within EPS • 1 EPS had a mental health policy and strategy, 7 services 'in development'	Study aimed to establish current practice in supporting the mental health of children and young people within Scotland.

[1] Research and development in Organisations model

				• EPs felt that they should have involvement in supporting the mental health needs of children and young people; most (*n=12*) felt involvement should be 'variable' whilst 7 thought it should be 'considerable'. 2 thought EPs should have 'some involvement' • Between initial training and CPD, the majority of services felt they were either 'very well equipped' or 'well equipped' to deal with mental health issues. A significant minority described themselves as 'in between' or 'not very well equipped' • Only a third of respondents felt that supervision supported them • 1 service reported knowledge and skills as a considerable barrier, whilst the majority (*n=15*) reported little or no barrier. The majority reported capacity in terms of time and levels of staffing a considerable barrier (16/21) • A number of mental health provisions were offered by services e.g. Nurture Groups, CBT, SFBT, narrative approaches, family intervention, training for school staff and specialist EP roles	
A grounded theory study of educational psychologists' mental health casework in schools. **Zafeiriou (2017).**	5 EPs from one LA	Thesis	Semi-structured interviews	• EPs gathered information about concerns through observation, consultation, direct and indirect assessment. EPs used therapeutic work when 'looking for the evidence'. EPs triangulated gathered information and shared hypotheses formulated based on psychological knowledge • EPs used solution-focused approaches during joint work with adults, whilst also drawing upon attachment theory, self-determination theory (SDT) and collaborative consultation • EPs' key qualities included ongoing, consistent communication of affect and cognitive attunement, empathy, respect, and shared decision making. EPs were able to lead problem-solving activities whilst ensuring adults are emotionally contained. This enabled challenging adults' perceptions, reframing their perceptions about the concern and planning actions to support the child • The study found that successful involvement from EPs was not limited to therapeutic interventions and provided evidence for EPs' successful support of children and young people's mental health needs through development of adults' skills and confidence • Contributors to success included EPs' close collaboration with school staff and parents, and involvement over time	Focus on EP casework in mental health, examining EPs' direct work with school staff and parents. Study highlights how EPs can be effective in supporting student mental health needs and argues for EPs' future involvement in educational policies and guidelines

				• Challenges: the nature of traded EPSs and schools commissioning EP involvement in individual casework	
Reaching for a shared understanding: exploring the views of educational psychologists and special educational needs coordinators about the role of the educational psychologist in supporting mental health and psychological wellbeing in schools. **Andrews (2017).**	4 EPs 3 SENDCos	Thesis	Semi-structured interviews	• EPs felt their role was to reframe the discourse around 'behaviour' to consider the communication of underlying emotional states and change school understanding of mental health and wellbeing to be less 'clinic-based' • EPs believed they are well-placed to support mental health and wellbeing in schools due to specialist knowledge of the latest research, the importance and impact of mental health upon attainment and emotional wellbeing and knowledge of children's development and the systems around children and young people • The EP role was not universally agreed by those outside the profession or within • EPs gave examples of support at the individual, group and whole-school level. EPs delivered wellbeing interventions such as CBT, mindfulness and PCP, and worked with other professionals. School level involvement: staff peer supervision or delivering training related to mental health and psychological wellbeing • EPs felt they are not typically associated with mental health and psychological wellbeing support and felt that schools perceived CAMHS to be the most relevant service. Additionally, EPs feared SENDCo perceptions of the role were limited to assessment for individual pupils, confirmed by all SENDCos in the current study • Barriers: government agenda, budgets and guidance. EPs recognised the voice of the profession is missing in government guidance	Explored the views of EPs and SENDCos around the EP role in supporting mental health and wellbeing in schools Differing views held by EPs and SENDCos highlights the need for a shared vision and active promotion by EPs of their skills and training relevant to the field of mental health and wellbeing. EPs and SENDCos expressed a need for clarity around EP activities on offer
The Role of the Educational Psychologist in Children and Young People's Mental Health: An explorative study in Wales. **Price (2017)**	Phase 1 questionnaires: 17 EPs from 9 LEAs 11 SENDCos from 6 LEAs (10 primary, 1 secondary)	Thesis	Mixed methods utilising questionnaires (quantitative phase) and semi-structured interviews (qualitative phase)	• 100% of EPs considered themselves to have a role in children and young people's mental health with 53% indicating this as 'definitely', whereas 47% indicated this as 'somewhat' their role. 100% of SENDCos considered EPs to have a role, describing EPs as the 'first port of call' and as knowledgeable and experts in the mental health field • Consultation and multi-agency work was most commonly reported by EPs and SENDCos. More than 50% of EPs also reported engaging in assessment, systemic intervention and therapeutic	Aimed to explore 'what is the current role/ practice of EPs in relation to children and young people's mental health?', the facilitators and barriers to this, the pressures on EPs, and how EPs can improve their work in relation to

	Phase 2 interviews: 6 EPs from 3 LEAs 6 SENDCos from 4 LEAs			intervention. One third of SENDCos reported 1:1 therapeutic work indicating this as the least common type of practice • Almost 25% of EPs did not perceive barriers to engaging in mental health interventions. Most common barrier: 'school constructions of the role'. More barriers identified than facilitators such as: lack of clarity on the EP role, competing demands such as statutory assessments, and the dominant 'medical model' perspective • 41% of EPs felt pressure to engage in mental health intervention, suggesting waiting lists and access to mental health provision exacerbated this • SENDCos viewed EPs as providing support and reassurance, and assessment such as evidence gathering or using measures of emotional wellbeing. Systemic work was reported the most common type of practice with SENDCos referring to a consultation model of practice, critical incidents, training and providing programmes of support. EPs were also seen as giving advice on where to go next	children and young people's mental health within a Welsh context. Additionally, a focus on SENDCo perceptions of the EP role in this area.
An exploration of clinical psychologist and educational psychologist constructs of mental health in the context of secondary school aged children **Miller (2016)**	6 clinical psychologists (CPs) and 6 EPs	Thesis	Semi-structured interviews	• EPs referred to theoretical frameworks in understanding mental health needs, however lacked a unified construct of mental health • EPs viewed themselves as filling gaps left by other services (due to funding cuts) but felt they may lack the appropriate training or skillset around supporting mental health difficulties. Service delivery model impacted time for direct work and limited supervision around therapeutic intervention. Academic attainment focus was perceived to reduce school capacity to prioritise mental health work. Direct therapeutic work emerged as a less saturated theme including building resilience and promoting mental health or adopting SFBT • EPs reported working with systems, for example, offering whole-school preventative approaches to mental health, collaborative information sharing and bringing different systems together. EPs felt that they were able to offer training to schools in managing low-level mental health needs and promoting staff wellbeing. EPs supported families through weekly parenting groups or helping them to navigate the system	Explored constructs of mental health in the context of secondary aged children and explored the CP and EP roles in supporting schools EPs discussed the need to make schools and other professionals aware of their skillset

				• EPs viewed themselves as person-centred; maintaining a holistic view of the young person, drawing on strengths and maintaining a future-orientated perspective, whilst advocating for the family • CPs suggested the broadening of the EP role (from cognitive assessments) had led to a shallower role and "dipping into too many approaches" (p. 87). CPs expressed concern at EPs working beyond their training or under inappropriate supervision when carrying out therapeutic interventions • Neither profession share an understanding of the other role. Both may be seeking to establish the uniqueness of their own roles, leading to "professional defensiveness" (p. 100)	

Table 2.5: Table to show the overview of included studies

2.7.5 Characteristics of included studies

During phase 3, repeated reading of the studies allowed for familiarisation. Data was extracted and tabulated including participant sample; methods; key findings; and relevance to the review question (Table 2.5). Where studies explored other professional roles e.g. school staff or clinical professionals, only data relating to the EP role have been reported. As the studies were similar in topic, extraction of initial themes occurred naturally whilst reading and summarising papers. A summary of included papers is given below.

Of the six papers, two were peer reviewed (Greig et al., 2019; Law and Woods, 2019) and four were unpublished doctoral theses (Andrews, 2017; Miller, 2016; Price, 2017; Zafeiriou, 2017). Five were qualitative studies reporting data from semi-structured interviews (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017; Zafeiriou, 2017) whereas one presented a quantitative survey (Greig et al., 2019). All studies took place in the United Kingdom: one in Wales (Price, 2017), one in Scotland (Greig et al., 2019) and four in England (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Zafeiriou, 2017). Three qualitative studies used semi-structured interviews in isolation (Andrews, 2017; Miller, 2016, Zafeiriou, 2017), whilst one mixed-methods study also included a quantitative questionnaire (Price, 2017), and one an additional focus group (Law and Woods, 2019). Three studies carried out research with only EPs as participants (Greig et al., 2019; Law and Woods, 2019; Zafeiriou, 2017), two with EPs and SENDCos (Andrews, 2017; Price, 2017), and one interviewed both EPs and clinical psychologists (Miller, 2016).

2.7.6 Appraisal of studies

There is no single appraisal tool considered the best method of appraising qualitative research (Petticrew and Roberts, 2006). Following meta-ethnography approaches, the Critical Appraisal Skills Programme for Qualitative Research Checklist (CASP, 2018) was selected, as used elsewhere in quality appraisal (Atkins et al., 2008; Campbell et al., 2003). Outcomes can be found in Table 2.6 below, showing ratings on a 0-3 scale. Detailed guidance materials used can be found in appendix 2.

Author	Was there a clear statement of aims?	Is a qualitative methodology appropriate?	Was the research design appropriate?	Was the recruitment strategy appropriate?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken in to consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Is the research valuable?
Law and Woods (2019)	3	3	3	3	3	2	3	2	3	3
Greig, MacKay and Ginter (2019)										
Zafeiriou (2017)	3	3	3	3	3	3	3	3	3	3
Andrews (2017)	3	3	3	2	3	3	3	3	3	3
Price (2017)	3	3	3	3	3	1	3	3	3	3
Miller (2016)	3	3	3	3	3	3	3	3	3	3

Table 2.6: Table to show CASP ratings for qualitative studies

3 = yes, 2 = partially, 1 = unclear, 0 = no

The CASP checklist was deemed inappropriate to assess the quality of the quantitative survey (Greig et al., 2019). Instead, a review of the strengths and limitations of the research was undertaken. The authors did not provide the survey instrument and provided 'themes' rather than the specific questions asked, meaning that construct validity was difficult to ascertain. However, a definition of mental health was provided to participants which may have enhanced the construct validity of the measure. Minimal participant details were reported, and it was unclear if PEPs responded to the survey or another representative from the EPS. This is seen as a further limitation as the results may not reflect the full diversity in practice, confidence, and skills amongst individual EPs. The reliability of results may therefore be questioned. Detail around the procedure and analysis were not reported, for example, it was unclear if the survey was completed online or via post and whether only descriptive statistics or inferential statistics were employed. Demographic information around EPS contexts were not reported, for example, the size of the EPS and the number of practising EPs, including any further characteristics of each geographical location. The study has limitations inherent to self-report data such as being susceptible to social desirability. Self-report data can also lead to reduced external validity, which is further compounded in that the findings pertain to Scotland. The survey gained a response rate of 59% which is over half of the EPSs contacted to complete the survey, a good number.

2.7.7 Translating the studies

Noblit and Hare (1988) acknowledge that the phases described in Table 2.1 are not distinct and may overlap or 'run parallel', translation therefore encompassed phases 4 and 5.

Within stage 4, Noblit and Hare (1988) suggest creating a list of themes, juxtaposing them and determining how they are related, often presented as tabulated themes across all studies. In line with this, a list of themes were generated, also occurring within stage 3, until no further themes emerged. Key themes were mapped across studies to see if they were related, highlighting those key initial themes emerging across and within papers. This process revealed ten themes: 'Limited scope of the EP role'; 'Threats to professional identity'; 'Within-child focus/ impact of labelling'; 'Psychological frameworks and perspectives'; 'Definition/ understanding of mental health'; 'Working with others through problem-solving'; 'Working at multiple levels'; 'Future Practice'; 'Facilitators and barriers'; and 'Competence'. Significant statements from the original studies used in the formulation of initial themes were also identified (appendix 3).

Reciprocal translation (phase 5) entails comparing themes in one account with the themes in others (Campbell et al., 2003). Thomas and Harden (2008) describe the term 'translating' as taking concepts from one study and recognising the same concepts in another, although they may not be expressed using identical words. The development of 'third-order interpretations' are perceived to go beyond the content of the original studies (Britten et al., 2002; Campbell et al., 2003). The initial arising themes were therefore compared and translated across each other to generate four third-order interpretations, illustrated in Table 2.7. Additionally, explanations or theories associated with the themes are extracted and a 'line of argument' is developed pulling the concepts together (Thomas and Harden, 2008). The synthesis and generation of a 'line of argument' is detailed below in the final two phases of the approach.

Initial theme	Third-order interpretation
Limited scope of the EP role	Voice of the profession absent from government guidance
Threats to professional identity	
Within-child focus/ impact of labelling	Medical model vs biopsychosocial model
Psychological frameworks and perspectives	
Definition/ Understanding of mental health	
Working with others through problem-solving	EP contribution/ unique role
Working at multiple levels	
Future practice	
Facilitators and barriers	Influencing factors
Competence	

Table 2.7: Table to show the development of third-order interpretations from initial arising themes across studies

2.7.8 Synthesis of included studies

Similarly to Campbell et al. (2003) and Dundon (2006), the synthesis is presented in relation to the key themes generated. Following each group of themes, their overarching third-order interpretations are presented in bold (see Table 2.7), expressing the way in which the themes were bought together across studies. As the synthesis includes both qualitative and quantitative research, a data-based convergent synthesis design has been adopted (Noyes et al., 2019). Finally, a line of argument provides an explanation of the interrelations between the third-order interpretations.

Limited scope of the EP role

This theme was evident across five of the six included studies, except for Zafeiriou (2017) who specifically focuses upon consultation as one aspect of mental health casework. The theme represented the EP role *as perceived by others* and the confusion expressed by others around the EP role. This can be further divided into the perceptions of school staff, particularly SENDCos, and other professionals and commissioners of services. SENDCos predominantly viewed the EP role as restricted to the assessment of learning for individual pupils, a view shared by EPs (Andrews, 2017; Price, 2017). Additionally, some SENDCos suggested they would only consider the EP where mental health or behaviour affected classwork or achievement (Price, 2017). Conversely, others suggested that EPs were "knowledgeable" and "experts" in relation to mental health (Price, 2017, p. 75). Similarly, Law and Woods (2019) felt that a broader understanding of the EP role was becoming more widely recognised by schools, however EPs felt other agencies perceived their role as restricted to learning support. This idea was further supported by EPs within Andrews' (2017) study who reported that other professionals did not usually associate EPs with mental health. Miller (2016) found that clinical psychologists valued the EP role in carrying out cognitive assessments, and even expressed concern over the broadening of the EP role. Therefore, EPs in this study felt that they needed to make both schools and other professionals aware of their skillset within this area. Greig et al. (2019) proposed that a gap exists between how EPs view their role and how it is viewed by others, particularly the government and commissioners of services.

Threats to professional identity

This small theme occurred across two studies (Law and Woods, 2019; Miller, 2016) however, it was felt to be pertinent to the above theme and to the encompassing third-order interpretation given below. The noted concern of others around EPs broadening their role led Miller (2016) to construct the notion of "professional defensiveness" (Miller, 2016, p. 100). Similarly, Law and Woods (2019) suggested that threats to professional identity created an ethos of protectiveness and hindered multi-agency working. Threat to the EP professional identity can be seen both *as a result* of the limited perception of others, and could be *potentially contributing* to the limited understanding of others, as through a lack of multi-agency working, other professionals are not aware of the broader contribution of the EP role within mental health.

Voice of the profession absent from government guidance

The themes 'Limited scope of the EP role' and 'Threats to professional identity' were taken to form a third-order interpretation 'Voice of the profession absent from government guidance'. The data suggest that there is either a lack of recognition of the EP role, or a lack of clear definition when included in policy and guidance surrounding mental health. This has led EPs, SENDCos and clinical psychologists to call for greater clarity around the role (Andrews, 2017; Miller, 2016; Price, 2017). Doctoral research has highlighted that government guidance does not make it clear to schools that mental health and wellbeing is part of the EP role (Andrews, 2017; Zafeiriou, 2017), echoed in published research from Scotland (Greig et al., 2019). Significantly, Andrews' (2017) findings suggest that there are differing views expressed between EP participants about their role within mental health and the degree to which this formed a major or minor part of the role. Price (2017) also found that EPs were divided between whether mental health was 'definitely' or 'somewhat' their role. This equivocation may hold a relationship with the absence of professional representation within guidance; and potentially contribute to the restricted understanding of the role on the part of others, therefore potentially contributing to the professional identity threat.

Within-child focus/ impact of labelling

This theme occurred across three studies, Law and Woods (2019), Andrews (2017) and Miller (2016). Law and Woods (2019) and Miller (2016) found that EPs held conflicting views around the utility of 'labelling' and diagnoses. EPs perceived that labels could promote a

'within-child' perspective and could potentially become a child's definition of themselves, thus describing labels as "static" (Law and Woods, 2019, p. 105) suggesting mental health was "fixed" (Miller, 2016, p. 57). However, EPs also recognised that labels could promote access to services, facilitate early intervention, and avoid blame on the child or their parents, carers, or teachers (Law and Woods, 2019; Miller, 2016). The SENDCo sample in Andrews (2017) and the clinical psychologist sample in Miller (2016) viewed the EP role as focusing on cognitive assessment, reflecting a within-child focus. Miller (2016) suggested that EPs expressed caution with language and were reluctant to use the term 'mental health', preferring the term 'emotional wellbeing' (Andrews, 2017; Miller, 2016).

Psychological frameworks and perspectives

EPs reported applying a wide range of psychological perspectives to support their understanding of presenting behavioural needs or mental health (Law and Woods, 2019; Miller, 2016; Zafeiriou, 2017). These include interactionist and ecological paradigms (Law and Woods, 2019; Miller, 2016), attachment theory (Law and Woods, 2019; Miller, 2016; Zafeiriou, 2017), psychodynamic theory (Law and Woods, 2019; Miller, 2016) and solution-focused approaches (Law and Woods, 2019; Zafeiriou, 2017). Similar theoretical perspectives were common across all studies, although two gave further examples. Law and Woods (2019) noted that cognitive and neurobiological factors, humanistic and behaviourist approaches were adopted, perhaps due to their study's emphasis upon practice around behaviour. Zafeiriou (2017) proposed that theories such as SDT (Ryan and Deci, 2000) and collaborative consultation approaches were employed by EPs within consultation around mental health casework. Zafeiriou (2017) illustrated that drawing upon these perspectives, joining theory with evidence, enabled EPs to work successfully around the mental needs of children and young people in schools.

Definition/ Understanding of mental health

This theme was identified within Law and Woods (2019), Price (2017), Andrews (2017) and Miller (2016). The latter two authors suggested that EPs experienced difficulty defining mental health as a concept and appeared to hold different understandings to other professionals, such as school staff and clinical psychologists respectively. Andrews (2017) suggested that, in contrast, school staff may have a perception of mental health that is "clinic-based" (Andrews, 2017, p. 54). Law and Woods (2019) found EPs referred to externalising and internalising behaviours, connecting externalising behaviours and SEMH

needs. Examples of behaviours were broad, suggesting that EPs considered a range of behavioural presentations as reflective of mental health needs. Miller (2016) found that EPs adopted a view that mental health is changeable rather than fixed. A consensus around a social constructionist approach and consideration of wider systems and ecological factors was evident across all studies.

Medical-model vs biopsychosocial model

The themes 'Within-child focus/ impact of labelling', 'Psychological frameworks and perspectives' and 'Definition/ understanding of mental health' contributed to the third-order interpretation 'Medical-model vs biopsychosocial model'. EPs' reluctance to employ labels and adopt a within-child perspective appear consonant with the paradigms and psychological perspectives EPs work from. This has been understood to represent the biopsychosocial model of mental health (Cooper et al., 1994), reflected in EPs' understanding of mental health 'interacting with the environment' (Andrews, 2017; Law and Woods, 2019; Miller, 2016). Although Miller (2016) found that the EP sample in their study lacked a unified construct of mental health, a social constructionist and ecological approach was evident, suggesting some consensus in the way mental health is constructed (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017). The various paradigms employed emphasise that EPs adopt a flexible, rather than fixed, position towards mental health in relation to individuals and their contexts. The suggestion that school staff adopt a 'clinic-based' perception of mental health (Andrews 2017) implies that this may be the dominant perspective communicated to schools within guidance. This may be problematic given that Miller (2016) suggested the notion of labels may generate fear amongst school staff. This third-order interpretation suggests that the difficulty may lie with the divergence between EPs construction of mental health and the medical model, perceived to dominate currently.

Working with others through problem-solving

This theme emerged across all studies, which discussed working with families in addition to school staff. This was thought to "bring different systems together" (Miller, 2016, p. 71). Greig et al. (2019) suggested that EPs viewed their main role as supporting others in regular contact with the young person, and Law and Woods (2019) and Zafeiriou (2017) suggested that EPs empowered and upskilled adults. The idea of problem-solving arose within three studies (Andrews, 2017; Law and Woods, 2019; Zafeiriou, 2017) and contributed to helping reframe adults' perceptions. Within Andrews (2017), one SENDCo specifically commented

on the value of the EP in supporting collaborative problem-solving with parents and other professionals. Additionally, Andrews (2017) and Price (2017) spoke of multi-agency work with other professionals, although professionals beyond CAMHS were not specified.

Working at multiple levels

This theme was identified across all studies apart from Zafeiriou (2017), who focused specifically upon mental health casework. Studies found that EPs were engaging in a range of activities across multiple levels and systems, for example, individual direct work or assessment (Andrews, 2017; Greig et al., 2019; Law and Woods, 2019; Miller, 2016; Price, 2017), intervention with groups (Andrews, 2017; Law and Woods, 2019), consultation with staff, parents and carers or other professionals (Andrews, 2017; Greig et al., 2019; Law and Woods, 2019; Price, 2017; Zafeiriou, 2017), and more systemic whole-school work such as training, supporting the development of a mental health policy and providing staff supervision (Andrews, 2017; Greig et al., 2019; Law and Woods, 2019; Miller, 2016; Price, 2017).

Future practice

The notion of future practice was discussed in four studies, where EPs expressed their desire to develop their practice or work in different ways (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017). EPs expressed a desire to work more in the field of mental health and wished to have a therapeutic role with children and young people and to support the mental health of staff (Andrews, 2017; Price, 2017). Similarly, Law and Woods (2019) found that EPs wanted to increase their use of consultation and therapeutic work. Furthermore, EPs in Law and Woods (2019) expressed a wish to work more systemically within schools and the LA, and to work more preventatively with greater opportunities for multi-agency collaboration. The idea of multi-agency collaboration also arose from EPs within Miller (2016) who expressed a desire to work collaboratively with clinical psychologists.

EP contribution/ unique role

Limited multi-agency working was reported, and indeed barriers to this were identified. Direct therapeutic work often emerged as a less saturated theme, or EPs discussed barriers to this (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017). It was evident across two studies that EPs wished to work to support the mental health of children and young people

through the delivery of therapeutic interventions (Law and Woods, 2019; Price, 2017). This suggests that where this was occurring in practice, it was perceived by EPs to be minimal with the exception of the Scottish EP sample (Greig et al., 2019). The sense that EPs worked with adults in contact with the young person was found across all studies. The EP role can be seen as working with others, such as school staff, families and other professionals, across multiple levels, reframing their ideas through problem solving, and bringing systems together (Miller, 2016; Zafeiriou, 2017). Price (2017) suggested that evidence of EP mental health intervention in a number of forms sets it apart from other branches of psychology, suggesting a unique contribution. The studies highlighted a tension between the work EPs were involved in and the kind of work they would like to be involved in (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017), indicating areas for practice development for EPs.

Facilitators and barriers

All studies identified barriers to EP practice in the area of mental health, and only three identified facilitators (Law and Woods, 2019; Price, 2017; Zafeiriou, 2017). Significantly, there was no overlap between the facilitators identified by the three studies. Discrepant views emerged within studies in that facilitators identified were also identified as barriers for some (Law and Woods, 2019; Price, 2017): specifically, 'the perception of the EP role' and 'opportunities for multi-agency working' (Law and Woods, 2019). Additionally, Zafeiriou (2017) identified that involvement over time was a facilitator to EP work in the area of mental health however overwhelmingly, time was identified as a barrier across all five of the remaining studies. Time was perceived to limit the delivery of therapeutic interventions (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017).

The service model of delivery arose as a barrier in four studies (Andrews, 2017; Miller, 2016; Price, 2017; Zafeiriou, 2017), hindering time for direct work (Miller, 2016). However, in Price (2017) two participants expressed that the consultation model of delivery facilitated their engagement in mental health work. Multi-agency working was revealed as a barrier across three studies (Greig et al., 2019; Law and Woods, 2019; Miller, 2016) and the pressures arising from statutory duties (Andrews, 2017; Price, 2017). EPs expressed a view that schools' awareness and understanding of mental health was a barrier to their engagement in mental health work (Andrews, 2017; Miller, 2016; Price, 2017). The studies suggested that since schools are assessed on academic outcomes rather than emotional wellbeing, there may be reduced capacity to prioritise mental health initiatives.

Competence

This theme was found in all studies and captured discussions around EPs' skills, knowledge, confidence and competence. Skills appeared across all studies, with two proposing the skills that EPs contribute (Law and Woods, 2019; Zafeiriou, 2017), whilst three expressed a concern around EPs feeling deskilled (Andrews, 2017; Miller, 2016; Price, 2017). Skills included empathy (Law and Woods, 2019; Zafeiriou, 2017) listening, containing, attuning and being collaborative (Zafeiriou, 2017). Zafeiriou (2017) postulated that EPs' skills grow as a result of engaging in mental health work; and one participant in Miller (2016) felt their skillset was limited but wanted to develop this through practice. EPs within the Scottish study reported that their skills and knowledge presented little or no barrier to meeting mental health needs (Greig et al., 2019). Similarly, Andrews (2017) found that EPs reported specialist knowledge such as the latest research, an understanding of the impact of mental health upon attainment and emotional wellbeing, and their knowledge of child development and systems around young people. Despite this, there was an expressed fear of working in the field of mental health and one participant felt this may be due to the confidence and skills of EPs (Andrews, 2017). Price (2017) found conflicting findings in relation to EPs' views of their knowledge, confidence, and competence, as although confidence and competence were identified as a facilitator, they were also highlighted as barriers. Participants expressed concern around competence within complex cases and felt their confidence was affected due to skills diminishing over time (Price, 2017).

Influencing factors

The presence of more barriers than facilitators emerging from the literature suggests that EPs are working within contextual constraints. It could be argued that for facilitators such as 'good relationships between schools and EPs', 'a positive perception of EPs' and a view that there is a role for EPs within this domain to develop (Law and Woods, 2019), EPs must have opportunities to practice and demonstrate their skills with confidence. This could be hindered by the suggestion that schools prioritise academic outcomes rather than emotional wellbeing. The pressures of statutory duties may also arise as a result of this. This serves as a further barrier for opportunities for EPs to practice in this area, to demonstrate their wider skills, and develop good working relationships with schools.

Three studies appeared to suggest that on the whole EPs were knowledgeable and skilled (Greig et al., 2019; Law and Woods, 2019; Zafeiriou, 2017). However, discrepancy existed within studies around EP competence (Andrews, 2017; Miller, 2016; Price, 2017). Some of the identified facilitators and barriers are thought to interact with the development of competence as they limit opportunities for EPs to engage in mental health work, such as time and the service delivery model. As data suggests that skills grow as a result of engaging in mental health work (Miller, 2016; Zafeiriou, 2017), it could be seen that limited opportunities could contribute to EPs feeling deskilled. This is supported by the suggestion that skills diminished over time (Price, 2017) and participants not practising in the area of mental health often, leads to them feeling deskilled (Andrews, 2017).

2.7.9 Line of argument synthesis

A 'line of argument' synthesis involves the construction of an interpretation, serving to reveal what is hidden in individual studies and discover a 'whole' among a set of parts (Noblit and Hare, 1988). The synthesis indicated that EPs are practising within contextual constraints that may be created or exacerbated by the distinction between the medical model versus the biopsychosocial model (Cooper et al., 1994). This in turn impacts upon the perceived EP contribution or unique role as there appears to be discrepancies between EPs' practice, according to guiding theoretical models and frameworks, and the practice or understanding of others, potentially influenced by the medical model. These constraints are seen to be interconnected in nature, a combination which creates tension for the EP role and may contribute to the voice of the profession being absent within government guidance. Figure 2.2 depicts a model of this line of argument followed by further explanation of the relationships within the model.

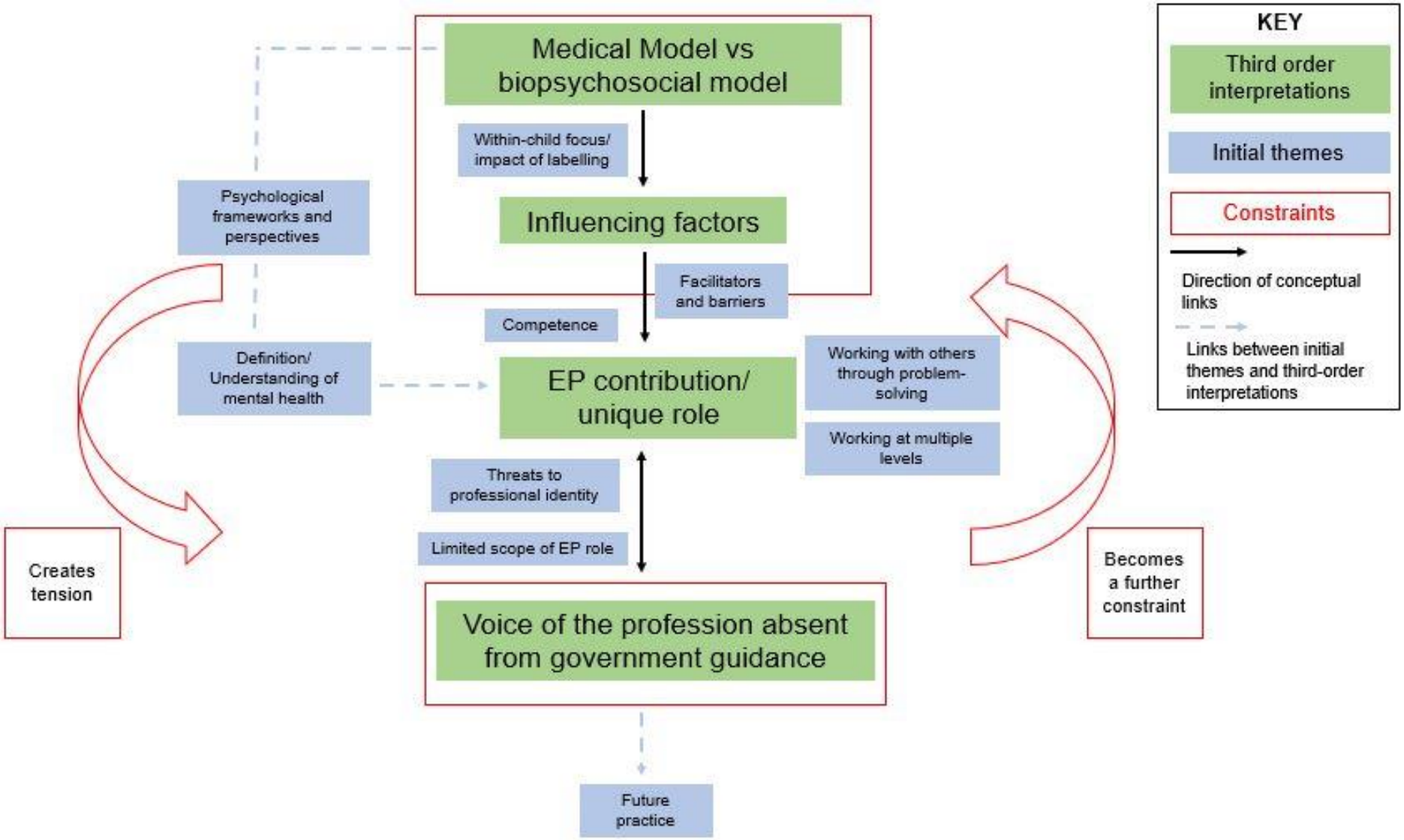


Figure 2.2: Model depicting the line of argument

The model suggests that the third-order interpretation ‘Medical model vs biopsychosocial model’ is the most prevalent interpretation, linking to the remaining three third-order interpretations. These can be seen to be mapped in a hierarchical nature with the medical-model vs biopsychosocial model dominating, which then affects ‘influencing factors’, which in combination impact on the ‘EP contribution/ unique role’. Taken together, these provide a potential rationale for the third-order interpretation ‘Voice of the profession absent from government guidance’. It is important to consider the contribution of the initial arising themes in understanding the model and the interrelations between the third-order interpretations.

The ‘Medical model vs biopsychosocial model’ has been interpreted to impact EPs’ competence and skills and create or exacerbate barriers to EP practice within SEMH work thus, being linked to ‘influencing factors’. One interpretation is that some EPs may feel in conflict with the dominating medical model, preferring not to identify with it, potentially affecting their perceived competence and skills. Additionally, EPs’ confidence, skills and knowledge may be undermined through not working within the model perceived to dominate policy and practice. EPs expressed a difficulty with the terminology ‘mental health’ preferring the term ‘emotional wellbeing’. ‘Mental health’ is prevalent within government guidance and could lead one to infer that the medical model perspective is reinforced by the government. As this guidance is communicated to schools, this is likely the model reflecting schools’ understanding of mental health; a theme which arose as a further barrier to EPs’ engagement in SEMH work. Arguably, the applicability of the medical model to an educational context could be questioned.

Thus ‘influencing factors’ can be seen to impact on the EP contribution and unique role. Barriers such as time, the service model of delivery, and lack of multi-agency working can be seen to lead to limited opportunities. Such limited opportunities to work with others around SEMH could contribute to the reported lack of understanding of the EP role, as others are not aware of the EP contribution. In turn, this lack of understanding could also limit the opportunities presented to EPs to engage in such work, as they are not thought of as professionals who can provide a contribution in this area. Thus, the views of others are seen to restrict the opportunities available to EPs. Schools’ increasing focus on academic performance could promote a limited scope of the EP role through utilising EPs for assessment of learning predominantly. This could then lead to additional reported barriers such as the pressures of statutory duties. As mentioned, it can be seen that the government reinforces the medical model view in guidance around mental health and behaviour through

terminology used (DfE, 2016), and that Ofsted promote the emphasis on academic attainment in their assessment of schools (Ofsted, 2019; Young Minds, 2017). Additionally, the impact of barriers upon role identity, development and opportunities could also be seen to reinforce EPs' sense of limited confidence in the EP contribution or uniqueness of their role. It is suggested that opportunities are necessary for EP skills and confidence to develop and thus, a lack of opportunities could lead to diminished skills over time and in turn, lower confidence. The sense of feeling deskilled or unconfident could result in EPs not engaging in mental health work. This has a bidirectional impact in that EPs do not develop the confidence or skills as a result of not carrying out SEMH work.

The EP role has been reported as one that works across systems at multiple levels, engaging in problem-solving with others, utilising various theoretical paradigms to reframe adults understanding of mental health difficulties. EPs also consider the impact of the environment and interacting factors, reflective of a biopsychosocial view. Despite working from a range of theoretical perspectives and paradigms, some EPs may feel unclear or unconfident about their definition of mental health possibly due to this contrasting with the medical model view. Consequently, this could provide an explanation for why EPs are not implicated in mental health guidance and why the voice of the profession is absent, or why some report a lack of confidence or limited role in mental health. Thus, the EP contribution or potential unique role may not be associated with mental health due to differences in theoretical frameworks, definitions, and models of practice adopted, which could be misunderstood by others.

The contextual constraints that EPs face are seen to create a tension between current practice and EPs wishes for future practice: conceptualised as espoused practice versus practice in the real-world. A lack of professional representation in guidance could be contributing to the reported undefined role for both EPs and other professionals. This is then felt to create an additional constraint, interacting with the existing constraints of the medical model and contextual factors to create a recursive cycle, resulting in tension around the EP contribution and potential unique role.

2.7.10 Study rationale and unique contribution

The reported limited understanding of the broader role of EPs by schools and other professionals has led to a call for greater clarity around the role (Andrews, 2017; Atkinson, Corban and Templeton, 2011; Greig et al., 2019; Law and Woods, 2019; Miller, 2016; Price, 2017). The line of argument proposed a number of factors which may contribute to the suggestion that the voice of the profession is absent from government guidance. Research has also found differing views between EPs themselves regarding whether their role within SEMH is pertinent or minimal. This highlights the value of a stronger representative professional identity within the area of mental health.

The varied findings related to EPs' confidence, skills and knowledge (Andrews, 2017; Price, 2017) represent individuality amongst a small sample of EPs, with only two studies exploring EP skills (Law and Woods, 2019; Zafeiriou, 2017). Numerous facilitators and barriers were identified, with discrepancies across studies representing a complex picture. Exploration of facilitators and barriers from a wider number of EPs in various geographical locations may illustrate the most commonly occurring factors, allowing for a deeper understanding of their impact upon EPs' engagement in mental health work.

Greig et al. (2019) propose that the EP profession needs to be proactive in promoting their skills and knowledge, and their embedded position in schools to avoid maintaining a peripheral position to the current mental health agenda, providing a clear rationale for the current study. The research is timely given that data collection will occur around the time of the implementation of trailblazer sites. Particularly this will coincide with the establishment and operation of the MHSTs, identified as providing early intervention, whilst the role of EPs in providing early intervention has been seldom acknowledged. Thus, exploring how EPs are working within the current Green Paper proposals, for example links between MHSTs and EPSs, will illuminate the impact of current legislation on the EP role in this area.

Existing research has been carried out at a local level, often in one or two LAs. Suggestions for future research include sampling EPs from a range of LAs to elicit any geographical and practice variations (Law and Woods, 2019; Zafeiriou, 2017). Despite studies in Scotland, at a whole-service level (Greig et al., 2019), and Wales (Price, 2017), it is of interest to extend these investigations to England, given the current government initiatives around mental

health. Thus, this research aims to build upon existing literature by carrying out a national level survey of EPs' involvement in SEMH work within England, in light of the new mental health initiatives. Furthermore, it is hoped that the research may shed light on potential factors that support or hinder EP engagement in SEMH work. The study therefore hopes to inform future development in mental health policy and EP practice through the research questions below.

2.8 **Research Questions**

1. *What is current EP practice in supporting children and young people's mental health?*
2. *What are EP's perceptions of their confidence, skills and knowledge in relation to mental health work?*
3. *What factors are influencing delivery of mental health work?*
4. *What are the opportunities for engaging in mental health work?*

Chapter 3: Methodology

This chapter considers the theoretical position and methodological approach adopted in this study. An overview of the key theoretical paradigms of research are presented, followed by a rationale for the study's adoption of pragmatism. Methodological considerations for a mixed methods web-survey design are outlined followed by consideration of issues of reliability and validity. The development of the survey measure is outlined, in addition to the procedures employed within the current study. The chapter concludes with a description of the data analysis methods.

3.1 Theoretical considerations

Research is a process of systematic inquiry designed to collect, analyse, interpret and use data (Mertens, 2015). Empirical research focuses on building upon existing knowledge about a phenomenon (Mertens, 2015). Robson and McCartan (2016) suggest that research provides an evidence base to influence and enhance practice. It is argued that an understanding of theoretical paradigms is necessary as this has implications for each decision taken within the research process and influences the chosen methodology (Mertens, 2015).

In educational and psychological research there are four major paradigms: post-positivism, constructivism, transformative and pragmatic (Mertens, 2015) (Table 3.1). Paradigms draw upon assumptions of ontology (the nature of reality) and epistemology (the nature of knowledge and the relationship between knowledge and reality). Such assumptions therefore inform how the researcher attempts to obtain knowledge and understandings; thus, the methodology adopted.

	Post-positivism	Constructivism	Transformative	Pragmatic
Ontology	One reality which is knowable within a specified level of probability	Multiple, socially constructed realities	Recognises that various versions of reality are based on social positioning	There is a single reality, but all individuals have their own unique interpretation of reality
Epistemology	Asserts the importance of objectivity	There is an interaction between researcher and participants. Values are made explicit	There is an interaction between researcher and participants. Knowledge is socially and historically situated. Issues of power and trust are considered	Relationships in research are determined by what the researcher deems appropriate to the particular study
Methodology	Primarily quantitative and decontextualised	Primarily qualitative. Contextual factors are described	Primarily qualitative but quantitative and mixed methods can be used. Takes account of historical and contextual factors	Methods are matched to research purposes and specific research questions. Often mixed methods approaches are adopted

Table 3.1: Table to show the major research paradigms and associated beliefs (adapted from Mertens, 2015)

During the early stages of the research process here, a number of possible paradigms were considered:

- A constructivist paradigm using Q methodology to explore the views of EPs within one LA was considered. However, it was felt this would not yield results that were transferable to other LAs and reflective of the wider profession, and therefore would not answer the research questions effectively.

- The post-positivist paradigm was considered in relation to administering a purely quantitative survey, however this was felt to not add depth to the research and enable contextual factors to be explored adequately. It was felt that the opportunity to carry out a wide-scale piece of research was a unique contribution of the current study, and thus, incorporating both quantitative and qualitative data would extend the current literature findings.

- A constructivist paradigm was considered by utilising focus groups to inform the survey measure however this was felt to be unachievable in the time frames. Furthermore, the logistics of conducting focus groups with geographical representation sufficient to inform a national level survey was felt to be beyond the scope here.

3.1.1 Paradigm selected: Pragmatism

Consideration of the above led the researcher to adopt the pragmatist paradigm to answer the four research questions (section 2.8). Pragmatists consider the research questions to be more important than the method they use or the worldview underlying the method (Mertens, 2015). A pragmatic approach to investigation considers ‘what works’ to answer the research question and yields real answers to real questions (Mertens, 2015; Cohen et al., 2018; Creswell and Creswell, 2018).

Pragmatism is not committed to any one philosophical assumption about reality, instead drawing from both qualitative and quantitative assumptions, lending itself well to mixed methods research (Creswell and Creswell, 2018). A mixed methods approach to data collection could therefore be employed, allowing for a more comprehensive understanding of the phenomena to be obtained (Cohen et al., 2018). This acknowledges that phenomena are

complex; and that a single method approach may be insufficient, resulting in partial, selective and incomplete understanding (Cohen et al., 2018). A pragmatic paradigm adopts a practical rather than idealistic approach and is practice-driven, reflecting the aims of the current study to be of practical value (Cohen et al., 2018).

3.2 Mixed Methods research design

The research design considers the research purpose, theory, research questions, method, sampling procedures and ethical considerations (Robson and McCartan, 2016). Research designs can be fixed, flexible and mixed, as informed by the researcher's chosen paradigm (Robson and McCartan, 2016). As the pragmatic paradigm is closely linked with mixed methods designs, these will now be considered in more detail.

Mixed methods refers to the use of both quantitative and qualitative methods to answer research questions in a single study (Mertens, 2015). Both features are incorporated in the design and at the stages of data collection and analysis (Teddlie and Tashakkori, 2009). Mixed methods research can allow for richer data to be gathered and the meanings in data to be probed through triangulation (Cohen et al., 2018; Robson and McCartan, 2016). This is also a helpful approach where there are more than one research question; potentially requiring both quantitative and qualitative data (Cohen et al., 2018; Robson and McCartan, 2016). Mixed methods research addresses both the 'what' through quantitative data, and the 'how' or 'why' through qualitative data (Cohen et al., 2018). Thus, mixed methods can enable a more comprehensive picture of the topic of the research (Robson and McCartan, 2016).

Mertens (2015) suggests that data collection of both quantitative and qualitative data can occur in parallel (both kinds of data are collected and analysed concurrently or in close proximity) or sequential form (one type of data informs the data collection of another type of data). The current study collects and analyses both quantitative and qualitative data at the same time, using a parallel mixed methods approach.

The current study explored EPs' views of their role within SEMH and consideration of the ontology and epistemology of various research paradigms led to the pragmatic paradigm being adopted. The study aimed to collect data through a mixed methods web-based survey,

incorporating quantitative and qualitative features at the stages of data collection and data analysis: to provide a more in-depth picture of EPs' involvement in SEMH work. The quantitative data aimed to gather information around how often EPs were engaging in particular types of work and aimed to set the research within its context. The qualitative data aimed to explore the detail around the nature of EP work and to add depth to the quantitative data.

3.3 Data collection method: Survey method

Surveys are used pervasively in educational and psychological research (Mertens, 2015), for many research purposes; exploratory, descriptive and explanatory (Robson and McCartan, 2016). Given that the current survey adopted both closed- and open-ended questions, it was both descriptive and exploratory. Surveys can be used when seeking to gather large-scale data from a representative sample, to see if certain observed characteristics occur with a degree of regularity, or certain factors correlate with each other (Cohen et al., 2018). As surveys often employ closed questions where answers are selected from a list of given options, this can be seen to restrict the amount of detail obtained from participants. In the current study, the adoption of a mixed methods design enabled the inclusion of qualitative, open-ended questions, which aimed to contextualise the quantitative data and to develop a more detailed picture around the topic of study.

Surveys have many advantages as a form of data collection. They can be administered to a large and representative sample of participants and completed anonymously (Mertens, 2015), and are therefore a potentially time efficient method for collecting data compared to other methods such as interviews. Surveys can be administered in a variety of media such as through telephone, face-to-face, and mail and web-based software relying on self-completion (Mertens, 2015; Robson and McCartan, 2016). The advantages of web-based surveys are that they provide convenient access to samples, and respondents can consult records to inform their answers before responding (Mertens, 2015). Additionally, self-completion questionnaires can enable a wider geographical distribution (Robson and McCartan, 2016). Web-based surveys also avoid interviewer effects and are cost effective (Mertens, 2015; Robson and McCartan, 2016).

Possible disadvantages include the potential effects of respondent characteristics, for example, their memory, knowledge, experience and motivation (Robson and McCartan, 2016). Surveys can be prone to issues of selective recall and response bias (Robson and McCartan, 2016). A disadvantage of web-based surveys, as for formal postal surveys, can be that the researcher does not have the opportunity to probe for more in-depth answers, or to determine if the respondent understood the question correctly (Mertens, 2015; Robson and McCartan, 2016). A typically low response rate is also common, and as the characteristics of non-respondents are unknown, difficulties can occur in ascertaining the representativeness of the respondents (Robson and McCartan, 2016). Low response rates are considered more likely when questionnaires are longer in length, unless the respondent endorses the importance of the topic (Mertens, 2015). It is essential that questions are worded in a way which is unambiguous to enable participants to interpret the question correctly and answer accurately (Cohen et al., 2018; Mertens, 2015). Such issues will be considered below in more detail when reporting the survey design and process.

3.4 Quality of the research

The reliability and validity indicators of both quantitative and qualitative features determine the trustworthiness of the data and any conclusions drawn.

3.4.1 Quantitative research

Reliability considers the stability of a measure and whether the data collection provides consistently accurate data over time (Mertens, 2015). Reliability within a descriptive survey design may be more problematic as it is recognised that participants' answers reflect those given at a single point in time (Mertens, 2015). However, reliability can be achieved by presenting all respondents with the same standardised questions, which have been carefully worded after piloting (Robson and McCartan, 2016). Reliability can be affected by unsystematic errors such as within participant factors of motivation or alertness and the time taken to complete the survey (Mertens, 2015).

A number of types of validity are relevant to the current research. Internal validity comprises of content validity which relates to the extent that the items in the survey represent the domain of interest in the research study. External validity considers whether the conclusions

drawn can be generalised to other settings. Within surveys, external validity is affected by the representativeness of the sample in relation to the wider population (Robson and McCartan, 2016). Further threats to validity include the absence of a measure for comparison and thus measurement error, and participant threats such as social desirability or participant memory and motivation. As such, self-report data can affect the validity of the study (Mertens, 2015). Internal validity in surveys is questioned in relation to whether the participants' true thoughts and feelings have been obtained (Robson and McCartan, 2016).

3.4.2 Qualitative research

Criteria for evaluating the quality of qualitative research have been established as an alternative to the above. Table 3.2 defines these alongside the quantitative version of each.

Qualitative criteria	Description of criteria	Quantitative version
Dependability	Dependability concerns the appropriateness of inquiry decisions (Teddlie and Tashakkori, 2009). This requires a clear description of the research process.	Reliability
Credibility	Credibility is concerned with the correspondence between the respondents' perceptions of social constructs and the way the researcher conveys their viewpoints (Mertens, 2015). Triangulation can enhance credibility.	Internal validity
Confirmability	Confirmability is achieved by ensuring qualitative data can be tracked to its source and the researcher making explicit the logic used to interpret the data (Mertens, 2015).	Objectivity

Transferability	Relies on thick description of the participants within the study	External validity

Table 3.2: Table to show the criteria for evaluating qualitative research and the quantitative version of the criteria

3.4.3 Mixed Methods research

The inclusion of both quantitative and qualitative data may enhance the reliability of surveys (Cohen et al., 2018). Triangulation of both sets of data enhances the validity of the findings (Robson and McCartan, 2016). Mertens (2015) suggests that using the respective quality indicators for the quantitative and qualitative aspects of the study can be an appropriate method of appraising study quality. Specifically in relation to mixed methods research, it is suggested that the researcher considers the justification for adopting a mixed methods design, considers the match between the purposes and research question and the method chosen, and carefully considers the integration and interpretation of the findings (Mertens, 2015).

Teddlie and Tashakkori (2009) suggest *inference quality* incorporates both internal validity and credibility and refers to evaluating the conclusions made through integrating both the quantitative and qualitative findings. *Inference transferability* incorporates external validity and transferability and is the degree to which the conclusions drawn can be applied to other people and contexts (Teddlie and Tashakkori, 2009). The authors propose a framework of inference quality and transferability which consist of both ‘design quality’ and ‘interpretive rigour’. Design quality encompasses:

- Design suitability: the appropriateness of the methods in answering the research questions
- Design fidelity: the quality and rigor of design implementation
- Within-design consistency: compatibility of the components of the design (i.e. data collection procedures, sampling etc.)
- Analytic adequacy: appropriateness of data analysis procedures

A more detailed evaluation of how these pertain in the current study will be discussed in Chapter 5.

3.5 Development of the current survey

A bespoke survey instrument was developed by the researcher. The method of planning and developing the survey was informed by the stages outlined by Cohen et al. (2018) and Mertens (2015). This six-stage process is represented in Figure 3.1 and each stage is described in detail further below.

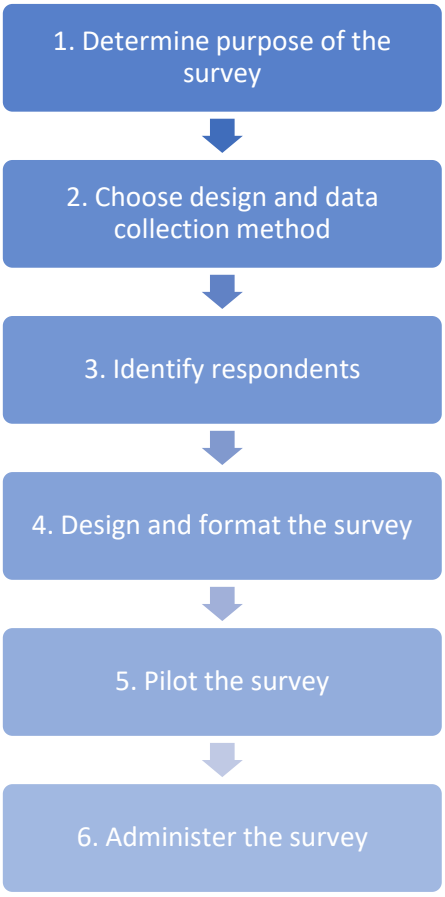


Figure 3.1: Process of developing the current survey

1. The purpose of the survey was informed by literature in Chapter 2, which identified the need to establish the current activities EPs carry out to support children and young people's mental health and to explore EPs' perceptions of their confidence, skills and knowledge in the area of SEMH. Exploring what opportunities exist for EPs to engage in SEMH work, considering barriers and facilitating factors, was felt to extend the current evidence base. The rationale for the study and research questions led to a survey being identified as a suitable method.

2. The purposes led to the design of an exploratory survey, aiming to describe the characteristics of a sample at one point in time (Mertens, 2015).
3. Participants for the research were identified as members of the EP profession[2].
4. The design of the survey considered the need for both quantitative and qualitative questions, the layout, organisation of the questions and response formats. This stage led to the creation of the survey on the web-based platform Qualtrics (https://www.qualtrics.com/uk). Further detail is provided in sections 3.5.1 and 3.5.2.
5. The survey was piloted to identify its utility and fitness for purpose. Questions and responses were amended accordingly (see section 3.5.3).
6. The survey was distributed: see Data Collection process (section 3.9) below.

3.5.1 Development of questions and rationale for inclusion

Survey questions related to each research question (appendix 4), with a rationale for their inclusion. Demographic questions assessed the representativeness of the sample and provided contextual information around responses.

Questions sought the information the researcher aimed to obtain, avoiding ambiguous wording (Cohen et al., 2018; Robson and McCartan, 2016). Questions were organised into a logical sequence (Mertens, 2015), through blocking questions that were related on the same page. Oppenheim (1966) suggests that the order of questions begin with factual questions before proceeding to attitudinal ones and placing demographic questions last. Thus, the logical sequence of the survey followed a format of beginning with unthreatening, factual, closed-ended questions and rating scales, before interspersing more sensitive closed-ended questions around EP opinions, attitudes and views. Open-ended questions were placed towards the end of the survey again interspersed amongst some closed-ended factual questions, before closing with demographic questions (Cohen et al., 2018). The types of response are considered below. See appendix 5 for a copy of the full survey.

[2] This included Trainee EPs and HCPC registered EPs at varying levels of the profession currently practising within England (see section 3.8)

3.5.2 Types of response

As a mixed methods survey, both closed and open-ended response formats were used. Closed-ended question formats included the use of multiple-choice (nominal data) and Likert scale responses (ordinal data). Participants had opportunity to give short narrative responses to open questions. Potential approaches and interventions were gathered from scoping EPS brochures to see which interventions and training were on offer, informing closed-ended response options.

Likert scales were adopted for the following topics:

- Frequency of EP involvement with SEMH casework
- Frequency of interventions
- The nature of this work, for example, at the individual, group or whole-school level
- EPs' views around their confidence, skills, and quality of initial professional training in SEMH, supervision and the priority and promotion of SEMH work in practice

A number of decisions were considered regarding the Likert scale development. The most common Likert scale has five fixed alternative expressions, usually labelled 'strongly agree', 'agree', 'undecided', 'disagree', 'strongly disagree' (Robson and McCartan, 2016). Questions concerning the frequency of EP work used a four-point rating scale with the labels 'frequently', 'sometimes', 'rarely' and 'never'. The remaining Likert scales assessing EPs' views utilised a five-point Likert scale (see example in Figure 3.2).



	Confident	Somewhat confident	Neither confident nor unconfident	Somewhat unconfident	Unconfident
Individual level	○	◉	○	○	○
Group level	○	○	○	◉	○
Whole school level	○	○	○	◉	○
Strategic/ Local authority	○	○	○	◉	○

Figure 3.2: Example of five-point Likert scale

The decision to include a neutral response on five-point Likert scales avoided forcing respondents to make a choice, which could lead to abandonment of the survey (Cohen et

al., 2018). The neutral response ‘unsure’ or ‘don’t know’ was provided, as appropriate (Figure 3.3).

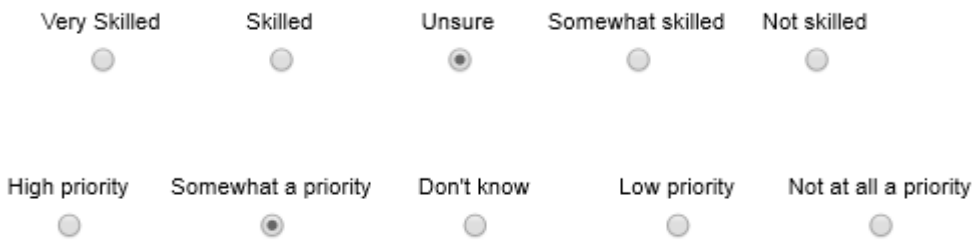


Figure 3.3: Example of neutral responses on five-point Likert scales

3.5.3 Piloting the survey

The questionnaire was pre-tested informally with colleagues to inform the questions, their wording, and response formats (Robson and McCartan, 2016). A formal pilot was then conducted with seven participants, with those in a variety of roles, seeking representativeness of the profession (see Table 3.3). Pilot participants were invited directly to take part via a link. Participants were asked to note how long the survey had taken, and to fill in a response feedback form to comment on the wording of questions and the response options provided. Participants were given opportunity to give additional feedback, on the addition or deletion of questions, the format of the survey and ease of use of the survey platform.

Role of pilot participants	Survey completed and data submitted	Feedback form provided
PEP	Yes	Yes
Member of AEP Executive	No	Yes
Senior EP	Yes	No
EP with SEMH specialism	Yes	Yes
Maingrade EP	No	Yes
Maingrade EP	Yes	Yes
Year 3 TEP	Yes	Yes

Table 3.3: Table to show the roles of pilot participants and details of pilot response

Feedback led to the following:

- Amending instructions to give further explanation around the response required
- Providing examples for responses
- Amending the wording of some questions
- Amending the response options on Likert scales, and adding ‘none’ and ‘unsure’ tick box options
- Adding additional options for types of training and interventions
- Adding a visual progress bar and a back button for ease of navigating the survey

More detailed pilot participant response feedback is provided in appendix 6.

3.6 Ethical considerations

The current study adheres to the BPS Code of Human Research Ethics (BPS, 2014) and the University of Nottingham Code of Research Conduct and Research Ethics (University of Nottingham, 2016). As such, ethical approval for this study was granted by the University of Nottingham’s School of Psychology Ethics Committee in July 2019 (appendix 7). Ethical considerations are outlined below.

Informed consent was ensured by dissemination of a recruitment letter (appendix 8) emailed out to services and posted to a professional forum, and an information sheet forming the front page of the survey. The information sheet gave full information around the purpose of the study, the research aims and questions, and instructions on how to complete the survey (appendix 5). Additionally, respondents were made aware that responses would form the researcher’s doctoral thesis and therefore may be published to support dissemination of the findings. Participants were required to select a button to provide their informed consent and that they understood their right to withdraw at any point by exiting the survey before submitting their responses.

Confidentiality was ensured by using an anonymous survey link, which gathered no information about the respondents. Participants were not asked for their name or the name

of the service they worked in. Participants were informed the data would only be used for the purpose of the study and were made aware of the potential risk of hacking. Upon completion of the survey, participants were provided with contact details of the researcher, the researcher's supervisor and the Chair of the Ethics Committee and reminded of the opportunity to ask questions. The data was downloaded onto an encrypted memory stick and stored in compliance with the Data Protection Act (2018).

3.7 Stakeholder engagement

A number of stakeholders of this study were identified:

- University of Nottingham: this study fulfils a research requirement of the Doctorate in Applied Educational Psychology
- EPSs: given the aim to inform and develop EP practice within this area, EPSs are considered a key stakeholder. The EPS in which the researcher completed their placement within the capacity of a TEP was also a key stakeholder
- EPs within England: EPs were key participants and the research aimed to inform and develop EP practice within the area of SEMH
- Children, young people and their families and schools: despite not being directly involved in the current research study, exploration of current EP practice and directions of future practice is thought to also benefit stakeholders that EPs work with in day-to-day practice

3.8 Participants and sampling

Small-scale surveys commonly employ non-probability samples (Robson and McCartan, 2016). The researcher attempted to ensure that a representative sample of the target population was recruited, by ensuring wide access to the survey. As such, a non-probability sampling technique was employed. The study employed multiple methods for participant recruitment to ensure a wide reach in order to maximise the number of surveys returned. This will be outlined in further detail in the data collection section (3.9) below.

Participants for the current study were identified as members of the EP profession. Purposive sampling ensures that the researcher accesses knowledgeable people by virtue

of their professional role (Cohen et al., 2018). Convenience sampling involves the use of readily available participants, and although frequently used as a sampling method in research, external validity is decreased (Mertens, 2015). A snowball strategy was also employed by requesting that EPs share the survey with colleagues to maximise the number of responses (Mertens, 2015). The researcher attempted to recruit participants at various levels of the profession including the initial stages of professional training (TEPs), those in promoted roles, through to PEPs.

3.9 Data Collection process

3.9.1 Recruitment of participants

An anonymous reusable link to the survey and a participant recruitment letter (appendix 8) were posted to 'EP-Net', a professional educational psychology email forum. The recruitment letter and link to the survey were also emailed to PEPs within different EPSs. The survey was also distributed by the professional body, the AEP via an email bulletin. Additionally, in line with a snowball sampling strategy, colleagues were asked to support with circulating the survey to other colleagues. Prompting emails and reminders were posted to EP-Net and emailed to colleagues to maximise the return rate.

3.9.2 Procedure

Data collection occurred through self-completion via the web-based survey. The participant recruitment letter was disseminated via email and included brief information about the study, a link to the survey, and detailed the time it would take to complete. The initial page of the survey detailed the information sheet (appendix 5), giving information around the purpose of the survey, the research questions, and how to complete the survey. Participants were asked to select a 'Yes' or 'No' box to provide their consent to participate in the study, and to confirm they were aware of how to ask questions, their right to withdraw, and their agreement to sharing their data anonymously.

Questions were grouped according to their content and presented on an individual screen with instructions around how to answer each. Participants were required to click 'next'

following the completion of each page and set of questions. At the end of the survey, demographic data was gathered such as the participant's age, gender, years practising as an EP, their level of qualification (i.e. Masters or Doctorate), and their geographical location to support the analysis of data. Upon submitting their data, participant responses were downloaded from the Qualtrics platform into the Statistical Package for the Social Sciences (SPSS, version 26) to support with analysis which will be discussed next.

3.10 Data analysis

Relationships and patterns in the quantitative data were explored through descriptive statistics and frequency data (Cohen et al., 2018). Qualitative data were analysed using qualitative content analysis (QCA) (Robson and McCartan, 2016; Schreier, 2012). Analyses were conducted separately and then combined through triangulation to generate meta-inferences about the data.

3.10.1 Conducting statistical analyses

Statistical power is the probability that the research will detect a true effect and will not find an effect where none exists; that is the probability of obtaining a statistically significant result (Cohen et al., 2018). Four factors affect statistical significance including: power, effect size, sample size and significance criterion. It is important to consider the sample size required in order to give a power that will produce a statistically significant result. Tabachnik and Fidell (2007) propose a formula to support with calculating the minimum sample size:

$$N > 50 + 8m$$

N = number of participants

M = number of independent variables

This study had 13 variables (current EP practice, competence, influencing factors, opportunities and 9 demographic variables) leading to a minimum sample size calculation as follows:

$$N > 50 + (8 \times 13)$$

$$N > 154$$

3.10.2 Data cleaning

A total of 335 responses were submitted. Of these, 155 were recorded as complete as participants had reached the end and submitted, leaving 180 partial responses which were treated as participant's right to withdraw and were not included in the final analysis. Of the 155 complete responses, some participants chose not to answer every question however, these were still included in the final analysis. Data were downloaded into SPSS which eliminated manual data entry by the researcher, achieving less error (Robson and McCartan, 2016). Data were screened, and partial responses and one duplicate submission were removed. Following this, quantitative and qualitative responses were separated, to enable analyses. A final number of 154 returned surveys were included in the overall analysis.

The survey produced nominal and ordinal level data, typically considered to be non-parametric (Cohen et al., 2018). Univariate analysis commenced with measures of central tendency, descriptive statistics and frequency data.

3.10.3 Conducting Content Analysis

Content analysis (CA) defines the process of summarising and reporting written data (Cohen et al., 2018) inferring answers to research questions from textual data (Krippendorff, 2004). It can be used in coding open-ended questions in surveys (Robson and McCartan, 2016; Weber, 1990) and uses both qualitative and quantitative operations on texts. This method was judged to be in line with the methods and aims of the current study.

Words are classified into fewer content categories based on their meanings or shared connotations (Weber, 1990). CA is a process of data-reduction through use of category counts, with frequency indicating the importance of, attention to, or emphasis on that idea or reference (Krippendorff, 2004; Weber 1990). Weber (1990) suggests there is no single right

way to do CA and that researchers must judge the methods appropriate to their research purposes.

QCA describes the meaning of qualitative material in a systematic way by classifying data in relation to a coding frame (Schreier, 2012). The current study followed the process outlined in Figure 3.4.

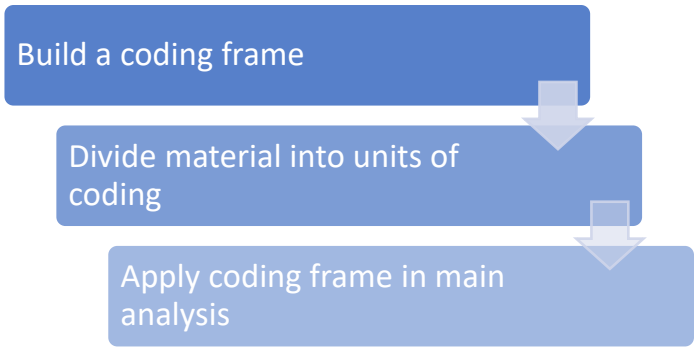


Figure 3.4: Process of Qualitative Content Analysis (adapted from Schreier, 2012).

A coding frame consists of main categories (the aspects of interest, largely directed by the research questions), and subcategories (what the data described about these main categories). Researchers usually employ a mixed strategy, generating a coding frame which is both concept-driven and data-driven (Schreier, 2012), which was adopted in the current analysis. The main categories were concept-driven, building on the existing survey structure and individual survey questions, informed by the literature. The survey therefore provided a deductive framework for generating the main categories and some subcategories of the coding frame. Additional subcategories were more data-driven, emerging from the data and therefore generated inductively.

The entire qualitative data set was consulted when building the coding frame and thus, was modified accordingly during this process. The coding frame was developed using traditional methods of textual analysis and followed a process of subsumption: coding data under already existing categories or creating further subcategories as necessary (Schreier, 2012). The units of coding were defined as the individual participant response to each question. Due to the volume of data, no formalised inter-rater reliability was calculated in relation to the coding. However, the researcher attempted to achieve reliability by reviewing codes with a

fellow researcher, an EP colleague, and their research supervisor, particularly for more conceptual categories related to more open-ended questions. As the study was primarily capturing descriptions of EP activity, and therefore created less conceptual categories, this was considered sufficient reliability.

The coding frame was built on NVivo (version 12), and raw data uploaded in preparation for the main analysis where the researcher applied the coding frame to each question and each qualitative response in turn (Schreier, 2012).

3.11 Summary of Methodology

This chapter discussed the rationale for adopting a mixed methods web-based survey design incorporating both quantitative and qualitative data, informed by the pragmatic paradigm. The quantitative and qualitative analyses are reported in the next chapter.

Chapter 4: Results

This chapter presents respondent characteristics followed by results in relation to each of the four research questions. Quantitative data are followed by qualitative data and syntheses of the findings, by question. Content analysis data tables, located in the Appendices, are cross-referenced throughout.

4.1 Characteristics of the sample

4.1.1 Respondent characteristics

Data from 154 respondents were included in the analysis. Maingrade EPs were strongly represented (see Table 4.1) and the majority, but not 100%, were trained to doctoral level. PEPs were underrepresented within the sample, however, may be less likely to be involved in a high level of individual casework and therefore may have found some questions less relevant to their main role. Two EPs reported having a specialism within SEMH.

Table 4.1: Number of respondents by role

Role	*N*	Percentage of sample
Maingrade EP	65	42.2%
Trainee EP	37	24.7%
Senior EP/ Senior Practitioner	28	18.2%
Newly Qualified EP	15	9.7%
Principal Educational Psychologist (PEP)	5	3.2%
Did not respond	4	2.6%
Total	**154**	**100%**

The majority of respondents worked full time (40.9%), followed by a high proportion of TEPs on a training bursary (23.4%) (Figure 4.1): 10 did not provide this information.

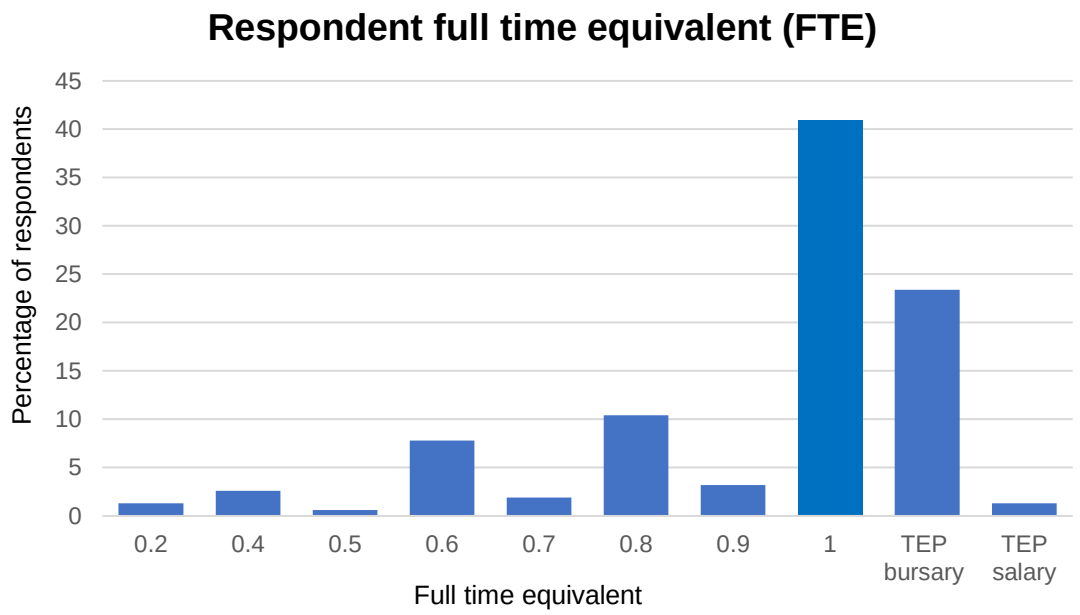


Figure 4.1: Bar chart to show the percentage of respondents by their full time equivalent (FTE)

Females were the highest number of respondents (Table 4.2) in line with the known high percentage of female representation within the EP profession (Lyonette et al., 2019).

Table 4.2: Characteristics of respondents by gender

Gender	*N*	Percentage of sample
Female	136	88.3%
Male	14	9.1%
Prefer not to say	2	1.3%
Did not respond	2	1.3%
Total	**154**	**100%**

The sample contained a significant representation of those in the younger age brackets (Figure 4.2): one person did not provide this information.

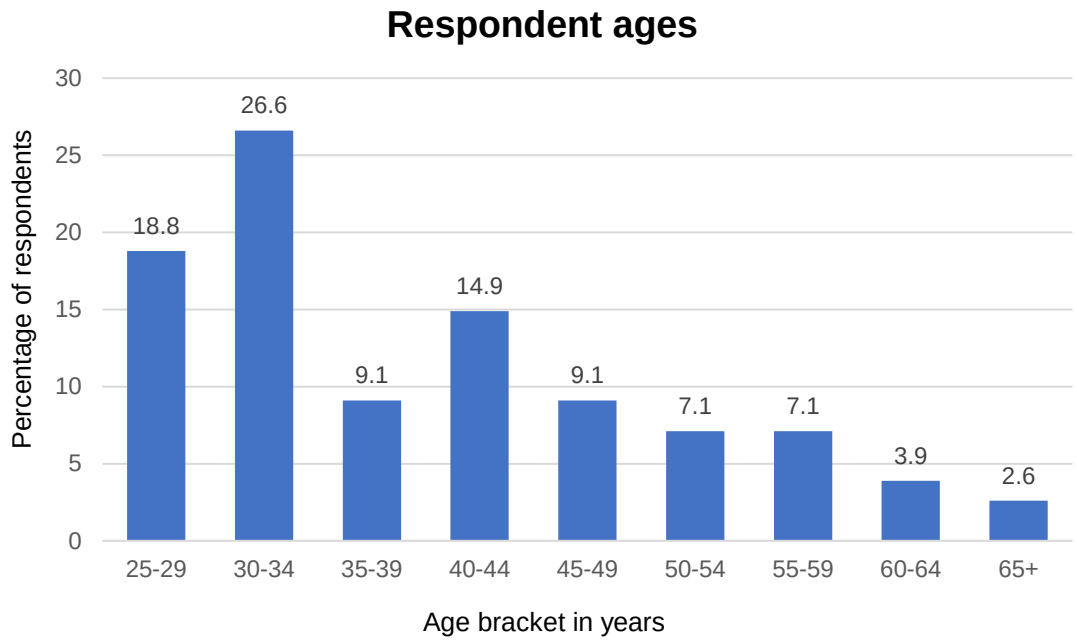


Figure 4.2: Bar chart to show the percentage of respondents falling in each age bracket

Respondents varied in the number of years they had been practising as an EP. The highest number of responses came from those practising for a smaller number of years and from TEPs in year 3 (Figure 4.3).

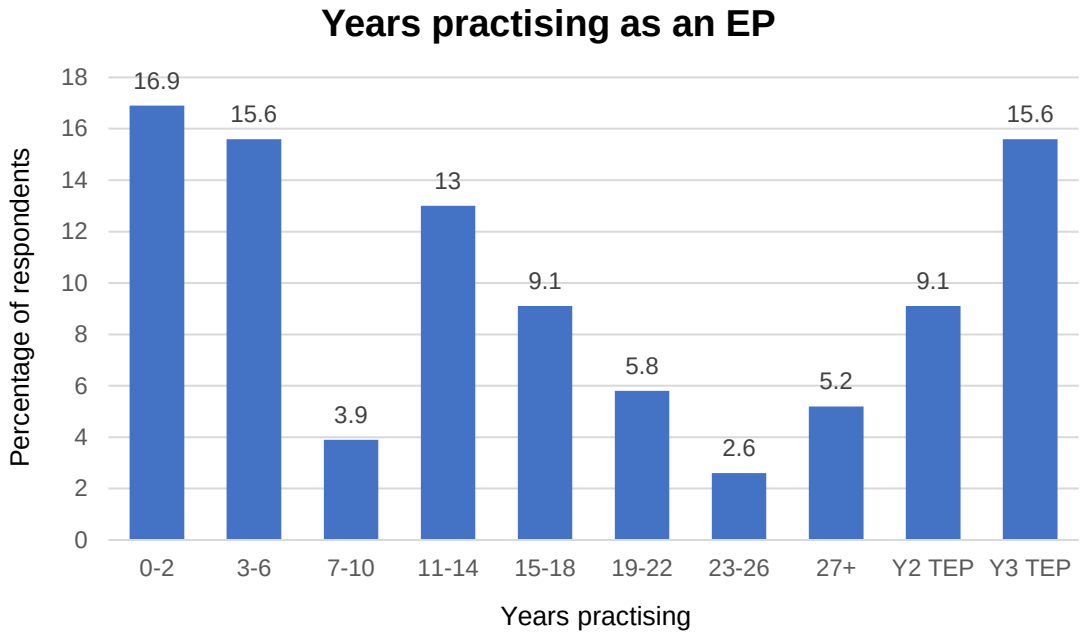


Figure 4.3: Bar chart to show the percentage of respondents by their number of years practising

Most participants had qualifications to doctoral level[3] (see Figure 4.4): four did not respond.

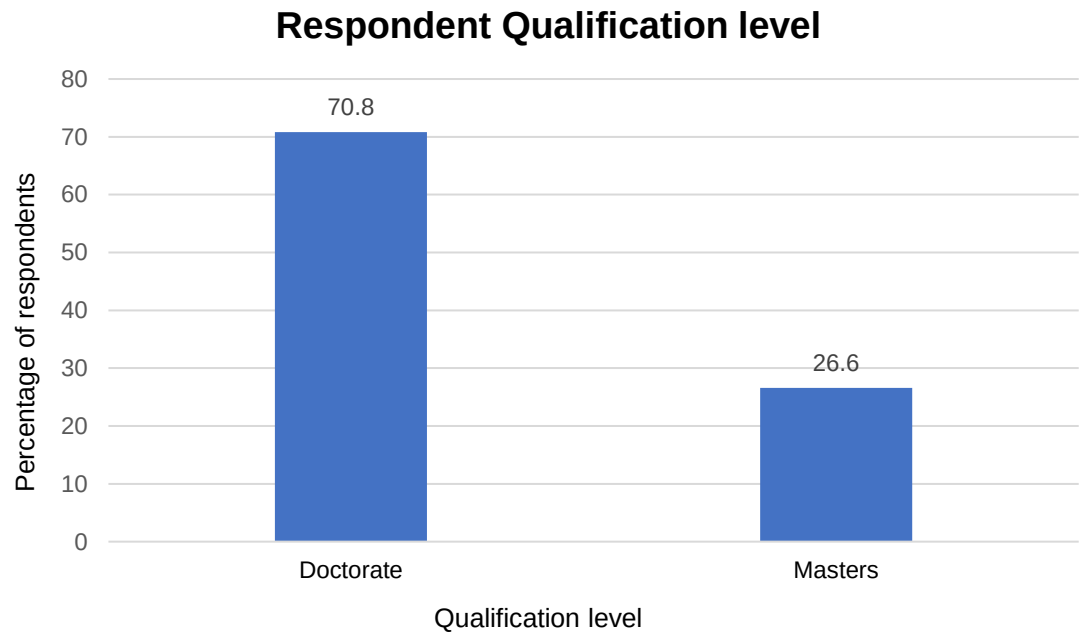


Figure 4.4: Bar chart to show the percentage of respondents in relation to their qualification level

[3] This includes initial training and CPD doctorates

4.1.2 Respondent region and service context

For geographical location (Table 4.3), the East and West Midlands regions were most strongly represented, potentially accounted for by the reach of the snowball sampling strategy.

Table 4.3: Respondent characteristics by region

Region	*N*	Percentage of sample
North West of England	14	9.1%
North East of England	6	3.9%
Yorkshire and The Humber	6	3.9%
West Midlands	25	16.2%
East Midlands	39	25.3%
East of England	8	5.2%
London	20	13.0%
South West of England	14	9.1%
South East of England	16	10.4%
Did not respond	6	3.9%
Total	**154**	**100%**

Respondents worked within different service delivery models (Table 4.4). The most common was that of local authority traded service delivery. EPs employed in other ways included working both for the local authority and in private practice, and those directly employed by a Multi Academy Trust of schools.

Table 4.4: Respondent service delivery model

Service delivery model	*N*	Percentage of sample
Local authority traded	73	47.4%
Local authority part-traded	52	33.8%
Local authority non-traded	12	7.8%
Private company	5	3.2%
Social enterprise	1	0.6%
Private practitioner	2	1.3%
Other	7	4.5%
Did not respond	2	1.3%
Total	**154**	**100%**

The majority of participants (38.3%) reported not knowing if they were working in an area located in a Trailblazer site for the Mental Health Green Paper proposals (Figure 4.5): 27.3% reported working in an area located in a Trailblazer site whilst 33.1% did not. Two participants did not respond.

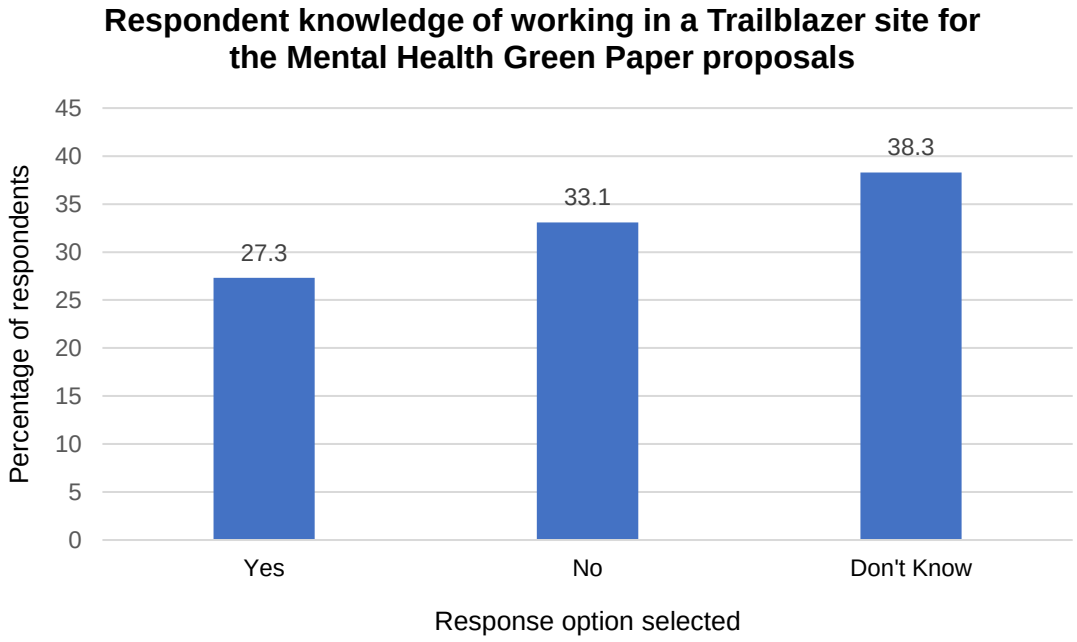


Figure 4.5: Bar chart to show the percentage of respondents working in a Trailblazer site for the Mental Health Green Paper proposals

4.2 Research Question One: What is current EP practice in supporting Children and Young people's mental health?

4.2.1 Descriptive analysis

Respondents identified how many individual children and young people they had been involved with through consultation, individual casework, and statutory assessment around SEMH needs in the last year (Table 4.5).

Table 4.5: Table to show frequency of responses for types of EP involvement with SEMH cases

Number of children and young people	Percentage of sample *(N)*		
	Consultation	**Individual casework (e.g. assessment/ intervention)**	**Statutory work**
0	3.2% *(5)*	1.9% *(3)*	3.9% *(6)*
1-5	13.6% *(21)*	13.6% *(21)*	23.4% *(36)*

5-10	13.0% *(20)*	14.9% *(23)*	28.6% *(44)*
10-15	15.6% *(24)*	18.8% *(29)*	16.9% *(26)*
15-20	12.3% *(19)*	19.5% *(30)*	13.6% *(21)*
20+	39.0% *(60)*	28.6% *(44)*	13.0% *(20)*
Did not respond	3.2% *(5)*	2.6% *(4)*	0.6% *(1)*

Most were involved with more than 20 children and young people with SEMH through either consultation or individual casework, such as assessments or interventions. The data shows less involvement with statutory work for children and young people with SEMH, with the most frequently occurring response being between 5-10 cases (see appendix 9 for further information).

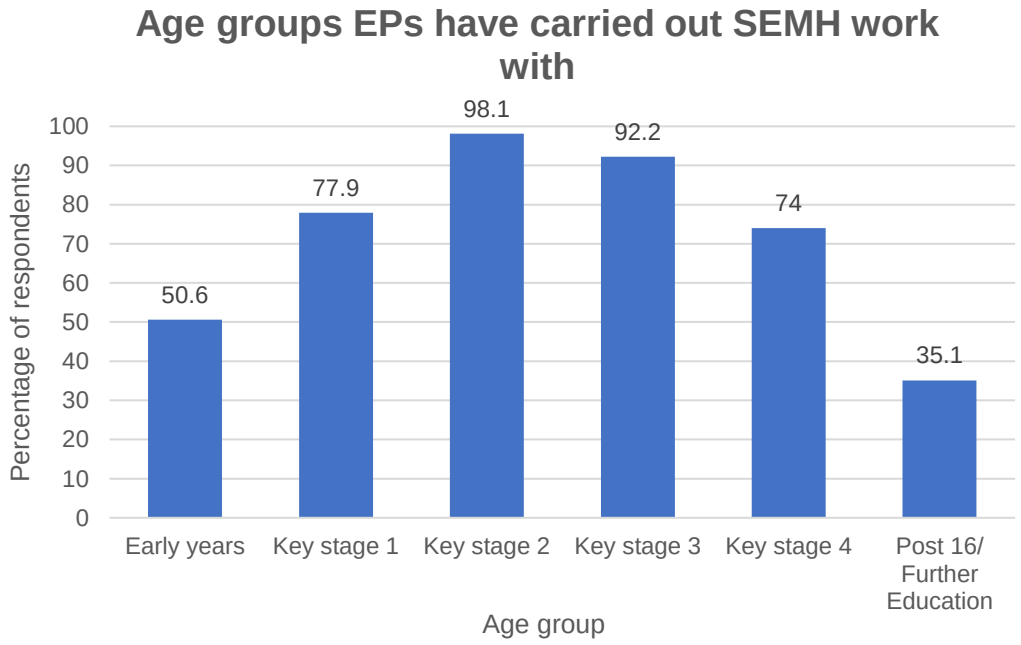


Figure 4.6: Bar chart to show the percentage of respondents reporting working with SEMH cases within each age group

Whilst involvement was with all ages around SEMH from Early Years (EYs) to Post-16 and Further Education (FE), the majority was with Key Stages 2 and 3 (Figure 4.6). Fewer worked with Post-16 and FE groups. Interestingly, around 51% of the sample reported

engaging in SEMH work within the EYs, where around 49% did not. Examples of work within key stages were analysed using content analysis, see section 4.2.2.

The majority were working with Key Stage 2 pupils the most (43%), closely followed by Key Stage 3 (40.9%) (Table 4.6). A smaller percentage reported EYs (2.6%) and Post-16 and FE (1.3%) as most frequently worked with. Thus, a significant minority of the sample reported working with those in the youngest and oldest age ranges most frequently, which may be explained by Post-16 being a relatively newly developing area of practice for EPs.

Table 4.6: Table to show the age range EPs report working with the most

Age group	*N*	Percentage of sample
Early Years	4	2.6%
Key Stage 1	10	6.5%
Key Stage 2	66	42.9%
Key Stage 3	63	40.9%
Key Stage 4	9	5.8%
Post-16 and Further Education	2	1.3%
Total	**154**	**100%**

Table 4.7 shows activities respondents are mostly involved in around SEMH: assessment, closely followed by consultation, contributing least to research around SEMH. Examples and 'other' responses can be found in section 4.2.3.

Table 4.7: Table to show respondents' activity within the area of SEMH

Activity	*N*	Percentage of sample
Assessment	149	96.8%
Consultation	147	95.5%

Intervention	125	81.2%
Training	130	84.4%
Research	45	29.2%
Other	27	17.5%

Respondents were asked about their involvement in supporting staff wellbeing (two did not respond to this question). Just under half reported delivering training around staff wellbeing and a high percentage (44.8%) were carrying out staff supervision (Table 4.8). Only 23% were not involved in supporting staff wellbeing, suggesting the remaining 77% are involved in some form. Additional activities given included group processes such as Force Field Analysis and group problem-solving sessions, critical incident and bereavement support, training, and informal support for staff wellbeing (appendix 10).

Table 4.8: Table to show percentage of respondents supporting staff wellbeing

Activity	***N***	**Percentage of respondents**
Training	74	48.1%
Supervision	69	44.8%
Staff support groups	43	27.9%
Other	40	26%
None	36	23.4%

The most reported intervention offered by EPSs was PCP[4], closely followed by MI, SFBT, and CBT-based interventions (Figure 4.7). Eye Movement Desensitisation Reprocessing (EMDR) and Dyadic Developmental Psychotherapy (DDP) were the least offered interventions. Five people did not respond to this question. Most frequently reported for the 'other' category were ELSA, Emotion Coaching (EC), Lego Therapy, Acceptance and

[4] References for interventions, resources and assessments which are reported in the results are offered in an additional reference list (page 185)

Commitment Therapy (ACT) and Mindfulness. A full list of additional interventions can be found in appendix 11.

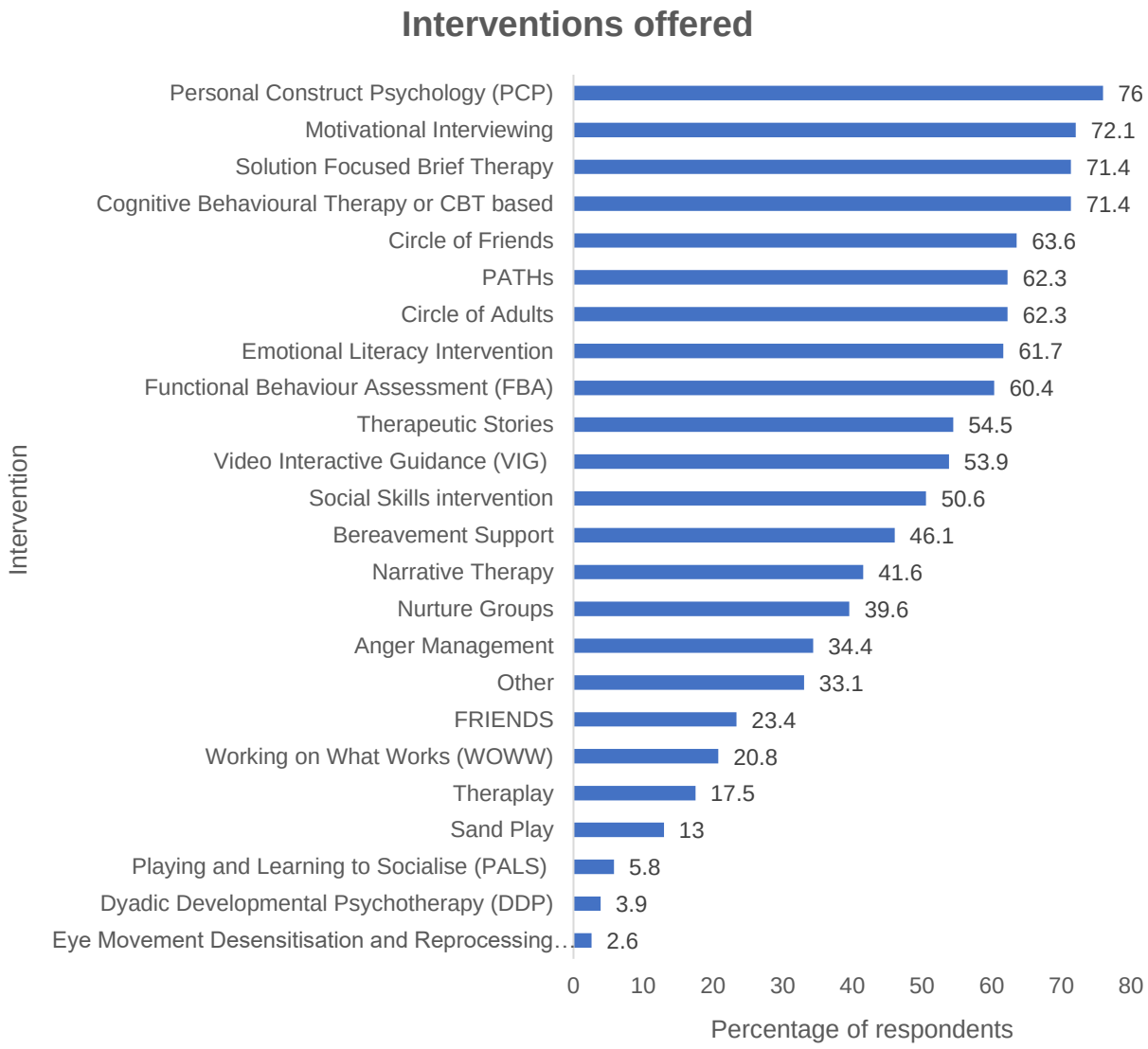


Figure 4.7: Bar chart to show percentage of respondents reporting interventions offered by them or their EPSs

Individuals were asked to rate the frequency with which they delivered each of the above interventions (Table 4.9)[5]. Two provided no data.

[5] DDP was not provided as a response option for participants in this question, therefore no data was collected regarding respondents' personal delivery of this intervention

Table 4.9: Table to show the frequency at which respondents personally carried out the interventions offered by their EPS

Intervention	Percentage of respondents				
	Frequently	**Sometimes**	**Rarely**	**Never**	**Did not respond**
Cognitive Behavioural Therapy or CBT based	5.2%	26.6%	40.3%	24.7%	3.2%
Motivational Interviewing	3.2%	21.4%	40.9%	26.6%	7.8%
Solution Focused Brief Therapy	14.3%	28.6%	32.5%	20.1%	4.5%
Circle of Adults	9.7%	29.9%	19.5%	33.8%	7.1%
FRIENDS	0%	2.6%	11%	74%	12.3%
Eye Movement Desensitisation and Reprocessing (EMDR)	0%	0%	0%	88.3%	11.7%
Therapeutic Stories	1.9%	14.9%	25.3%	50%	7.8%
Nurture Groups	3.9%	9.1%	14.3%	64.3%	8.4%
Functional Behaviour Assessment (FBA)	20.8%	37%	13.6%	22.7%	5.8%
Circle of Friends	1.3%	21.4%	33.1%	35.7%	8.4%
Narrative Therapy	4.5%	10.4%	20.8%	56.5%	7.8%
PATHs	9.7%	27.9%	22.7%	31.2%	8.4%
Social Skills intervention	5.2%	19.5%	27.3%	40.9%	7.1%
Playing and Learning to Socialise (PALS)	0%	0%	1.9%	87%	11%
Sand Play	0.6%	2.6%	4.5%	81.8%	10.4%
Video Interactive Guidance (VIG)	5.8%	9.1%	8.4%	67.5%	9.1%

Working on What Works (WOWW)	2.6%	5.2%	9.7%	72.1%	10.4%
Personal Construct Psychology (PCP)	28.6%	36.4%	18.8%	11%	5.2%
Bereavement Support	5.8%	20.8%	22.7%	43.5%	7.1%
Anger Management	3.9%	19.5%	22.7%	45.5%	8.4%
Theraplay	0.6%	2.6%	6.5%	81.2%	9.1%
Emotional Literacy Intervention	11%	22.7%	20.8%	38.3%	7.1%

PCP was the most frequently delivered intervention, followed by FBA (Table 4.9) although, the majority reported that they only delivered these interventions 'sometimes' (see descriptive statistics in appendix 12). Interestingly, although MI, SFBT and CBT-based interventions were offered by a high proportion of services (Figure 4.7), relatively small percentages of the sample reported delivering MI and CBT-based interventions themselves, with a high percentage noting they rarely delivered these interventions. SFBT was the third most frequently delivered intervention, yet most respondents rated their delivery of this as 'rarely' or 'never'.

Table 4.10: Table to show percentage of respondents delivering interventions at each level

Level at which interventions are delivered	**Percentage of respondents**				
	Frequently	**Sometimes**	**Rarely**	**Never**	**Did not respond**
Individual	61%	26%	9.7%	1.9%	1.3%
Group	11%	40.9%	35.1%	11%	1.9%
Whole-school	18.8%	27.9%	30.5%	19.5%	3.2%

Table 4.10 illustrates that interventions are most frequently delivered at the individual level, 'sometimes' at the group level, and 'rarely' at the whole-school level (see descriptive statistics in appendix 13). One participant did not respond.

Similarly, respondents were asked about training packages they or their EPS offered (Figure 4.8): six did not respond. The most reported training offered by EPSs was on attachment, followed by EC and ELSA. Working with puppets and anti-bullying training were offered least. 'Other' training can be found in appendix 14.

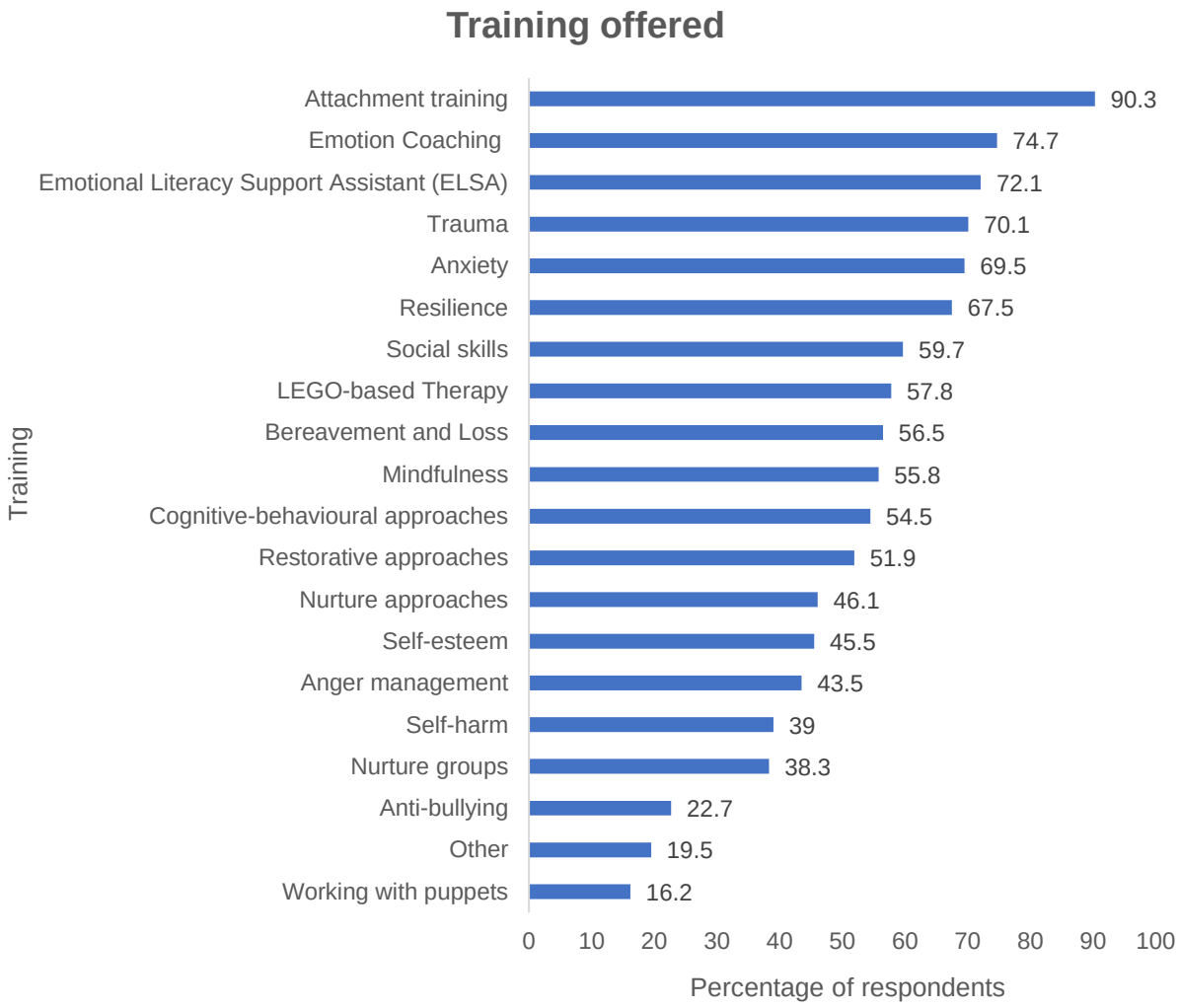


Figure 4.8: Bar chart to show percentage of respondents reporting SEMH training offered

Types of SEMH training delivered and at which level is shown in Table 4.11. Training was mostly delivered at the whole-school, then group levels, but some delivered training with parents or at the strategic or LA level. Examples at each level can be found in section 4.2.3.

Table 4.11: Table to show percentage of respondents delivering training at each level

Level at which training is delivered	***N***	**Percentage of sample**
Group	94	61.0%
Whole-school	106	68.8%
Parent	55	35.7%
Strategic or Local authority	57	37%
None	15	9.7%
Did not respond	3	1.9%

The majority of respondents believe that SEMH work should be part of the EP role (Table 4.12): one respondent disagreed.

Table 4.12: Table to show percentage of responses in relation to whether SEMH should be part of the EP role

SEMH work should be part of the EP role	***N***	**Percentage of sample**
Yes	152	98.7%
No	1	0.6%
Unsure	0	0%
Did not respond	1	0.6%

Most considered they would engage in SEMH work with a child or young person where another SEMH agency is involved (Table 4.13).

Table 4.13: Table to show percentage of respondents who would engage in SEMH work where another SEMH agency is involved

Engaging in SEMH work where another SEMH agency is involved	*N*	Percentage of sample
Yes	141	91.6%
No	13	8.4%

4.2.2 Content analysis of the work EPs reported at each Key Stage

Respondents provided examples of the types of work carried out with each age group at the individual, group, and systemic level (Tables 4.14-4.19). Frequencies are reported, accompanied by interpretative commentary, with illustrative excerpts from the content analysis[6]. Fuller tabulations are presented in the Appendices, and cross-referenced throughout, below.

Within the EYs age range, the most frequent activity was consultation followed by statutory work (Table 4.14). Reasons for involvement included challenging behaviour, children's early life experiences, or emotional and communication difficulties.

"Some of these children have been experiencing heightened levels of anxiety and have demonstrated challenging behaviour as a result."

Individual level involvement included consultation, *"helping schools to better understand the child's needs and implementing strategies"* (appendix 15), assessment such as play-based assessment or FBA, observation, and statutory work. Various support for settings, for example planning transition to primary and work with parents such as parenting interventions were reported as individual level work. Additionally, interventions such as VIG, with both parents and/or with setting staff were noted by a smaller number of EPs.

[6] Terms reflect those used by respondents, hence any variation, including acronyms which can be found in the Glossary of Terms (page 14).

Group and systemic level work around EYs included training and formal and informal group processes such as group consultation or Circle of Adults. Support was also offered for whole school policy or practice development or training in EC and contributing to an ASD pathway.

Table 4.14: Table to illustrate examples of EP activities across the individual, group and systemic level within the Early Years age range

Early Years	Subcategories	Frequency *(N)*
Individual level	Consultation	23
	Individual level – not specified	15
	Statutory assessment	12
	Observation	9
	Assessment	6
	Around challenging behaviour	4
	VIG	4
	Supporting settings	3
	Around emotional and communication difficulties	3
	Around children's early life experiences	2
	Support for parents	2
Group level	Training and group processes	2
Systemic level	Systemic level – not specified	4
	Training	4
	Policy and practice development	3
	Circle of adults	2

Similarly, within Key Stage 1 (Table 4.15), the most frequent activity was consultation: with setting staff, with parents and carers and sometimes jointly. Assessment was next frequently reported at the individual level, which included using tools to gather pupil views such as Bear Cards and strength cards, and more standardised cognitive assessments. Reasons for involvement with this age group included emotional difficulties, and young people being at risk of exclusion or disengaged with education.

"Pupil at risk of exclusion – direct work with pupil and family."

"Individual work around anxiety."

Individual level involvement included carrying out interventions and therapeutic work such as SFBT, MI and individual Build to Express sessions (appendix 16).

Group and systemic level work with this age range also included training. At the group level, processes such as group consultation, Circle of Adults or reflective teams were again reported, in addition to one example of a group intervention, *"Team of Life"*. Support was also offered for whole school policy or practice development, such as implementing whole school interventions.

Table 4.15: Table to illustrate examples of EP activities across the individual, group and systemic level within Key Stage 1

Key Stage 1	Subcategories	Frequency *(N)*
Individual level	Consultation	41
	Individual level – not specified	27
	Assessment	27
	Statutory assessment	18
	Intervention and therapeutic work	9
	Observation	9
	Individualised plans	5
	VIG	4
	Around emotional difficulties	3
	With those at risk of exclusion or disengaged with education	3
	Around trauma	2
	Multi-agency meetings	2
	Around challenging behaviour	1
Group level	Group consultation with adults around the child	4
	Group level – not specified	2
	Training	2
	Intervention	1

	Training	13
Systemic level	Whole-school policy and practice work	9
	Systemic level – not specified	8

Within Key Stage 2 the most frequent activity at the individual level was again consultation, (Table 4.16) including bookable consultations, closely followed by assessment work. Respondents described using FBA and gathering pupil views through various means such as PCP-based approaches and scaling activities. Additionally, EP assessment to support SEMH included more standardised assessments both of learning, using cognitive assessments, or standardised questionnaires such as the Resiliency Scales. Interventions were reported increasingly with this age range and included Lego-based therapy, CBT, Narrative therapy, SFBT, PCP and MI (appendix 17). Similar to above, reasons for involvement with this age group included emotional difficulties and young people at risk of exclusion, or disengaged with learning. In this phase, however, respondents also reported work around self-harm and Emotionally Based School Avoidance (EBSA).

"Therapeutic work with a CYP who exhibits self-harming behaviour"

"School refusal due to anxiety"

At the group level, respondents engaged in group consultation and staff supervision most frequently, noting more group interventions with this age range such as Circle of Friends and Therapeutic Story Writing groups. Training was delivered mostly at the systems level and included EC and training around attachment and trauma. Additionally, systems level work included whole school projects for example, the Attachment Aware schools project, school-based reviews and learning walks, and use of whole-school audit tools.

Table 4.16: Table to illustrate examples of EP activities across the individual, group and systemic level within Key Stage 2

Key Stage 2	Subcategories	Frequency *(N)*
	Consultation	39
Individual level	Individual level – not specified	37
	Assessment	35

	Interventions and therapeutic work	23
	Statutory assessment	20
	Observation	8
	Individualised plans	7
	Multi-agency meetings	6
	Around emotional difficulties	6
	Around trauma and attachment	3
	With disengaged learners	3
	Around self-harm	2
	Around EBSA	2
	Support for parents	2
Group level	Group consultation and staff supervision	15
	Intervention	8
	Group level – not specified	6
	Support for parents	4
	Training	3
Systemic level	Training	22
	Systemic level – not specified	10
	Whole-school policy and practice	12

A similar pattern was found within Key Stage 3: the most frequent activity was again consultation, followed by unspecified individual work, and assessment (Table 4.17). Similar to Key Stage 2, respondents noted FBA, gathering pupil views and using standardised assessments. They reported using additional standardised questionnaire measures such as the Beck Youth Inventory, Myself as a Learner Scale and The Self Image Profile (appendix 18). Interventions were delivered slightly less than with Key Stage 2 however included similar interventions such as CBT, MI, SFBT, PCP and ACT. Reasons for involvement were similar to Key Stage 2, however there was an increase in frequency around emotional difficulties, exclusion and particularly EBSA within this age group.

"Difficulties around anxiety, emotion regulation and behaviour management, LGBTQ+, emotional literacy difficulties, self-esteem and self-image issues"

"Individual casework with pupils who have been excluded due to 'challenging behaviour'"

At the group level, respondents facilitated group consultation and problem-solving most frequently, for example, PATHs, MAPs and Solution Circles, and fewer group interventions. Similar training and whole-school policy and practice work to Key Stage 2 was delivered at the systems level.

Table 4.17: Table to illustrate examples of EP activities across the individual, group and systemic level within Key Stage 3

Key Stage 3	Subcategories	Frequency *(N)*
Individual level	Consultation	36
	Individual level – not specified	33
	Assessment	30
	Statutory assessment	19
	Intervention and therapeutic work	14
	Around emotional difficulties	8
	Around EBSA	6
	Observation	4
	Those excluded or at risk of	4
	Individualised plans	4
	Multi-agency meetings	4
	Around difficult home life	2
Group level	Group consultation and problem-solving	12
	Group level – not specified	5
	Staff supervision	2
	Training	2
	Intervention	1
Systemic level	Training	18
	Systemic level – not specified	11
	Whole-school policy and practice work	10

Again, at Key Stage 4 consultation was closely followed by assessment (Table 4.18). Assessment work was similar to Key Stage 3, and although similar intervention approaches were used, such as SFBT, CBT, MI and ACT, less intervention work was reported with this

age range. Reasons for involvement were again around emotional difficulties, EBSA and exclusion. Respondents also reported involvement with 'at-risk' populations for example:

"Working with CYP who are being groomed/working county lines"

"Around social anxiety and school refusal"

Group and systems level work with this age range included training and group processes, such as using a PATH with a year 11 pupil to plan next steps (appendix 19). Only two group interventions were reported including working with whole classes around exam anxiety. Similar whole-school approaches and training were delivered to those at Key Stage 3.

Table 4.18: Table to illustrate examples of EP activities across the individual, group and systemic level within Key Stage 4

Key Stage 4	Subcategories	Frequency *(N)*
Individual level	Consultation	28
	Individual level – not specified	24
	Assessment	18
	Statutory assessment	15
	Interventions and therapeutic work	9
	Around emotional difficulties	7
	Observation	6
	Multi-agency meetings	4
	Around EBSA	4
	Individualised plans	3
	Around at-risk populations	2
Group level	Group consultation and problem-solving	8
	Group level – not specified	4
	Staff supervision	2
	Intervention	2
	Training	2
	Training	11

Systemic level	Whole-school policy and practice work	8
	Systemic level - unspecified	8

Within Post-16 or FE work, the most frequent activity was statutory assessment (Table 4.19). Respondents reported being involved with this age range mainly around emotional and mental health difficulties.

"SEMH needs at this stage have been largely related to anxiety"

"Pupils with mental health difficulties in preparation for post 16 education."

CBT-based interventions were the most common intervention with this age group (appendix 20), however similar to the EYs age range, respondents did not report engaging in intervention frequently in the Post-16 phase. Assessment included using approaches to gather pupil views, such as PCP activities or self-completion questionnaires; and standardised cognitive assessments, similar to those at Key Stages 3 and 4. A small number reported working at the group and systems level, without further detail.

Table 4.19: Table to illustrate examples of EP activities across the individual, group and systemic level within Post 16 or Further Education settings

Post-16 or Further Education	**Subcategories**	**Frequency *(N)***
Individual level	Statutory assessment	9
	Around emotional and mental health difficulties	8
	Around transition	4
	Intervention	4
	Assessment	4
	Consultation	4
	Observation	2
Group level	Consultation	2
Systemic level	-	3

4.2.3 Content analysis of the activities EPs engaged in

Activities were reported for SEMH at the individual, group and systems level (Tables 4.20-4.26).

Regarding consultation practice, respondents noted consultations with school staff the most, in addition to joint home-school consultations with parents and carers, and consultations with other professionals, including from social care (Table 4.20). At the individual level, consultations were held for a variety of purposes, such as providing feedback and generating strategies and next steps, and providing advice and support.

"Contributed feedback of Pupil Voice and DA during a consultation with setting staff, parents and other agencies"

Respondents noted several theories and approaches within consultation: solution-focused approaches most often. Other examples included drawing on an attachment framework and FBA guided consultation. At the group level, most examples were given for group consultation and group processes such as Circle of Adults, PATH, Solution Circles and group supervision (appendix 21). Two respondents reported using consultation at a systems level but did not elaborate.

Table 4.20: Table to illustrate examples of EPs' consultation practice across the individual, group and systemic levels

Consultation	Subcategories	Frequency *(N)*
Individual level	With school staff	64
	With parents and carers	46
	Type of consultation: joint home-school	37
	With other professionals	20
	With social care	10
	Type of consultation: Multi-agency meetings	9
	With the young person	8

	Purpose of consultation: Providing feedback and developing strategies and next steps	6
	Purpose of consultation: Advice and support	5
	Type of consultation: Co-constructing plans	3
	Purpose of consultation: Review meetings	3
	Purpose of consultation: supporting others' understanding	3
	With CAMHS	2
	Type of consultation: Person-centred meetings	2
	Type of consultation: Bookable or Drop-ins	2
Group level	Consultation and group processes	16
	Joint consultations with groups of staff	5
	Joint consultations with school staff, parents and carers	4
	Joint consultations with other professionals	1
Systemic level	-	2

Respondents reported assessment of pupil views the most (Table 4.21) through a variety of techniques such as PCP, for example the Ideal Self, solution-focused approaches involving scaling, MI, and Kinetic Family Drawing (appendix 22). Additionally, a number of standardised tools and questionnaires such as Beck Youth Inventories, Boxall Profile, and Emotional Literacy Checklist were used. Other assessment activities included observation, statutory work, working with school staff, and carrying out learning assessments using both cognitive and dynamic assessment (DA). Assessment also included *"play/ games-based assessment"* and FBA. A small number reported consultation to form part of their assessment. At the group level, reports included FBA and assessment of *"class dynamics"*. Whole school policy and practice work included the use of the Boxall Profile at a whole school level and conducting pupil focus groups.

Table 4.21: Table to illustrate examples of EPs' assessment practice across the individual, group and systemic levels

Assessment	**Subcategories**	**Frequency *(N)***
Individual level	Assessment of pupil views	84
	Individual level – not specified	35
	Observation	19

	Statutory work	15
	Approaches to assessment	14
	Working with school staff	12
	Learning assessment	12
	Working with parents	11
	Purpose of assessment: assessment of needs, strengths and recommendations	7
	Purpose of assessment: Formulation of individual needs	5
	Purpose of assessment: Analysis of data	5
	Consultation	5
	Working with other professionals	3
	Around a variety of needs	3
	Purpose of assessment: Assessment of emotional literacy	2
	Purpose of assessment: Pre- and post- therapeutic work	1
Group level	Whole class	2
	Approaches	1
Systemic level	Whole-school policy and practice work	4

A wide range of interventions at the individual level included solution-focused interventions, therapeutic story writing, CBT and MI (Table 4.22). Respondents also reported indirect advice and support such as *"collaboratively co-constructing recommendations with school staff and parents"* (appendix 23). The most reported intervention carried out with staff was VIG. A range of group interventions were noted such as managing exam anxiety and CBT-based groups. WOWW was the only intervention specified for whole-class work, mentioned by three respondents. At the systems level, training staff in interventions and implementing whole school interventions such as EC were reported. Some barriers to intervention work were identified including having the opportunity to deliver interventions whilst training but not since qualification or wanting increased training and supervision.

Table 4.22: Table to illustrate examples of EPs' intervention practice across the individual, group and systemic levels

Intervention	Subcategories	Frequency *(N)*
Individual level	Interventions and therapeutic work for young people	59
	Indirect advice and support	22
	Individual level – not specified	18
	Intervention with staff	12
	Support for parents	6
	Assessment as intervention	2
	Individualised plans	1
Group level	Intervention for young people	20
	Staff support and group problem-solving approaches	10
	Whole-class work	7
	Group level – not specified	4
Systemic level	Training	5
	Whole-school support	3
	Systemic level – not specified	2
	Circle of Adults	1

Training was delivered at a range of different levels (Tables 4.23-4.26), through a variety of formats such as centrally organised training to SENDCos and workshops for parents and staff at a Sure Start centre. One participant reported school funding as a barrier to delivering training.

At the group level, a wide range of training was delivered though mostly around interventions (Table 4.23). Respondents gave examples of training around mental health and emotional wellbeing specifically such as anxiety, resilience and *'Mental Health First Aid'*. Training around attachment and trauma were also mentioned often. Training aimed to raise staff awareness and understanding around specific topics for example, EBSA, self-esteem, and Selective Mutism. A full list of the reported delivered training at the group level can be found in appendix 24.

Table 4.23: Table showing examples of training delivered by EPs at the group level

SEMH related training EPs delivered at the group level		
Subcategories	**Frequency *(N)***	**Examples of training** **(Frequency of individual training *N*)**
Intervention approaches	93	• ELSA (23) • Emotion Coaching (12) • Lego-based therapy (10) • CBT approaches (8) • Mindfulness (6) • Nurture groups (5) • SFBT approaches (4) • Motivational Interviewing (3)
Around mental health and emotional wellbeing	24	• Anxiety (12) • Resilience (3) • Emotional wellbeing and Emotional Development (2) • Mental Health First Aid (1)
Attachment and trauma informed	18	• Attachment (10) • Attachment and trauma-informed (6) • Trauma-informed (2)
Raising staff awareness and understanding around topics	15	• Emotionally-based School avoidance (3) • Self-esteem (3) • ADHD (2) • Selective Mutism (1)
Practice development	9	• Restorative Approaches (4) • Solihull Approach (2)
Bereavement loss and Critical Incidents	8	• Loss and Bereavement (7) • Critical Incidents (1)
Group Process	5	• Solution Circles (2) • Circle of Adults (2) • Process Consultation (1)

At the whole-school level, training was again delivered around interventions the most, closely followed by attachment and trauma (Table 4.24). Similar to the group level, examples were given of training around mental health and wellbeing specifically such as resilience, and anxiety and stress. Training around whole-school approaches such as Restorative

approaches and Emotionally Friendly Schools were also reported. A full list of reported whole-school training can be found in appendix 25.

Table 4.24: Table showing examples of training delivered by EPs at the whole-school level

SEMH related training EPs delivered at the Whole-school level		
Subcategories	**Frequency *(N)***	**Examples of training** **(Frequency of individual training *N*)**
Intervention approaches	72	• Emotion Coaching (36) • Mindfulness (6) • Lego based therapy (5) • ELSA (4) • Nurture approaches (4) • CBT approaches (2) • SFBT approaches (2) • Motivational Interviewing (2)
Attachment and trauma	55	• Attachment (33) • Attachment and trauma-informed (13) • Trauma-informed (9)
Mental Health and Wellbeing specific	37	• Resilience (13) • Anxiety and stress (10) • Mental Health and wellbeing (8) • Self-harm (3) • Emotional literacy (2) • Mental Health First Aid (1)
Raising staff awareness and understanding around topics	18	• ADHD (5) • Foetal Alcohol Syndrome (1) • Autism and SEMH needs (1) • Emotionally-based school avoidance (1) • Supporting LGBTQ+ pupils (1)
Whole-school approaches	13	• Restorative Approaches (8) • Emotionally Friendly schools (2) • Anti-bullying pledge (1) • Solihull Approach (1) • Sandwell Wellbeing Chartermark (1)
Bereavement and loss	8	• Bereavement and Loss

Understanding and managing behaviour	6	• Understanding functions on behaviour (2) • De-escalation (2) • Managing challenging behaviour (1) • Promoting Positive Behaviours (1)
Staff Wellbeing	6	• Staff wellbeing (5) • Staff support groups (1)

Respondents were also delivering a range of training with parents such as parenting approaches and interventions; EC and VIG most frequently (Table 4.25). Similar to training at the other levels, examples illustrated raising awareness and understanding around emotional and mental health difficulties, such as anxiety and bereavement and loss. Training included around needs such as attachment and trauma and Autism, and with foster carers and adoptive parents. Parenting courses were delivered by a small number. A full list of training with parents can be found in appendix 26.

Table 4.25: Table showing examples of training delivered to parents by EPs

SEMH related training EPs delivered with parents		
Subcategories	**Frequency *(N)***	**Examples of training** **(Frequency of individual training *N*)**
Parenting approaches and interventions	18	• Emotion Coaching (11) • VIG (3)
Raising awareness and understanding around emotional and mental health difficulties	13	• Anxiety (7) • Bereavement and loss (3) • Understanding SEMH needs of your child (2) • Managing anger with your child (1)
Raising awareness and understanding needs	12	• Attachment and trauma (6) • Autism (3) • Selective Mutism (1)
Workshops and parenting support	9	• Parent workshops around behaviour (3) • Confidence building (early years) (1) • School attendance (1) • Making sense of the Teenage Brain (1)

Parenting courses	5	• Incredible Years Parenting Courses (1) • Triple P Teen Courses (1) • Triple P 1:1 Courses (1)
With foster carers and adoptive parents	4	• 18-week attachment course for adoptive parents, foster carer & Special Guardian training • Foster carer training in emotion coaching
Participation in group processes	1	• MAP, PATH

At the strategic or LA level, training around mental health and wellbeing topics were most reported, for example, around resilience or self-harm (Table 4.26). This was closely followed by intervention approaches, with ELSA and EC reported most. Additionally, training was delivered to a variety of other professionals and groups of schools across the LA. A full list of the reported delivered training at the strategic or LA level can be found in appendix 27.

Table 4.26: Table showing examples of training delivered by EPs at the strategic or LA level

SEMH related training EPs delivered at the strategic or LA level		
Subcategories	**Frequency *(N)***	**Examples of training** **(Frequency of individual training *N*)**
Mental health and wellbeing	26	• Resilience (11) • Self-Harm (3) • Mental Health First Aid (2) • Mental Health and Wellbeing (1) • Anxiety and Depression (1)
Intervention approaches	23	• ELSA (9) • Emotion Coaching (6) • Restorative Practice (3) • Motivational Interviewing (2)
Attachment and trauma	12	• Attachment (5) • Trauma-informed (4) • Attachment and trauma-informed (3)

Raising awareness and understanding around topics	7	• Emotionally based school avoidance (2) • Human Givens (2) • ADHD awareness (1)
To other services and groups of staff across schools	7	• Training to other LA colleagues such as SALT, PHYSIO, Learning Support • Capacity Building across all primary and secondary schools
Bereavement, loss and critical incidents	5	• Grief and loss training and critical incident management to groups of head teachers/SENCOs (1)
Staff support	4	• Staff support groups (1) • Person centred planning (1)

Respondents mentioned systems level and LA research the most for example, around exclusions (Table 4.27). Practice-based evidence research was also highly reported followed by action research projects and evaluations of interventions and training. The examples noted in Table 4.27 illustrate significantly bespoke and contextualised projects. Doctoral thesis research, noted below, was reported by 13 respondents, one of which did not specify their topic.

Table 4.27: Table to illustrate examples of EPs' involvement with research around SEMH

Research		
Subcategories	**Frequency *(N)***	**Illustrative quotes**
Systems level and LA research	8	As a TEP, research into exclusion rates across a LA Secondary school staff audit across LA re most prevalent SEMH staff would like support with
Practice-based evidence research	8	Gathering Voice of young people about what is important to them at school from ethnic diverse backgrounds Links between being in care and youth crime

Action research and projects	6	Action research on attachment in the classroom, action research in developing trauma-informed behaviour policies Supporting whole school audits - collaborative action research
Evaluation of interventions or training	6	Evaluating SEMH programmes & interventions LA evaluation of the ELSA programme
Thesis research: interventions for anxiety	3	Current thesis research for doctorate. Looking at the impact of a mindfulness-based intervention on anxiety in children with Autism.
Thesis research: Research with staff and parents	3	Doctoral thesis looking at Adolescent SEMH needs and how parents can support these
Thesis research: Whole-class or whole-school approaches	3	Thesis research focusing on Human Givens as a whole school approach to SEMH
Thesis research: Vulnerable Groups	2	Thesis research into gaining CYP's views of Selective Mutism using PCP technique
Thesis research: Exclusion	1	Thesis research: An Appreciative Inquiry of factors which enable success at secondary school for students who have experienced fixed-term school exclusion

Other examples of SEMH work (appendix 28) included being involved in policy and practice development around SEMH (Table 4.28) for example:

"Promoting ideas around limiting exclusions across schools and at a city level"

"I am currently contributing to policy development within the local authority. We are putting together a trauma-informed behaviour policy for all schools in the area and I have been part of a working group developing this document"

Participants were also providing supervision and support, such as ELSA supervision, and were involved in systemic projects.

"Co-running our County's TaMHS Programme in terms of overseeing the work and recruiting schools into the programme."

"Systemic work about school non-attenders for pupils in specialist ASD provision and mental health needs"

Table 4.28: Table to illustrate 'other' examples of EPs' involvement with SEMH work

Other examples of SEMH work	
Subcategories	**Frequency *(N)***
Policy and practice development	10
Supervision and support	8
Systemic projects	7
Collaborative work	2

4.2.4 Synthesis of quantitative and qualitative findings of current EP practice around SEMH

Most respondents were involved with more than 20 children and young people with SEMH, suggesting a high level of SEMH work in the last year. Work in Key Stages 2 and 3 were most common for SEMH, and with Post-16 and FE age groups the least, potentially reflecting the relatively new area of practice for EPs. The sample appeared to be split regarding EYs work, with around half reporting involvement around SEMH and half not, indicating varied involvement.

Involvement at each age phase occurred for various reasons, however the level of reported SEMH difficulties appeared to increase with age. Particularly, difficulties related to EBSA and self-harm were first reported at Key stage 2, with an increased rate of reported EBSA, emotional difficulties and exclusions at Key Stage 3. Involvement with the Post-16 and FE age range appeared to be predominantly around emotional and mental health difficulties. Given these findings, it may be interpreted that EPs are less involved in early intervention

and prevention around SEMH. Further, EPs appear to be most involved with young people prior to, and after, transition to secondary education.

Although consultation and assessment were the most common activities around SEMH, data indicated that EPs engaged in SEMH work across all five core functions of the role (Scottish Executive, 2002), and at multiple levels of the system. Of these core functions, consultation occurred most frequently with all age phases except for Post-16 and FE. Quantitative data suggested that respondents mainly delivered interventions at the individual level although, most described this as 'sometimes' or 'rarely'. Interestingly, data highlighted that training was considered an intervention at the systems level, and a small number considered consultation to form part of their assessment, showing interrelations between the five core functions of the role. Across all age phases, training was the most common systems level work: the most frequent types delivered at all levels were around intervention approaches such as EC, attachment, mental health and wellbeing, and raising awareness of specific topics such as EBSA and Selective Mutism. Additionally, a high percentage (77%) reported supporting staff wellbeing, mainly in the form of training, followed by staff supervision. Although least reported, various examples of SEMH research were given.

Despite comparatively less involvement with statutory work for children and young people with SEMH, 26.6% of respondents reported statutory involvement with 15 or more cases in the last year. Statutory assessment was also the most frequently reported involvement with Post-16 and FE age groups, with qualitative data suggesting this was mainly around mental health needs. Additionally, respondents appeared to be involved with statutory assessment more frequently than therapeutic intervention with older age groups.

4.3 Research Question Two: What are EPs perceptions of their confidence, skills and knowledge in relation to mental health work?

4.3.1 Descriptive analysis

Respondents reported most confidence around individual level SEMH work (Table 4.29). The highest percentage for the response 'unconfident' related to work at the strategic or LA level. Combined scores for 'confident' and 'somewhat confident' across each of the levels

showed mostly strong confidence: Individual 91.6%; Group 80.6%; Whole-school 76%; Strategic/LA 50%. Descriptive statistics are located in appendix 29. Content analysis of the examples of the work respondents were confident to engage in, at all levels, can be found in section 4.3.2.

Table 4.29: Table to show EPs' confidence in their approach to SEMH work at different levels

Level at which EPs work	Percentage of sample				
	Confident	**Somewhat confident**	**Neither confident nor unconfident**	**Somewhat unconfident**	**Unconfident**
Individual	44.8%	46.8%	6.5%	1.3%	0.6%
Group	31.2%	49.4%	9.7%	8.4%	1.3%
Whole-school	33.8%	42.2%	7.8%	14.3%	1.9%
Strategic or local authority	22.1%	27.9%	18.2%	20.1%	11.7%

Most (77.9%) felt ‘somewhat confident’ or ‘confident’ working with other agencies (Table 4.30). While none were ‘unconfident’ a small percentage reported feeling ‘somewhat unconfident’.

Table 4.30: Table to show EPs' confidence working with other agencies around SEMH

Level of confidence	***N***	Percentage of sample
Confident	53	34.4%
Somewhat confident	67	43.5%
Neither confident nor unconfident	15	9.7%
Somewhat unconfident	18	11.7%

Unconfident	0	0%
Did not respond	1	0.6%
Total	**154**	**100%**

Most (76.6%) respondents rated themselves as ‘skilled’ working in the area of SEMH (Figure 4.9).

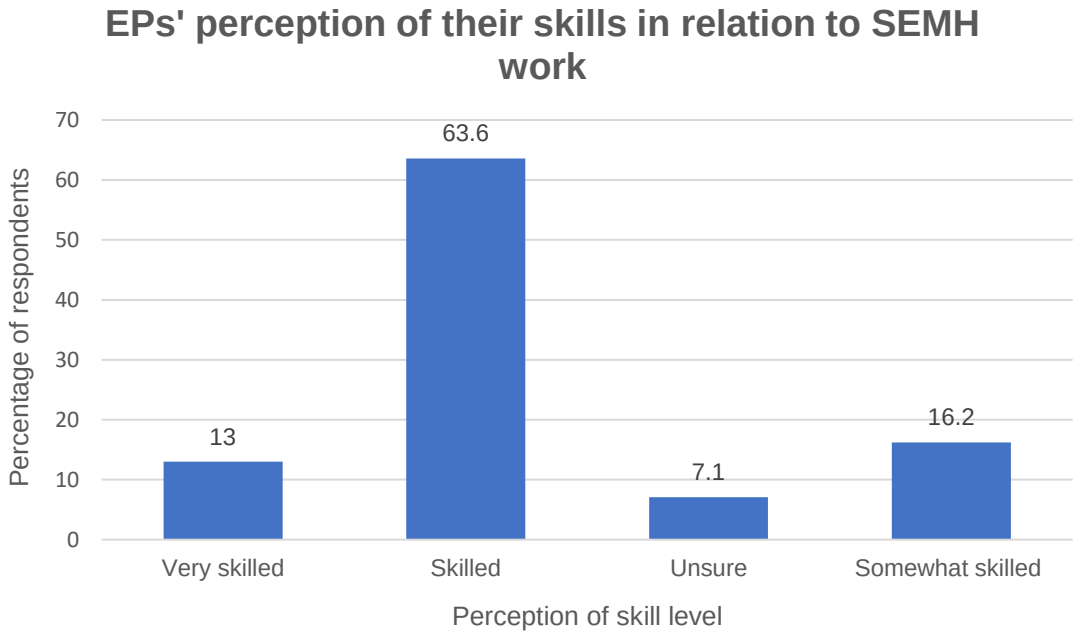


Figure 4.9: Bar chart to show EPs' perception of their skills in relation to SEMH work

Most felt ‘well supported’ in engaging in SEMH work as a result of their initial professional training, followed by ‘somewhat supported’ (Figure 4.10). A significantly small percentage of the sample reported feeling ‘not well supported’, however, many examples of CPD and further training were given, mostly around intervention approaches (see appendix 30).

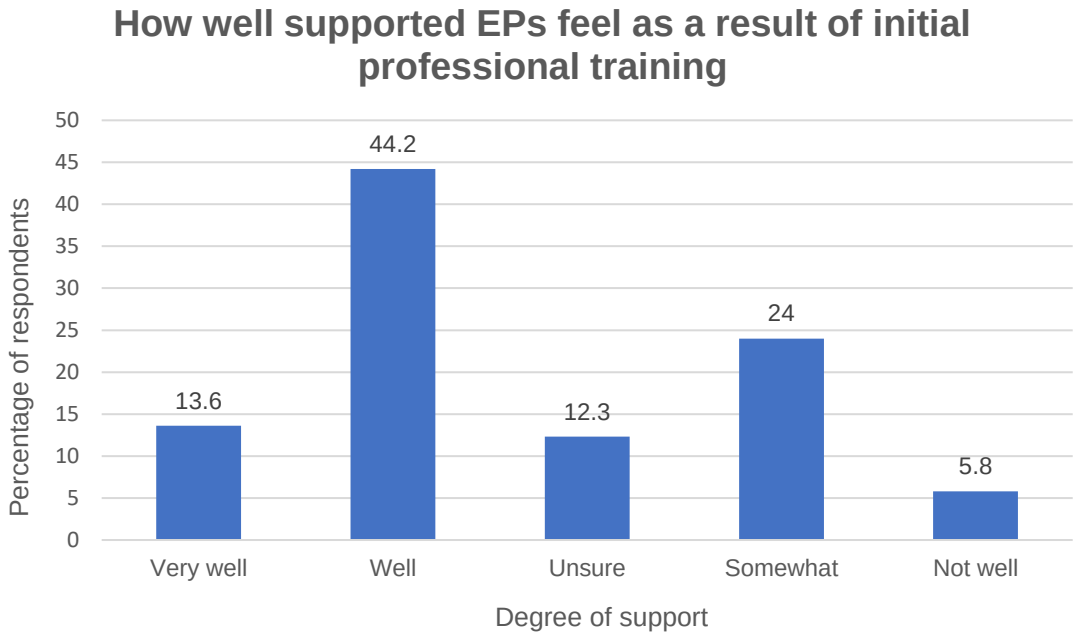


Figure 4.10: Bar chart to show how well supported EPs feel as a result of their initial professional training

Similarly, most felt 'well supported' or better (total 74.7%) by professional educational psychology supervision around their work involving SEMH (Figure 4.11). A significantly small percentage felt 'not well' supported. Interestingly, a higher percentage reported feeling 'very well supported' by supervision in comparison to feeling 'very well supported' by their initial professional training. One person did not respond to this question.

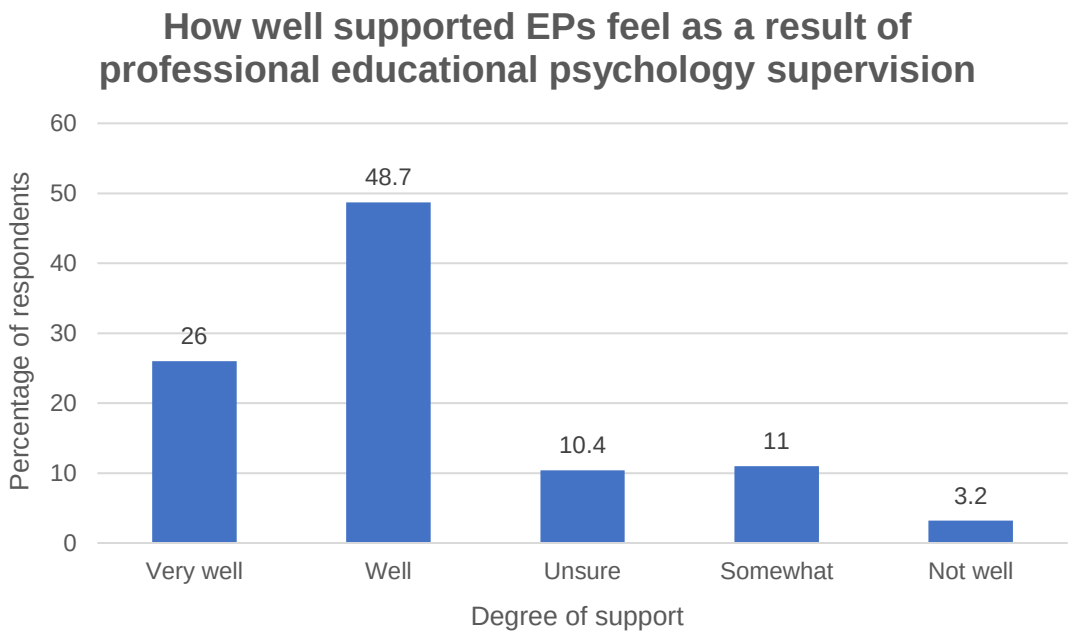


Figure 4.11: Bar chart to show how well supported EPs feel as a result of professional educational psychology supervision

4.3.2 Content analysis of examples of the activities EPs were confident to engage in

Respondents gave examples of the activities that they were most confident to engage in at the individual, group and systems levels (appendix 31-34).

At the individual level, respondents expressed confidence most often around engagement in interventions such as CBT, PCP and solution-focused work (Table 4.31). In assessment, respondents reported confidence in formulation and hypothesis development; in assessing needs such as resilience and self-esteem and adopting assessment techniques such as FBA and solution-focused scaling.

Table 4.31: Table to illustrate examples of activities EPs are confident to engage in at the individual level

Activities EPs are confident to engage in at the Individual Level	
Subcategories	**Frequency *(N)***
Interventions	82
Assessment	52
Consultation	20

Listening to young people and gathering their views	15
Supporting school staff and families	8
Triangulating views from others	4

Respondents reported confidence most often around interventions at the group level such as CBT based group work, noting also a variety of group consultations and use of group processes such as PATH, Solution Circles and Circles of Adults. There was confidence in delivering training at the group level to parents, in addition to training staff in the delivery of interventions such as ELSA, ACT and mindfulness. Additionally, facilitating peer and group supervision and delivering ELSA supervision were activities respondents felt confident with.

Table 4.32: Table to illustrate examples of activities EPs are confident to engage in at the group level

Activities EPs are confident to engage in at the Group Level	
Subcategories	**Frequency *(N)***
Intervention	69
Group consultation	38
Training	29
Supervision	12

At the whole-school level, confidence was most often around delivering whole-school training, with topics such as ELSA, attachment and trauma, bereavement and resilience. Respondents were confident supporting whole-school policy and practice development through audits, evaluation and reviewing and consulting with schools around policies.

"Introducing planning and reflection tools the school can then use for individual children"

"Consultation relating to whole school practices and policies relating to behaviour"

Group processes to support organisational change around SEMH needs, for example, Circle of Adults, PATHs and Force Field Analysis were also used with confidence.

Table 4.33: Table to illustrate examples of activities EPs are confident to engage in at the whole-school level

Activities EPs are confident to engage in at the Whole-school Level	
Subcategories	**Frequency *(N)***
Training	89
Policy and practice development	19
Consultation and group processes	15

At the Strategic and LA level, respondents stated confidence in delivering a wide range of training for example, anger management, MI, mindfulness, and EC. Respondents were confident in supporting project work for example, around inclusion or SEMH.

"Supporting the LA with implementation of the Wider Inclusion Strategy"

"Contribution to LA-wide initiatives to develop a strategic response to meeting SEMH needs"

Respondents described feeling confident in multi-agency liaison and in contributing to policy and guidance development. Two reported a lack of confidence in working at this level.

"Building support networks within the profession and organisation to help us to do our work well"

"Developing behaviour policy guidance & systems for graduated approach"

Table 4.34: Table to illustrate examples of activities EPs are confident to engage in at the strategic or LA level

Activities EPs are confident to engage in at the Strategic or LA Level	
Subcategories	**Frequency *(N)***
Training	30
Supporting project work	17
Multi-agency liaison	11
Policy and guidance development	10

4.3.3 Content analysis of the skills EPs perceived to be important when working within the area of SEMH

The importance of good interpersonal skills, such as being able to build relationships and rapport, and having empathy were noted the most important skills when working with schools around SEMH (Table 4.35).

"Building rapport and relationships with staff, parents, young people and other professionals."

"Understanding and having empathy with the student, parent and teachers"

Respondents highlighted skills such as attunement and being able to create trusting relationships. They also described being relatable and approachable to young people and families and being person-centred.

Consultation skills were identified as important, including organisational consultation skills, use of questioning to unpick needs, reframing needs and problems, and being a critical friend offering *"support and challenge"*. Linked to both consultation and interpersonal skills were good communication skills such as listening and being able to communicate psychological knowledge in a clear manner.

"Clear communication in the psychology that is being shared so that this is understood, relevant and able to inform practice"

Interestingly, respondents gave a range of qualities and values which they perceived as 'skills'. These included being open-minded, reflective, patient, creative, resilient, compassionate, and being inclusive and demonstrating anti-oppressive practice.

"You are aware of power, difference"

"Inclusive mindset and working towards preventing exclusions"

A number of respondents considered therapeutic skills as important, for example creating unconditional positive regard, a sense of containment and empowering adults around the child. Problem-solving skills were also important, particularly in supporting formulation around behaviour, unmet needs and collaboratively developing solutions to move situations forward.

"Being able to support formulation of the young person's situation to help increase understanding for the young person, staff and family"

Respondents also perceived using their knowledge as an important skill when working around SEMH, citing, for example, knowledge and understanding of mental health needs, child development, and psychological theory and research.

"Understanding of the wider impact of SEMH difficulties on learning and development"

"Understanding of key theories / concepts that underpin SEMH e.g. resilience, sense of belonging etc"

Additionally, respondents recognised their understanding of the school context as contributing to skilled work around SEMH. Furthermore, being collaborative was also reported as important *"to develop a shared understanding/ working hypothesis development with stakeholders".* Some reported that adopting a holistic approach was an important skill, in addition to their application of psychology and theoretical approaches for example, using models to guide formulation. A full list of reported skills can be found in appendix 35.

Table 4.35: Table to show the skills EPs reported as being important when working with schools around SEMH

Important skills when working with SEMH	
Subcategories	**Frequency *(N)***
Interpersonal skills	78
Consultation skills	45
Communication skills	43

EP qualities and values	35
Therapeutic skills	27
Problem-solving skills	23
Knowledge and understanding of mental health needs	20
Being collaborative	20
Knowledge of psychological theory and research	18
Taking a holistic approach	12

4.3.4 Content analysis of the theories and paradigms reported to guide EP practice in the area of SEMH

Respondents reported theories around attachment and trauma most often, followed by solution-focused approaches and PCP (Table 4.36).

"Personal Construct Psychology; behaviour always makes sense to the person who is exhibiting them and understanding where they are coming from and their construct of the world supports to understand the behaviour."

Ecosystemic theories such as Bronfenbrenner's bioecological model (Bronfenbrenner, 1979) were also frequently reported as guiding practice in this area, allowing EPs to adopt a *"holistic"* and *"interactionist perspective"*. Other frequent theories were behavioural theories such as Social Learning Theory, theories around functional behaviour and cognitive behavioural theories.

Respondents also reported a group of humanistic theories such as Maslow's Hierarchy of Needs (Maslow, 1954) and being *"person-centred"* as guiding their practice within SEMH work. Additionally, Positive Psychology and strengths-based approaches were considered important when working with SEMH.

"Positive psychology as many people with SEMH needs struggle to hold onto what they want to achieve and find it difficult to identify their strengths and what, if anything, is going well. This is one of the reasons I find approaches like PATHs so helpful."

There were references to various relationship-based theories, such as relational approaches, EC, attunement and VIG principles, nurture approaches and Restorative Practice informing work in this area. Respondents reported employing frameworks and models such as consultation frameworks and problem-solving models to guide their practice with SEMH work. Additional theories reported can be found in appendix 36.

Fewer reported the *paradigms* informing their practice around SEMH needs, however, behavioural and humanistic paradigms were most common (see appendix 37). Two respondents also highlighted the importance of adopting an eclectic approach to SEMH needs by adopting various theories and paradigms to reflect the broad range and individual nature of SEMH needs.

Table 4.36: Table to show the most common theories reported to guide EP practice in the area of SEMH

Theories guiding EP practice in the area of SEMH	
Subcategories	**Frequency *(N)***
Attachment and trauma theories	75
Solution-focused approaches	34
Personal Construct theory	31
Ecosystemic theories	30
Behavioural theories	28
Cognitive-behavioural theory	28
Humanistic theories	25
Positive Psychology and strengths-based approaches	20
Relationship-based theories	19
Frameworks and models	10

4.3.5 Synthesis of quantitative and qualitative findings around EPs' confidence, skills and knowledge in relation to SEMH work

Findings suggest that overall, respondents are confident engaging in varied work around SEMH, at multiple levels, including within multi-agency work. Greatest confidence for SEMH

work was at the individual level, and least in relation to strategic or LA levels. This may be expected, given that EPs reported less involvement within SEMH work at the strategic and LA level. Nevertheless, confidence was expressed around delivering training most frequently at this level. Additionally, although respondents described confidence with most core functions of the role, research was not mentioned, perhaps reflecting that respondents reported contributing less to research around SEMH. One may question whether the reported lack of opportunities to engage in research *contribute* to respondents not reporting confidence with research or whether EPs do not utilise their research skills *because* they feel less confident.

Analyses illustrated that most respondents perceived themselves to be skilled in relation to SEMH work, providing a wide range of skills and knowledge that the EP profession contribute. The wide range of theories and paradigms guiding practice around SEMH suggest a broad knowledge base in this area.

Whilst most felt well supported as a result of their initial professional training and their professional supervision, respondents appeared to feel better supported by current supervision than their initial professional training, which may be supportive to continuing development in this area.

4.4 Research Question Three: What factors are influencing the delivery of mental health work?

4.4.1 Descriptive analysis

Participants were asked to identify barriers to engaging in SEMH work that they experienced and were given the option to indicate 'other' barriers (appendix 38). 'Time constraints' was most frequently reported, followed by the level of statutory work (Table 4.37). Least reported was 'lack of opportunities', 26%, suggesting that there is opportunity, but not always the circumstances, to facilitate SEMH work.

Table 4.37: Table to show the frequency of barriers to EPs engaging in SEMH work

Barriers to engaging in SEMH work	*N*	Percentage of sample
Time constraints	100	64.9%
Levels of statutory work	84	54.5%
Trading	76	49.4%
Competing work demands	49	31.8%
Provision from other mental health agencies (such as CAMHS)	46	29.9%
Lack of opportunities	40	26%
Other	35	22.7%
Did not respond	15	9.7%
Total	**154**	**100%**

4.4.2 Content analysis of the barriers to engaging in SEMH work reported by EPs

Respondents reported several interrelated barriers to engaging in SEMH work (Figure 4.12). Frequency tables relating to this data can be found in appendix 39-44. Time constraints hindered the potential for longer term involvement in SEMH work for example, for ongoing direct work and therapeutic intervention. Further, it was noted that this affected the quality of involvement, impacting on respondents' ability to "*fully explore SEMH needs"*, "*be involved at a deeper level"*, and to see young people regularly. Respondents' service context contributed to this for example, their model of service delivery or working within LA constraints.

"Often within the consultation model of service delivery, we only have time for an initial consultation, some information-gathering work with the young person and a review consultation."

Time constraints were reported to arise from the demand for statutory assessment of SEN, which often took priority over other work, with some reporting this was also prioritised by schools. Linked to this, some considered trading of EPS work as a barrier, describing that schools did not prioritise SEMH work, such as therapeutic intervention or systems work.

"High level of statutory work means that there is little flexibility within the EP role; statutory demands often mean that we are not able to use our full skill set."

"Schools appear reluctant to spend their time and money on ongoing direct work which much SEMH interventions would require."

These factors restricted the type of work engaged in, for example, carrying out assessments but not intervention, limited engagement in "*in-depth SEMH work or training at an organisational level"*, and less multi-agency working. Some reported being a costly service in comparison to others delivering support around SEMH. Schools might prioritise other agencies for involvement or prioritise individual work *"for educational assessment"* rather than systems work. There were, therefore, restrictions in the opportunities to engage in varied SEMH work for a variety of reasons, including the perception of the EP role by others: some describing that EPs are not seen to have a role in SEMH or beyond learning needs.

"CAMHS are in every school so we rarely receive referrals for SEMH that are not statutory, and this is disappointing."

With regard to provision from other mental health agencies, respondents reported an absence of multi-agency working on the whole particularly between EPs and CAMHS. Additionally, long waiting lists for CAMHS was suggested to create barriers to children, young people and their families accessing support. A small number also noted that the capacity and skills of other agencies can create barriers, for example feeling that CAMHS staff are better placed to offer support in this area.

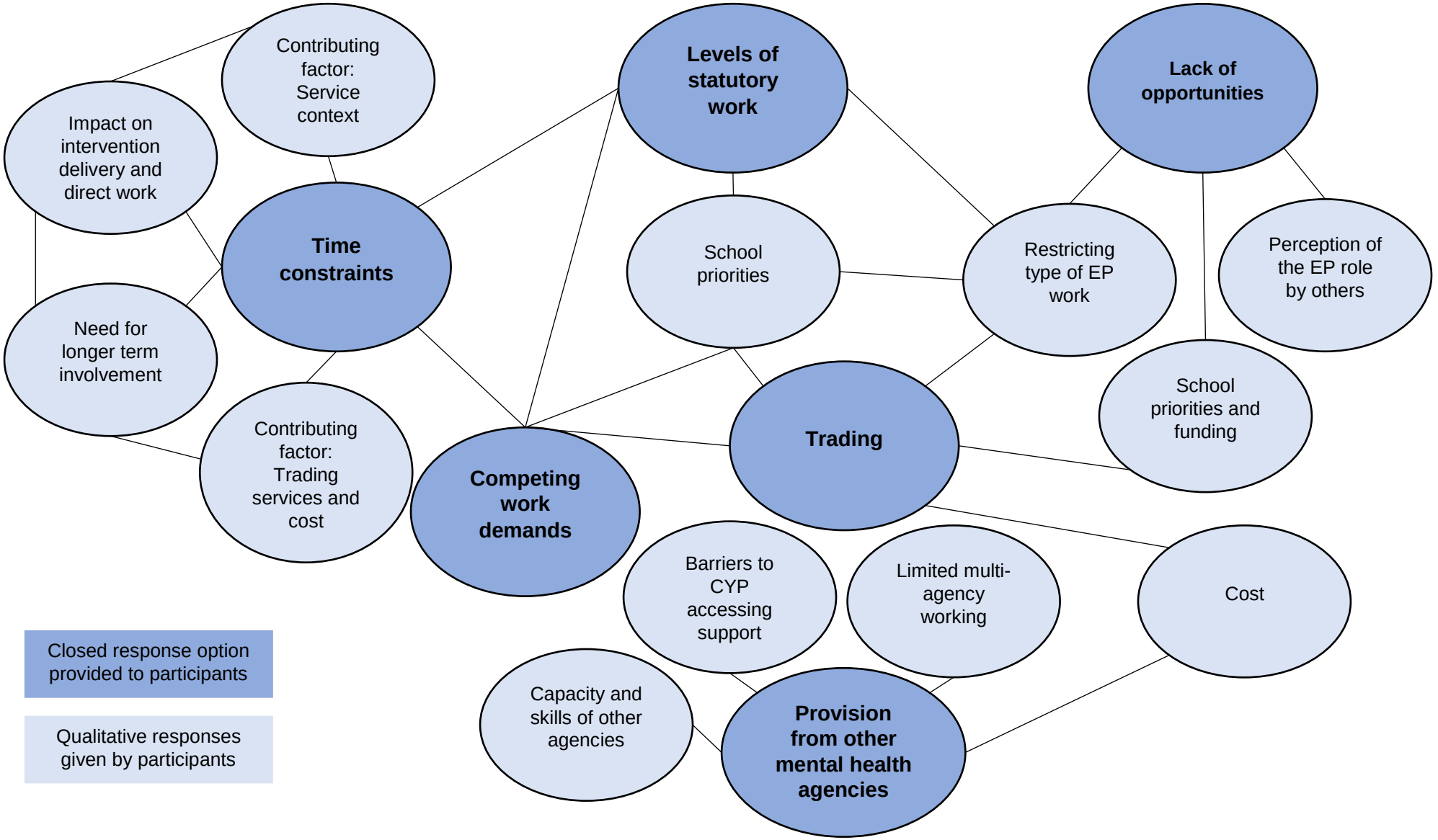


Figure 4.12: Concept map to illustrate the barriers EPs reported facing when engaging in work around SEMH

4.4.3 Content analysis of the facilitative factors to engaging in SEMH work reported by EPs

Respondents were asked if there were any factors that supported their engagement in SEMH work (Table 4.38) (appendix 45).

Table 4.38: Table to show the facilitative factors to engaging in SEMH work reported by EPs

Facilitative factors to engaging in SEMH work	
Subcategories	**Frequency *(N)***
School awareness of EP contribution	16
Supervision	15
Schools with increased awareness and understanding of the importance of SEMH	13
CPD, attendance at training events and conferences	13
Support from senior leaders	12
LA support	12
Relationships with schools	12
Relationships with other professionals and multi-agency work	12
Delivering training and project work	11
High levels of need	10
Promotion and communication of work	9
Knowledge, skills and experience within the team	9
Service reputation and being valued	9
Service ethos and culture	8
Service priority and commitment	8
Specialist roles	7
Supportive service and team	7
Initial training	6
Trading	6
EPs skills and knowledge	6
Virtual school funding and opportunities	6
Flexibility of the service	6
Working outside the LA	4
Supportive systems within the service	4
EPs interest and motivation	4
Policy and guidance	3

The facilitative factors most reported were schools' awareness of EPs contribution, and supervision. Having relationships with schools facilitated a fuller understanding of the EP role and contribution and has enabled schools to value EP input within this area.

"Having established relationships with schools which has led to a fuller understanding of the EP role and what the EPS might be able to offer in terms of supporting YP with SEMH needs, and staff in supporting YP."

An increased awareness and understanding on the part of schools of the importance of SEMH also facilitated EPs engagement with this domain, for example, schools therefore prioritising traded packages for therapeutic involvement. Supervision was a frequently reported facilitative factor, including some peer supervision models, such as within-service group supervision. Two respondents reported supervision delivered by those other than EP colleagues, such as by a CBT practitioner and by clinical psychology colleagues. Additionally, opportunities for CPD and training events and conferences were seen to facilitate engagement in SEMH work.

Support from various sources such as from the LA and from senior leaders were factors facilitating EP work around SEMH. LA support included being an inclusive LA, a focus on reducing exclusions, supporting the SEMH of young people, and recognising that EPs have a role in this. Senior leaders such as senior EPs and PEPs were described to be 'promoting' the EPS within the LA and giving time to EPs to pursue areas of interest and need. Relationships were also reported to be key, both with schools and with other professionals through multi-agency work. A small number described positive relationships with CAMHS, with health colleagues and with the youth justice team. Further, respondents felt part of a supportive team and benefitted from the knowledge, skills and experience of their colleagues; one reported that they were situated in a clinical team and another noted their supervisor was also a CBT practitioner.

A number of service factors included: the reputation of the service and being valued by both schools and the LA; SEMH being a service priority and commitment; and the ethos and

culture of the service, including flexibility and ability for EPs to engage in varied and creative opportunities.

4.4.4 Synthesis of quantitative and qualitative findings around barriers and facilitators to engaging in SEMH work

Qualitative responses illustrated interrelations between reported barriers and suggest complexity to the factors hindering EP engagement in SEMH work. Furthermore, qualitative data illuminated additional barriers such as the perception of the EP role by others, the service or LA context respondents were working within, and limited multi-agency working. Content analysis allowed for exploration around how these factors were experienced by EPs in practice, for example: the combination of time constraints, statutory work and trading leading to competing work demands and contributing to a 'lack of opportunities' to engage in SEMH work.

Despite reporting a number of barriers, respondents also highlighted numerous facilitative factors, with two respondents facing no barriers. Most frequently reported was schools' awareness of the EP contribution in the area of SEMH, supported by the relationships EPs developed with schools. Respondents shared that supervision and opportunities for CPD and training facilitated their engagement within SEMH work, with a small number receiving supervision from external professionals. This could be perceived to be supportive to EPs' confidence and competence when engaging in SEMH work and therefore suggestive of additional facilitative factors. In contrast, a small number highlighted opportunities for training and supervision, and their confidence and skills as barriers.

Total frequency counts suggest that slightly more barriers to engaging in SEMH work were given than facilitative factors. Variance may be explained by individual factors, for example, service and LA context, school funding and priorities, and individual relationships with schools. However, some barriers may be shared more widely across the profession for example, the perception of the EP role, particularly by the government or key stakeholders, and increased statutory work, however the variation within this is acknowledged. The data therefore suggests that various helping and hindering factors influence EPs' delivery of mental health work, and that facilitators for some may be barriers for others.

4.5 Research Question Four: What are the opportunities for engaging in mental health work?

4.5.1 Descriptive analysis

Table 4.39 illustrates that most systems or organisational work in relation to SEMH was delivered within primary settings (59.1%), and in Post-16 or FE settings the least (5.2%). 'Other' opportunities, and examples of the work within each setting is presented in section 4.5.2.

Table 4.39: Table to show the frequency of EPs engaging in systemic or organisational work across different educational settings

Settings	*N*	Percentage of sample
None	28	18.2%
Early Years	11	7.1%
Primary	91	59.1%
Secondary	75	48.7%
Post-16/ Further Education	8	5.2%
Other	19	12.3%
Did not respond	6	3.9%
Total	**154**	**100%**

Most reported that they engaged with multi-agency work around SEMH 'sometimes' (Figure 13). 'Frequently' and 'rarely' were rated at a similar percentage suggesting that engagement in multi-agency work varies.

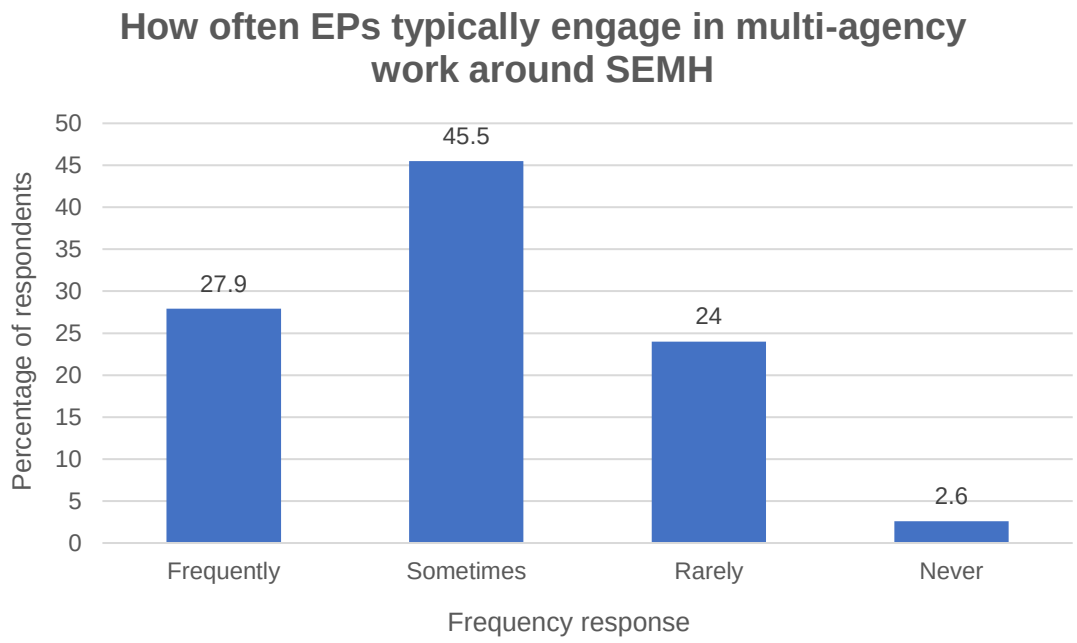


Figure 4.13: Bar chart to show how often EPs typically engage in multi-agency work around SEMH

The majority (77.9%) had not been considered a 'Lead Professional' within any mental health work (Figure 4.14). Among those who had, this was whilst no other agencies or professionals were involved, and one reported that they would only lead the case up to the point of referral (appendix 46).

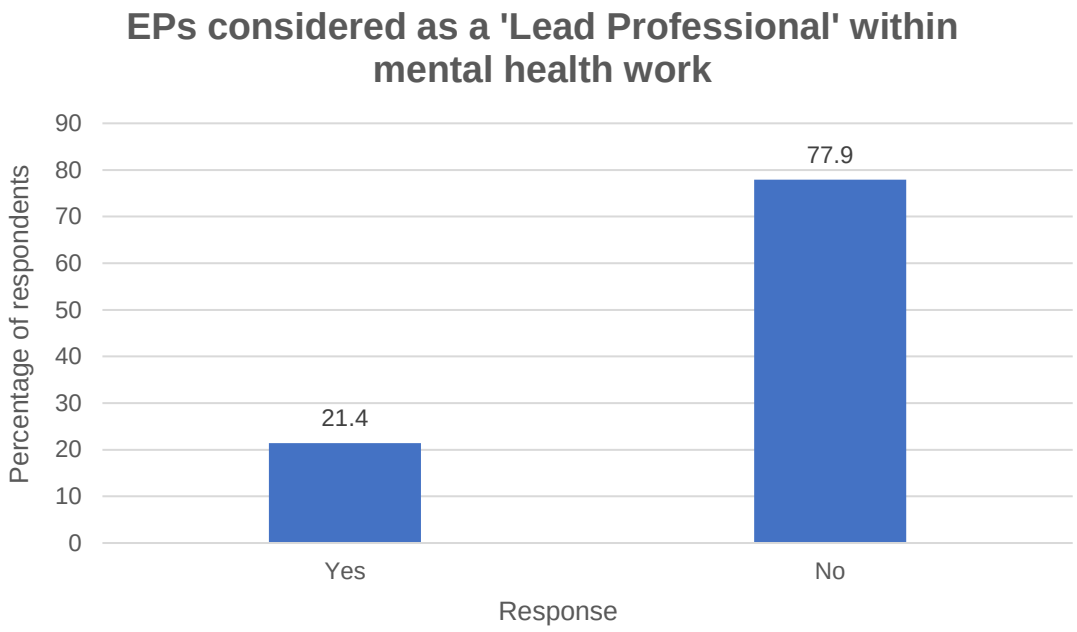


Figure 4.14: Bar chart to show percentage of EPs who had been considered as a 'Lead Professional' within mental health work

Only 29.2% were linking with school-based mental health lead staff such as a DSLMH or EMHPs (Figure 4.15; and examples, section 4.5.3). The most frequent response was that respondents had not linked with any school-based mental health lead staff.

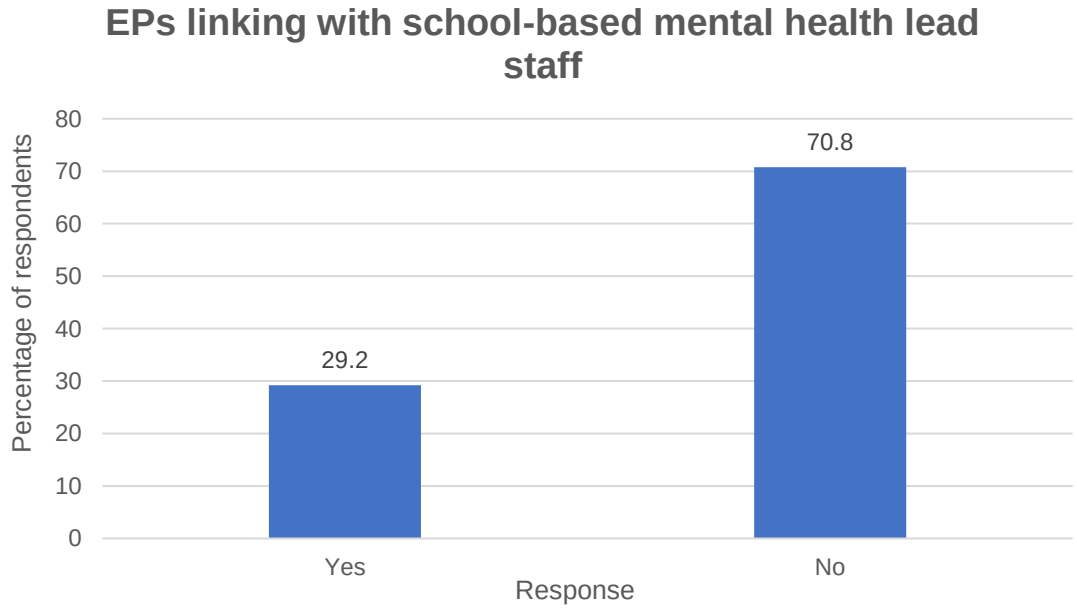


Figure 4.15: Bar chart to show percentage of EPs who had linked with school-based mental health lead staff

The majority (70.8%) had not been involved with any mental health developments within their LA (Figure 4.16). For the 29.2% that responded 'Yes' further details are presented in section 4.5.4.

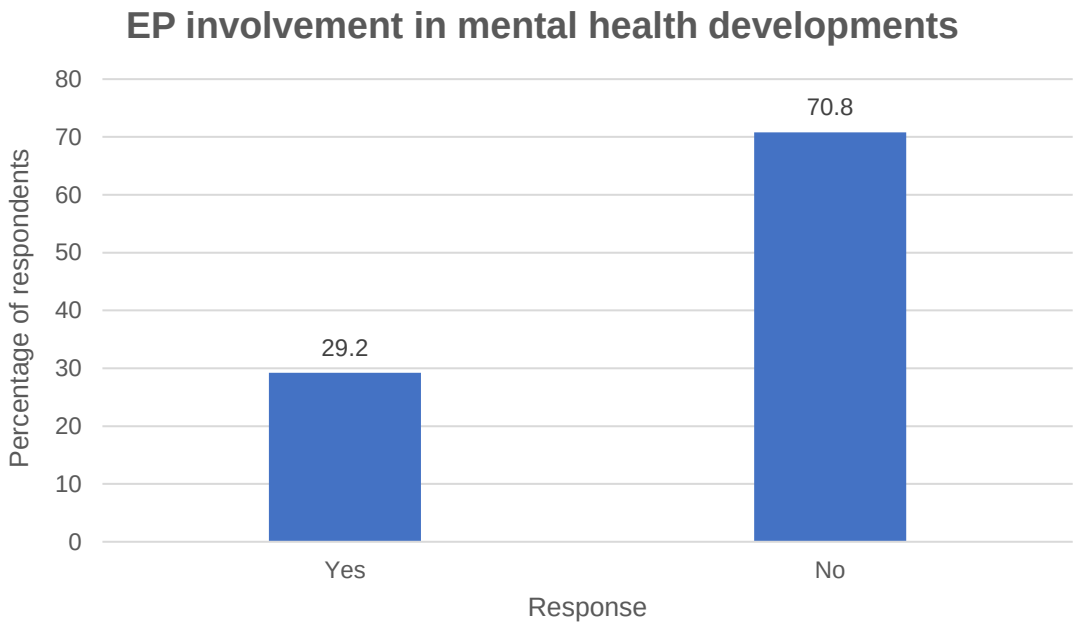


Figure 4.16: Bar chart to show percentage of EPs involved in mental health developments within their local authority

Overall, most recorded that SEMH was a high priority both within their EPS and within their locality (Table 4.40), most considering the EPS priority higher. A very small percentage of respondents reported that SEMH was a low priority in their EPS, and more a low priority in their locality. One person did not respond to this question.

Table 4.40: Table to show EP responses around whether SEMH is an identified priority in their EPS and within their local authority

SEMH is a priority	Percentage of respondents				
	High Priority	Somewhat a priority	Don't know	Low priority	Not at all a priority
Within the EPS	61.0%	30.5%	5.2%	1.9%	0.6%
Within the locality	48.1%	33.1%	10.4%	7.1%	0.6%

The primary promotion by the EPS of the EP role in SEMH work was through consultation, significantly more than other promotional methods (Figure 4.17). Responses to the 'other' option can be found in appendix 47. Two participants did not provide responses to this question. Data relating to the effectiveness of promotional methods can be found in appendix 48 as question wording resulted in no significant interpretation of the data.

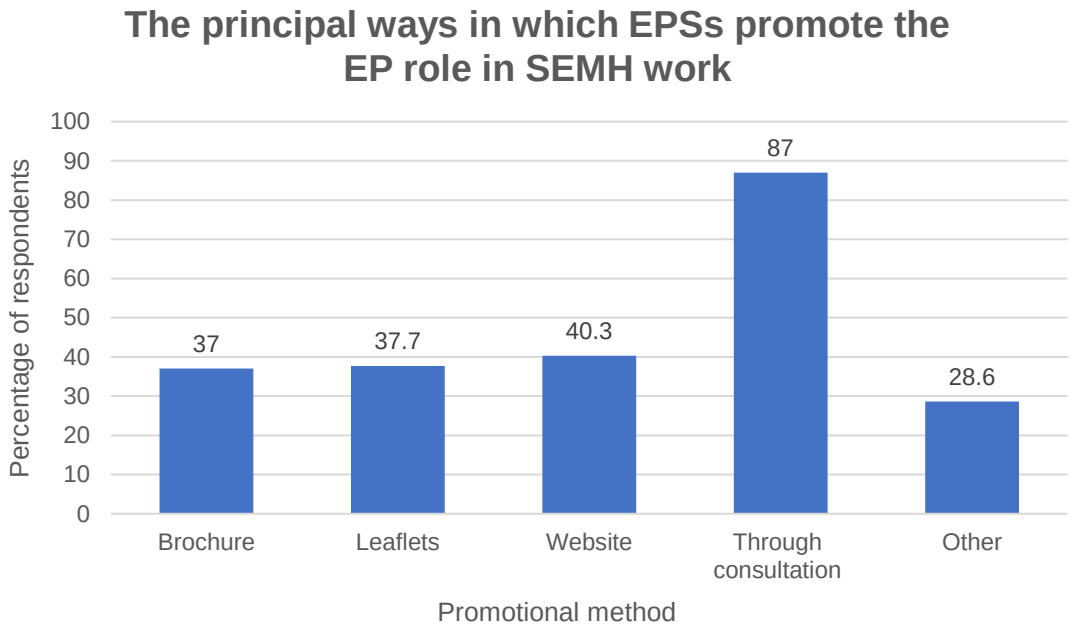


Figure 4.17: Bar chart to show percentage of EPs reporting methods employed by EPSs to promote the EP role in SEMH work

Most were 'unsure' around whether their EPS had a mental health policy, strategy, or other service guidance to support them with their SEMH work (Figure 4.18). Only 20% of participants (*n= 32)* reported that their EPS had such guidance. Examples of these can be found in appendix 49. Two participants did not respond to this question.

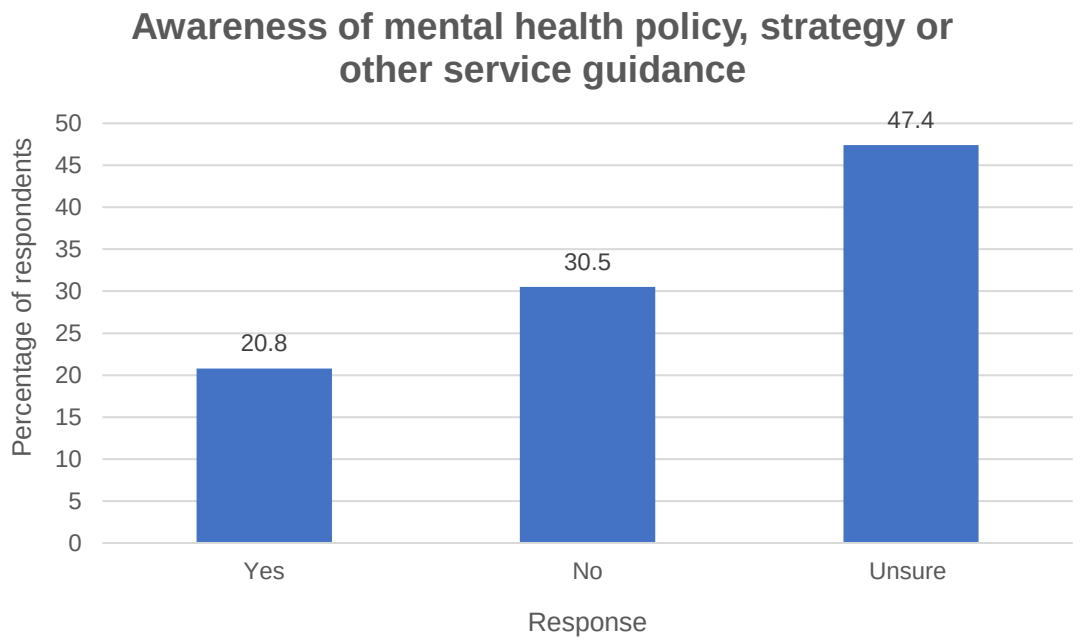


Figure 4.18: Bar chart to show percentage of EPs aware of an EPS mental health policy, strategy or other service guidance to support them with their SEMH work

4.5.2 Content analysis of the examples of systems or organisational work reported across settings

A small number gave examples of systems or organisational work being carried out around SEMH within the EYs (Table 4.41). This was mainly in the form of projects and policy development and training such as EC (appendix 50). One respondent noted their supervision for EYs Portage workers.

"Behaviour policy, education mental health practitioner support and project implementation"

Table 4.41: Table to show systemic or organisational work EPs reported carrying out in Early Years settings

Systemic or organisational work around SEMH in Early Years settings	
Subcategories	**Frequency *(N)***
Project and policy development	3
Training	3
Supervision and support for staff	1

Training was the most reported systemic or organisational work in primary settings (Table 4.42), including: EC, ELSA, Nurture Groups, challenging behaviour in the classroom, Academic Resilience Approach, Restorative Practice and *Mental Health First Aid* (appendix 51). In line with section 4.2.2, respondents' involvement in whole school approaches and policy development included work around behaviour policies, undertaking learning walks and implementing approaches such as an Attachment Aware schools programme.

"Supporting SLT to launch work from attachment aware schools training, use of emotional wellbeing audit tool for whole school to identify ways to build staff resilience"

Respondents also considered the facilitation of group processes such as MAPs, Force Field Analysis, Circle of Adults and PATHs to support organisational work within primary settings. ELSA training and supervision was reported in addition to general staff supervision. Additionally, some reported supporting staff to implement interventions, particularly following training. Examples of LA project work in relation to primary settings included:

"Education mental health practitioner support and project implementation"

"A 4-year project to develop SEMH in a designated area of the authority"

Five individuals noted carrying out systemic work within specialist settings such as Pupil Referral Units (PRUs) and SEMH specialist provisions.

Table 4.42: Table to show systemic or organisational work EPs reported carrying out in primary schools

Systemic or organisational work around SEMH in Primary schools	
Subcategories	**Frequency *(N)***
Training	30
Whole school approaches or policy development	17
Group processes	15
Supervision and staff support	13

LA project work	11
Consultation and meetings	4
Parent support	2

Training was again the most reported activity at this level in secondary settings (Table 4.43). This included ELSA, Mindfulness, Growth Mindset, attachment and trauma, anxiety, self-injurious behaviours, and restorative approaches training for senior staff (appendix 52). Whole school approaches were similar to primary settings, including:

"Emotional wellbeing audit tool to support secondary schools to inform School Improvement Plan".

"Using Solution Circles, working with SENCO to look at how we can support mental health through PSHE curriculum, considering adaptations to behaviour policy with SENCO to support pupils."

Additionally, projects such as the *"Mental Health Champions project"* and research, including using approaches such as Appreciative Inquiry and Realistic Evaluation were noted.

"Research around what is important in school for secondary pupils as part of our Ethnic Minorities working group, working with youth workers and school staff with the findings".

The facilitation of group processes and supervision and staff support was again prominent in organisational work within secondary settings.

"Force Field Analysis/workshop sessions with a designated group of secondary school staff to develop the school-wide response to managing challenging behaviour"

One participant reported delivering parent interventions and three discussed developing provisions for vulnerable groups such as around emotionally-based school non-attendance and a trauma-informed provision for children new to care. Seven noted carrying out systems

work within specialist settings such as additionally resourced centres in secondary schools, PRUs and SEMH specialist provisions.

Table 4.43: Table to show systemic or organisational work EPs reported carrying out in secondary schools

Systemic or organisational work around SEMH in Secondary schools	
Subcategories	**Frequency *(N)***
Training	21
Whole-school approaches or policy development	14
Projects and research	12
Group Processes	11
Supervision and staff support	9
Developing provision for vulnerable groups	3
Parent interventions	1

Only four respondents described organisational or systemic work in Post-16 or FE settings and this appeared mainly in the form of training such as *Mental Health First Aid*, ELSA and trauma-informed practice (appendix 53).

Table 4.44: Table to show systemic or organisational work EPs reported carrying out in Post-16 or Further Education settings

Systemic or organisational work around SEMH in Post-16 or Further Education settings	
Subcategories	**Frequency *(N)***
Training	4

Most 'other' examples appeared to be at a LA level, including within an *"Integrated therapeutic residential school for 8-16"* (appendix 54) and with the Autism Spectrum Condition (ASC) advisory service. Various examples of policy and practice work within and across LAs were reported for example, cross-county LAC exclusion work, project work related to EBSA and contribution to LA policy and guidance.

"Holding an 'Anxiety in schools' conference"

"LA guidance in collaboration with schools to develop a city-wide graduated response good practice guidance in relation to SEMH"

"County wide project work in relation to EBSA"

Training included *"ACE ambassador training within the local authority"* delivered to a range of services.

Table 4.45: Table to show responses to the 'other' category of systemic or organisational work EPs reported carrying out

Other examples of Systemic or organisational work around SEMH	
Subcategories	**Frequency *(N)***
Across various settings with various professionals	8
Policy and practice development	8
Training	3
Through consultation	2

4.5.3 Content analysis of examples of EPs linking with other mental health lead staff

Links with a range of other mental health staff and school-based mental health lead staff (Table 4.46) included eight reports of liaising with mental health staff as part of the Green Paper Proposals; for example liaison around Trailblazer implementation and with MHSTs.

"Yes I attend the Trailblazer steering group and may have a future role in supervision of the MHP"

One respondent shared that EMHPs were based in the same office as EPs and two described lead roles such as being a "*project co-lead for the EMHPs"* and being an *"EP link to CAMHS Trailblazer"* (appendix 55).

There were links with a variety of school-based staff such as pastoral staff in school, Inclusion Managers, ELSAs, SENDCos and with virtual school Head Teachers.

"Ongoing work with MH leads from schools -including in TaMHS accreditation work - designed to recognise and celebrate (and hence, also promote more of) good practice re MH work in schools."

Projects enabled links with other mental health leads such as the "*Mental Health Champions project"*, *"Headstart"* and *"Emotionally Friendly Schools"*. One respondent reported involvement in the training of EMHPs through the *"Mental Health in Schools project"*. Additionally, the delivery of whole school approaches to SEMH within secondary and Post-16 settings were noted. Furthermore, links with other mental health staff occurred through having additional mental health responsibilities for example, being an "*Education, Health and Wellbeing coordinator for a mental health partnership NHS Trust"* and through a TaMHS leadership role. Some reported multi-agency working through *"multi-agency panels"* and working with CAMHS.

"Our EPS works closely with our CAMHS around EBS non-attendance".

A small number stated that such links occurred through the course of their usual individual casework. Additionally, two reported barriers to linking with other mental health professionals such as funding and lack of resources.

Table 4.46: Table to show EPs' links with other mental health staff

EPs' links with mental health lead staff	
Subcategories	**Frequency *(N)***
As part of the Green Paper proposals	8
With school-based staff	7
Through projects	7
EPs with additional mental health responsibilities	6
Through training and supervision	5

With CAMHS and other mental health professionals	5
Through multi-agency working	4
Through individual casework	3
Developing links	2

4.5.4 Content analysis of EP involvement in LA mental health developments

Project and development work contributed most to LA mental health development work (Table 4.47). This included exclusions work and EPS working groups *"exploring how to improve our therapeutic intervention offer".*

"Development of an Intensive support team to support schools with high profile YP to reduce permanent exclusion"

Such work was also noted with other agencies, for example, with CAMHS, multi-professional work *"developing a new early years pathway around autism and social communication needs for children and their families"*, and working with the Education Welfare Service to develop a strategy to support EBSA.

"Liaison with CAMHS Universal Provision Workers to develop toolkit/strategy as part of a LA-wide project aimed at supporting SEMH needs in primary and secondary schools"

Respondents were also part of LA mental health developments in the form of established programmes such as ELSA, TaMHS and the *Mental Health in Schools* link programme (appendix 56). A smaller number noted being a representative for example, attendance *"at bimonthly meeting of CYP Mental Health Partnership"*, and working as part of the Green Paper proposals, *"facilitating a PATH session for the trailblazer project".*

Table 4.47: Table to show EP involvement in LA mental health developments

EP involvement in LA mental health developments	
Subcategories	**Frequency *(N)***
Project and development work	16
Part of specific programmes	9
Joint working	5
Research	4
Training	3
EPs as a representative	3
Part of Green paper proposals	2

4.5.5 Content analysis of EPs' hopes for future practice around SEMH

Respondents reported various hopes for their future practice around SEMH (figure 4.19) (appendix 57).

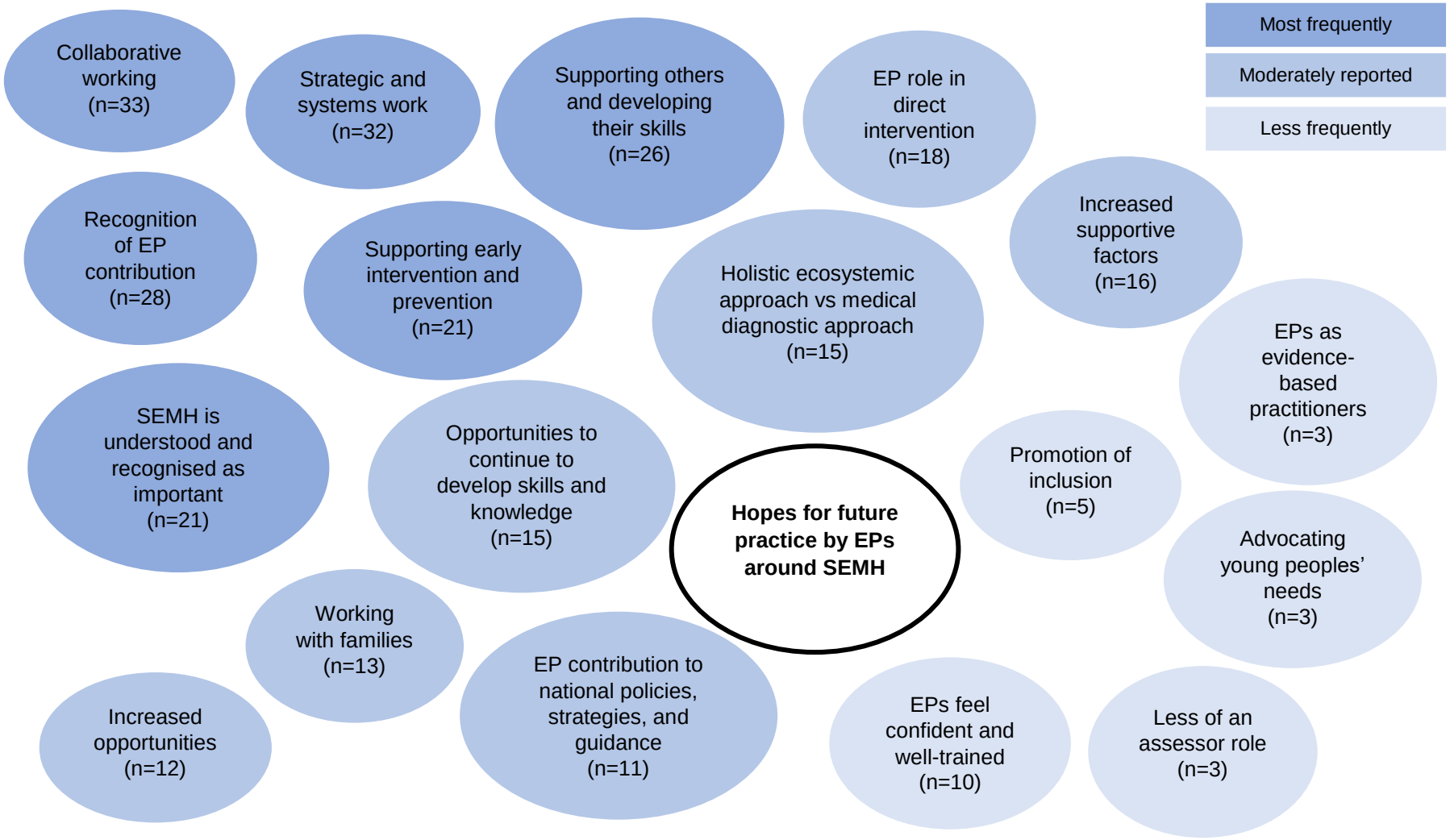


Figure 4.19: Concept map to illustrate EPs hopes for future practice around SEMH

Greater collaborative and multi-agency work with more opportunities with CAMHS were noted hopes. A small number also hoped *"to be involved at a wider level across agencies and with green paper developments".* More strategic and systems work was an aspiration, for example, more opportunities to carry out preventative work at the whole-school level and develop whole-school approaches to SEMH. Some reported wanting involvement in LA strategic work and projects.

"That greater systemic, whole school and LA work can be developed to work preventatively."

Respondents also hoped for a recognition of the EP contribution within the area of SEMH by schools, the government, and other professionals. Respondents wanted *"to be valued for our skills and application of psychology around SEMH"* and a recognition of the profession's understanding of children's mental health in the context of school. Respondents hoped to be recognised within government initiatives and that *"schools will recognise that we are able to bridge the gap between long CAMHS waiting times."* Similarly, some shared the hope that EPs would contribute to national policies, strategies and guidance around SEMH.

"To be seen as integral, key pieces of the jigsaw by schools and by government."

"We are included! many government initiatives/consultations completely ignore EPs and the work they are already doing in schools to support SEMH."

Hopes were shared around supporting others and developing their skills such as providing staff training, delivering interventions alongside staff, and supporting staff wellbeing. There was a sense of building capacity within schools and empowering adults around the child.

"Inclusive vision allied to developing the skills of those around the child in the community, rather than becoming therapists or deskilling those around the child."

Respondents hoped *"to be involved in prevention and early intervention work"* by becoming involved earlier rather than at *"crisis points"*, preventing exclusions, and providing therapeutic support to prevent CAMHS referrals and long waiting times. Respondents also

hoped that SEMH would be better understood and recognised as important by schools, LAs and parents. Respondents described that SEMH would be *"as important as cognition and learning"* and would become normalised with less stigma attached to SEMH needs. As such, it was hoped that schools would *"see the value in investing time in SEMH interventions"* and prioritise whole-school approaches above the focus on academic attainment. Similarly, it was hoped that SEMH would also be a priority for the development of EPSs and EPs.

Most wished for more involvement in direct intervention for example, individual therapeutic interventions, VIG, and group interventions around anxiety management and resilience. One participant suggested they would like "*less focus on individual CBT work"*. Respondents hoped for an increase in supportive factors for example, access to *"good quality supervision"*, *"more time to support this work at the group/ whole setting level"*, and *"time and funding for multi-agency working and person-centred planning".* Additionally, participants reported not wanting to feel *"constrained by statutory assessment pressures'* and a desire for SEMH work to be *"linked with statutory work in a coherent way".*

Opportunities to develop skills and knowledge such as through training and CPD *"to continue to enhance knowledge and skill"* and enable more individual SEMH work were desired. A number of respondents highlighted the importance of adopting a holistic ecosystemic approach rather than a medical and diagnostic approach and expressed a desire to work with families *"to develop internal support systems".*

"I hope that we will be able to contribute the importance of a 'whole child' and eco-systemic approach to new developments that deflect from the within child clinical approach."

It was hoped that "*we can become more involved in supporting SEMH needs, particularly mental health needs"* and that the profession would have increased opportunities for longer-term involvement in SEMH work in the future.

4.5.6 Content analysis of EPs' concerns for future practice around SEMH

Figure 4.20 illustrates the reported concerns for future practice around SEMH.

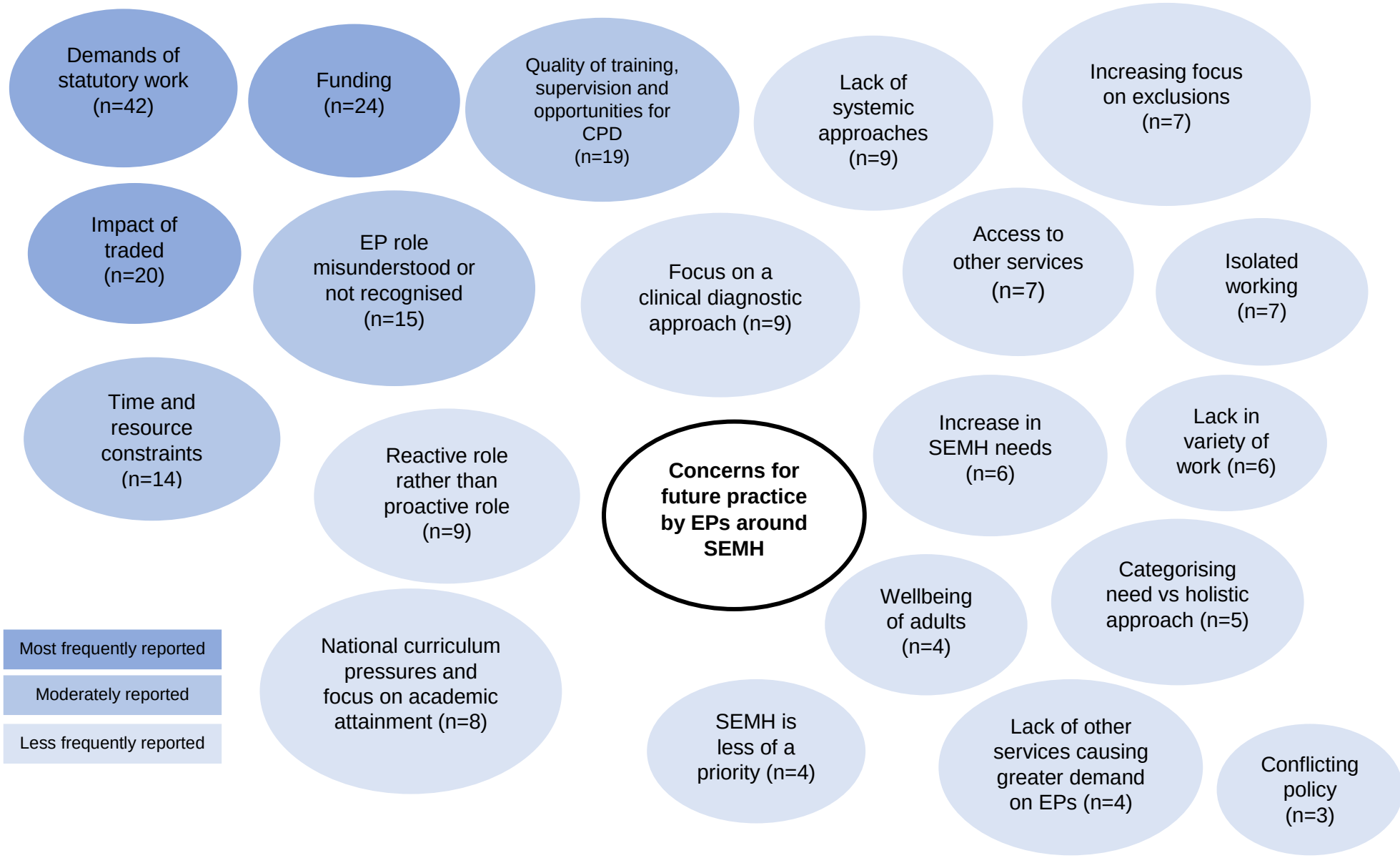


Figure 4.20: Concept map to illustrate EPs concerns for future practice around SEMH

Concerns for future practice were in line with reported barriers noted previously. The increasing demands of statutory work were felt by some to take priority and lead to *"less opportunities to practice their skills in supporting pupils with SEMH"*. Some also reported concern around *"LA EP burnout due to statutory demands and excess workload"* (appendix 58). Furthermore, participants shared concern that *"we continue to be responding when it has already reached crisis level and often only through statutory work"*, feeling that this hindered their engagement in *"early intervention/ preventative work".* A small number expressed fear that *"our role is reduced to only statutory work"* within future practice.

"Time for more complex or ongoing therapeutic work is reducing due to statutory demands."

A lack of funding in schools, ongoing austerity policies and budget cuts were noted. A lack of school funding was said to lead to *"schools not having the funding to 'purchase' time for support in this area"* and *"barriers to schools implementing recommendations".* A small number of respondents reported EPs as a gatekeeper to funding.

"Reduced school budgets often lead to EP work that will lead to access to funding being prioritised over SEMH work."

Trading was considered a concern by some, for a variety of reasons including schools not prioritising SEMH and EPs being inaccessible to some. Respondents expressed concerns around services offering support for free, potentially leading to competition, and time constraints related to traded hours. One participant shared concern around the ethics of trading.

"Trading can be a barrier especially at a time when health is providing increased support in schools for free."

The quality of training, supervision, and opportunities for CPD were also reported a concern for future practice in SEMH work. Particularly, some respondents reported inadequate training and supervision to take on therapeutic work, with three suggesting that initial training is not sufficient to prepare EPs to undertake this type of work. Furthermore, participants also

discussed not having enough CPD, time, or opportunities to engage SEMH work in order to develop their skills, confidence and practice. Two shared reservations around EPs being *"treated as therapists"* or *"straying into area they are not expert in"*.

"I worry that SEMH issues are not adequately covered in EP training and then we don't get to work with these issues enough once qualified, so we could become deskilled as a professional group."

"Lack of expertise in specific interventions and inadequate supervision - I think of the EP role as more similar to a general practitioner, not a specialist and some SEMH interventions require more specialism than TEP training can prepare us for."

A number expressed concern that the EP role would be misunderstood or not recognised for example, *"being overlooked by politicians and those making key decisions"* or education and health professionals not recognising the EP contribution within this area. Particularly, some reported not wanting to be *"left out of the picture"*, *"side-lined"* or to *"continue to be under-used in a concerning area where we are well-placed to make effective change"*.

"I am concerned that the role of EPs and their unique contributions to support children SEMH needs is not well understood by health and educational professionals."

"Lack of knowledge of our service nationally - greater focus on CAMHS etc. and little reference to EPs in green paper."

Respondents noted concerns around time and funding constraints for example, *"not having sufficient time and resources for effective working"*, and *"workload and funding pressures reducing opportunities to engaging in a range of SEMH work"*, ultimately leaving young people and families without support. In particular, they reported a lack of time hindering the ability to engage in ongoing individual therapeutic work or work with families.

"Lack of time to support children directly. Hard to give weekly/fortnightly appointment for CBT type work."

“Unless we work together with schools and FAMILIES, there will be little or no progress. I am concerned that there is not enough time/money for this.”

4.5.7 Synthesis of quantitative and qualitative findings of opportunities to engage in mental health work

It appears that the main opportunities for organisational or systems work around mental health occur through training and policy and practice work, mostly in primary settings and least in Post-16 or FE settings. This may be expected, given that EPs reported less involvement with SEMH work both within Post-16 and FE settings and at the strategic and LA level. Overall, multi-agency work appeared to be varied, with most reporting this ‘sometimes’, and a relatively small percentage were a ‘Lead Professional’ or linking with other mental health-based staff. Those considered a ‘Lead Professional’ described that this was whilst no other agencies or professionals were involved, which may suggest that EPs are not considered the lead professional often within multi-agency work within this area.

Interestingly, a high number of respondents hoped for more opportunities for collaborative working and for strategic and systems work, supporting early intervention and prevention. A small number expressed concern around isolated working and limited opportunities for multi-agency work, and a lack of systems work within future practice. The data therefore suggested that EPs hold somewhat similar hopes and concerns for future practice for example: a number of respondents hoped for opportunities to continue to develop their skills and knowledge, however, the quality of training, supervision, and opportunities for CPD were also expressed as concerns for future practice, with some suggesting these are inadequate to support EPs’ work in this area. This may be seen to influence the opportunities available for EPs to engage in SEMH work. Additionally, respondents hoped that there would be a recognition of the EP contribution within the area of SEMH and that SEMH would be recognised as important. Arguably, this may lead to more future opportunities for EPs within mental health work. However, concern was expressed that the EP role within this area may be misunderstood or not recognised.

Findings suggest that EPs may not be regularly involved in wider mental health practice beyond individual casework, and only a small number are currently reported to be liaising with Green Paper developments.

4.6 Summary of findings

This chapter presented the descriptive analysis and content analysis of the data gathered. In response to each research question both sets of data were synthesised and summarised above. Key findings from each research question are integrated below.

The analysis indicated involvement with a high number of children and young people with SEMH, primarily at an individual level through consultation and casework. This may be explained, in part, by the fact that respondents were most confident to engage in individual level SEMH work. Consultation was carried out most at all age phases except for Post-16 and FE age groups, however respondents reported working with this age group the least. This is somewhat of a concern, given that the reported levels of SEMH difficulties appeared to increase with age. Most SEMH work was carried out with Key Stages 2 and 3 and around half were involved with EYs work, potentially suggesting less early intervention and preventative work. Although consultation was the most frequently reported activity, respondents reported feeling confidence around this less frequently than for individual intervention and assessment. Consultation was also the primary method for promoting the EP role within SEMH work. Given there were less reported opportunities for consultation at the Post-16 or FE age range, one could question how the EP role in this area is communicated to Post-16 and FE providers. A potential lack of knowledge may be seen to exacerbate the limited involvement at this age phase.

Nevertheless, SEMH work was demonstrated across all five core functions of the role and at multiple levels of the system. Respondents appeared to perceive these activities as interlinked rather than discrete for example, consultation was considered to form part of assessment and training was considered a systems level intervention. Training was the most frequently reported systems level work and respondents noted delivering a wide range related to SEMH, an activity perceived to facilitate engagement in SEMH work. Although reported less often, respondents were still offering valuable support at the organisational and systems level across all age phases including at the whole-school and LA level. However, this was least reported in EYs and Post-16 or FE settings, which may be expected given that respondents were involved with these age groups less often. A high number were supporting staff wellbeing in a variety of ways including staff supervision which respondents felt

confident to deliver and considered supportive to their organisational and systems level work. Respondents hoped to engage in more staff wellbeing and strategic and systems level work in future practice around SEMH.

The analysis outlined that individual interventions were most frequently reported as activities respondents were confident to engage in, despite reporting less opportunities and barriers to engaging in these. However, this may be explained by factors beyond EPs' control such as trading, school funding and priorities, and time constraints related to statutory demands: all reported as barriers and concerns for future practice within the area of SEMH. Although statutory demands were reported as a barrier, respondents reported less involvement with statutory work for children and young people with SEMH, suggesting that EPs may be involved in statutory assessment of SEN frequently for other reasons than SEMH. Respondents described that this takes priority, creates time constraints, and therefore hinders engagement in SEMH focused work.

Although respondents stated that they would engage in SEMH work where another agency is involved, and felt confident to, this occurred less often in practice and was considered a current barrier and a concern for future practice. Additionally, respondents hoped for more collaborative work in the future. Many barriers were reported which appeared to interlink and constrain EPs' engagement in SEMH work, including the perception of the EP role by others. However, some respondents reported that where schools had an awareness of the EP contribution, this facilitated their engagement in SEMH work, suggesting variation in EP practice. Similarly, a recognition of the EP contribution in this area within future practice was considered necessary to enable engagement in varied SEMH work.

Most believed that SEMH should be part of the EP role and felt skilled and knowledgeable in this area, with the analysis suggesting that EPs contributed a variety of skills. Despite this, a small number reported feeling that other professionals such as CAMHS were better placed to offer support in this area. Linked to this, most respondents felt well supported by their initial professional training and supervision, and some reported that supervision, training and CPD supported their involvement within SEMH work, hoping this would continue in future practice. However, this was not the case for all respondents, with some reporting opportunities for training and supervision, and their confidence and skills as barriers to engaging in SEMH work and expressed concern around this in future practice.

The following chapter will discuss these findings in relation to the literature reviewed in Chapter 2.

Chapter 5: Discussion

This study aimed to explore current EP practice around supporting children and young people's SEMH within England through a national level survey, seeking representation of the profession. Responses from 154 participants were analysed using descriptive statistics and content analysis.

Within this chapter, key findings for each research question are discussed in relation to existing research. The study's methodological strengths and limitations are presented, and implications for EPs' practice are considered before exploring directions for future research. Finally, a conclusion of the study is provided.

5.1 Summary of findings in relation to existing research

5.1.1 Research Question one: current EP practice supporting children and young people's mental health

Age phase

At the point of responding, most respondents were involved with more than 20 children or young people with SEMH, primarily at an individual level through consultation or individual casework. The high incidence of individual level work has been documented generally (DfEE, 2000; MacKay, 2002; Shannon and Posada, 2007) and is perhaps unsurprising, however suggests limited involvement at other levels of the system: factors impinging this are discussed in section 5.1.3. Nevertheless, this finding suggests a relatively high level of involvement around SEMH, and therefore the importance of exploring this in more detail.

Respondents were involved with lower (Key Stage 1 and EYs) and higher age groups (Key Stage 4 and Post-16 and FE) the least around SEMH, surprising given the acknowledged importance of early intervention (DoH and DfE, 2017; House of Commons, 2018). It could be hypothesised that less early intervention and prevention contributes to the reported high involvement at Key Stages 2 and 3. Interestingly, this falls either side of young people's transition to secondary school, potentially leading to increased requests for support given

research highlighting the impact of transitions upon emotional wellbeing (Jindal-Snape et al., 2020; Morris and Atkinson, 2018a; West et al., 2010). It may be that young people's needs are identified more by schools within these age phases.

The absence of early intervention in practice was again highlighted by only around half of the sample supporting SEMH within the EYs. Sadler et al. (2018) note that mental health difficulties can occur from early childhood, within those aged two to four years, thus EPs may not be engaging in early intervention to potentially prevent mental health difficulties developing over time. The utility of the EP role within EYs has been recognised elsewhere (Dennis, 2004; Douglas-Osborn, 2017; Shannon and Posada, 2007) however the resource of time has been cited as a barrier to involvement with this age range. Time was reported as a barrier within the current study, potentially explaining the limited involvement within EYs. Nevertheless, the current findings illuminate the types of SEMH work EPs are involved in within the EYs.

Contrastingly, mental health difficulties are reported to be higher in young people aged seventeen to nineteen (Sadler et al., 2018): yet data here illustrates least professional involvement with older age ranges. The limited involvement at Post-16 and FE may reflect that post 19 years is a newly developed area of practice, given the stipulation that EPs work with young people up to the age of 25 years (DfE, 2015). Despite this being newer territory, the potential role for EPs working with Post-16 and FE age groups have been identified at the systemic, group and individual level, including support for SEMH needs (Bell, 2015; Morris and Atkinson, 2018a). This nevertheless appears little reflected in practice amongst the current sample.

Nature of involvement

Whilst involved in SEMH work through the five core functions of the role (Scottish Executive, 2002), respondents reported most involvement in assessment closely followed by consultation. That assessment practice was mainly around pupil views, including using measures of emotional wellbeing, replicated existing findings (Law and Woods, 2018; Price, 2017). Consultation was reported highly across all age groups, resonating with suggestions that EPs viewed their main role as supporting others in regular contact with the young person (Greig et al., 2019). Thus, findings supported research highlighting consultation with staff, parents and carers or other professionals (Andrews, 2017; Greig et al., 2019; Law and

Woods, 2019; Price, 2017; Zafeiriou, 2017). This may be considered a positive finding given the desire for more consultation reported by Law and Woods (2019). Consultation was viewed as a means to support staff wellbeing, corroborating the findings of Zafeiriou and Gulliford (*in press*). Consultative and systemic approaches have been considered unique to the EP role, potentially suggesting a unique contribution within the area of SEMH (Ashton and Roberts, 2006; Miller, 2016).

Although a high proportion of services *offered* a wide range of interventions, respondents reported minimal delivery of interventions, substantiating suggestions that therapeutic intervention is a less common area of practice (Law and Woods, 2019; Miller, 2016; Price, 2017). Despite longstanding suggestions that therapeutic practice may develop within the profession (Atkinson, Corban and Templeton, 2011; Gulliford, 1999), this is not reflected in the current sample, with respondents still wishing to do more of this. The data confirmed barriers identified in previous research (Atkinson, Corban and Templeton, 2011), for example: time, schools' perceptions of the EP role and the levels of statutory work, illustrated in section 5.1.3.

Contrary to the findings of Atkinson, Bragg et al. (2011), the most frequently *delivered* intervention was PCP followed by FBA. Nevertheless, SFBT, CBT and MI were popularly *offered* by services. Although third most frequently delivered, SFBT was delivered rarely, and reports of CBT and MI were even less respectively. This divergence may be explained by respondents in the current study reporting their delivery of discrete interventions for young people, rather than their application of approaches in various functions of EP practice (Atkinson, Bragg et al., 2011). As such, respondents utilised solution-focused approaches most within consultation, concurring with research (Atkinson, Bragg et al., 2011; Law and Woods, 2019; Stobie et al., 2005; Zafeiriou, 2017). The emphasis found elsewhere on learning therapeutic practices in training but finding limited use in practice (Atkinson, Corban and Templeton, 2011) was expressed by respondents. In contrast to Atkinson, Corban and Templeton (2011), therapeutic interventions were delivered more with primary-aged than secondary-aged pupils, potentially explained by the overall higher involvement in primary settings.

Needs

Respondents were involved with a range of mental health needs such as anxiety, self-harm and EBSA. Particularly, data suggested that difficulties related to self-harm and EBSA were evident at Key Stage 2 and appeared to increase with age, in line with reported statistics (Sadler et al., 2018). Assuming mental health needs increase with age strengthens concern that EPs are less involved with early intervention and with older age groups around mental health needs. Teachers were the most commonly cited source of support for young people with mental health needs (Sadler et al., 2018), highlighting a role for EPs in supporting staff. Authors have suggested that EPs are not routinely involved in supervision or supporting staff wellbeing, and that school staff may be unaware of this role (Rae et al., 2017). Promisingly, a high percentage of respondents in this study reported such involvement, deemed important to support staff to respond effectively to young people's mental health needs (Kidger et al., 2010; Young Minds, 2017).

Despite discrepant views from EPs regarding their role in SEMH (Miller, 2016; Price, 2017), the overwhelming majority of respondents here considered that SEMH work should be part of the EP role. This suggests a desire to continue work in this area and emphasises the need to establish a professional identity in the area of mental health, echoing existing research (Andrews, 2017; Fee, 2011, Greig et al., 2019; Miller, 2016; Price, 2017). Authors have recognised a lack of, and barriers to, multi-agency working (Farrell et al., 2006; Greig et al., 2019; Law and Woods, 2019, Miller, 2016). The current study replicated such findings, however, most respondents would also engage in SEMH work with a young person where another SEMH agency is involved: opportunities for such are discussed further in section 5.1.4.

Echoing previous research, data here suggested involvement at the systems level such as training (Andrews, 2017; Greig et al., 2019; Law and Woods, 2018; Sharpe et al., 2016), whole-school approaches to supporting SEMH (Andrews, 2017; Law and Woods, 2018; Sharpe et al., 2016), and group consultation for teachers (Law and Woods, 2018). The high level of training reported appears to contrast the findings of Law and Woods (2019): training was the most frequently reported systems level work across all settings, with a wide range related to SEMH. Examples provide evidence of EPs' increased contribution to strategic work and capacity building across a number of settings (Farrell et al., 2006), explored further in section 5.1.4.

5.1.2 Research Question two: EPs perceptions of their confidence, skills and knowledge in relation to mental health work

Discrepancies exist in the literature regarding EPs' confidence, skills and knowledge working in the area of SEMH, with some suggesting limited training or EPs feeling deskilled (Andrews, 2017; Miller, 2016; Price, 2017). Overall, respondents in the current study reported feeling confident to engage in varied work around SEMH, at multiple levels and within multi-agency work.

Greatest confidence for SEMH work was at the individual, and least at strategic or LA levels. In line with the literature, confidence in assessment appeared to be underpinned by skills in formulation and hypothesis development (Law and Woods, 2019; Price, 2017; Zafeiriou, 2017). Some authors have highlighted the importance of opportunities to develop skills and confidence in SEMH work (Price, 2017; Zafeiriou, 2017). The findings from this study suggest that respondents felt less confident about activities they engaged in frequently such as assessment and consultation. This is interesting as these core activities are at the heart of professional practice. Furthermore, respondents felt most confident to deliver individual interventions, despite reporting limited opportunities in practice. As noted earlier, however, EPs may experience barriers to delivering interventions beyond their control. Respondents felt confident in multi-agency work but again engaged in this work less frequently. Thus, it is possible that a lack of opportunities might not necessarily equate to a lack of confidence and skills. Similarly, confidence and skills in an area of work, might not amount to opportunities to engage in this kind of work.

A small number expressed low confidence and skills as barriers to engaging in SEMH work. Anxieties around role definition and the perception that other services may be more typically considered, or better placed, for mental health support aligned with previous research (Andrews, 2017; Atkinson, Corban and Templeton, 2011; Law and Woods, 2019; Miller, 2016). However, similar to Greig et al. (2019), most perceived themselves to be skilled and knowledgeable in relation to SEMH work. The data extends beyond previous reports (Law and Woods, 2019; Miller, 2016; Zafeiriou, 2017) identifying a wider range of skills and knowledge that EPs are perceived to contribute. Paradigmatic flexibility has been considered

distinctive to the EP role (Law and Woods, 2019), in evidence here through the broad range of theories and paradigms reported to guide practice around SEMH.

The identified skills show significant overlap with the literature, for example: reframing needs and adults' perceptions (Andrews, 2017; Ashton and Roberts, 2006; Zafeiriou, 2017) through problem-solving (Andrews, 2017; Law and Woods, 2019; Zafeiriou, 2017), therefore strengthening findings from small-scale studies with fewer EPs. The findings align with Zafeiriou and Gulliford (*in press*) identifying the importance of consultation skills and *"support and challenge"*, drawing on empathy and therapeutic skills such as containment. Law and Woods (2019) also highlighted the importance of consultation to empower adults and "give away psychological knowledge" (p. 105), skills noted in the current study. Zafeiriou and Gulliford (*in press*) highlight the value of supporting children and young people's mental health through developing adults' skills and confidence; a strong desire expressed by respondents for their future practice.

EPs' specialist knowledge has been recognised in previous research (Andrews, 2017; Ashton and Roberts, 2006; Zafeiriou and Gulliford, *in press*), also evident in the broad sample of the current study, including: knowledge and application of psychological theory, child development, and the research and evidence-base around children and young people's mental health. Furthermore, EPs' understanding of the school system and context was perceived as important knowledge contributing to skilled work around SEMH, echoing previous research (Squires, 2010; Weeks et al., 2017; Zafeiriou and Gulliford, *in press*). The combination of such knowledge is potentially distinctive to the profession, highlighting their position at the intersection between psychology, health and education. The sense that EPs grounded their formulation in psychological knowledge and theory was evident, consistent with existing findings (Law and Woods, 2019; Leadbetter, 2010; Miller, 2016; Zafeiriou, 2017).

The wide range of theories and paradigms guiding practice around SEMH reflect a broad knowledge base, supporting existing research. Attachment and trauma theories were most prominent (Law and Woods, 2019; Miller, 2016; Zafeiriou, 2017), followed by solution-focused theories (Law and Woods, 2019; Zafeiriou, 2017). Furthermore, similar to Zafeiriou and Gulliford (*in press*), SDT and collaborative consultation were utilised within EP work around mental health. Interestingly, the current findings challenge existing literature, in

identifying PCP as the theory most commonly guiding practice around SEMH. This may be owing to the utility of PCP in eliciting young peoples' perceptions, (e.g. Sheffield and Morgan, 2016), mirroring further study data which suggested that EPs valued the importance of gathering pupil views within SEMH practice.

Consonant with previous research, psychodynamic, humanistic, cognitive and neurobiological, and behavioural paradigms were all reported (Law and Woods, 2019; Miller, 2016; Zafeiriou and Gulliford, *in press*). Bronfenbrenner's Ecological Systems theory (Bronfenbrenner, 1979) was frequently cited as guiding practice around SEMH. Data here appeared to reinforce the view that EPs should adopt a holistic, interactionist and psychosocial perspective on mental health needs, and a desire to move away from a medical-diagnostic approach and within-child deficit model (Durbin, 2010; Fee, 2011; Law and Woods, 2019; Miller, 2016). It has been suggested that these different models cause conflict for EPs (Fee, 2011), proposed within the line of argument synthesis in section 2.7.9.

Initial professional training, CPD and supervision were supportive to respondents' engagement in SEMH work, however in contrast to Greig et al. (2019), the current sample reported feeling better supported by professional supervision in comparison to their initial professional training. This is an important point as opportunities for CPD and quality supervision are likely to support professional development in this area and are key for future practice (Fee, 2011; Squires and Williams, 2003).

5.1.3 Research Question three: factors influencing delivery of mental health work

The current study allowed for a greater understanding around the complex interrelationships between barriers the profession has faced and their impact upon engagement in SEMH work. Barriers echoed existing literature, suggesting they have persisted within practice over many years. Time constraints were the most reported barrier to undertaking SEMH work (Andrews, 2017; Farrell et al., 2006; Greig et al., 2019), followed by statutory demands; the interaction of these affecting long-term, 'deeper involvement' and delivery of therapeutic interventions (Andrews, 2017; Atkinson, Corban and Templeton, 2011; Law and Woods, 2019; Miller, 2016; Price, 2017). Respondents felt that statutory assessment was prioritised over other work, triangulating existing research (Atkinson, Corban and Templeton, 2011). This is confirmed by statistics which demonstrate an increase in the proportion of children

with statements of SEN or Education, Health and Care (EHC) plans since 2007 (Long et al., 2020). Findings appear to reflect that the capacity of services is a central barrier to supporting young people's mental health (Sharpe et al., 2016) and that educational support services appear to be least accessed for mental health support (Sadler et al., 2018).

Further complexity was found in that barriers for some may be facilitative factors for others and vice versa, with such variance potentially explained by individual factors for example: respondents' service and LA contexts, individual relationships with schools, and school funding and priorities. Barriers have been suggested to prevent EPs expanding their work (Farrell et al., 2006) evident in data from the current sample. Such barriers were said to lead to a 'lack of opportunities' therefore restricting the types of SEMH work respondents reported involvement with, explored further in section 5.1.4.

According with previous research (Fallon et al., 2010; Lee and Woods, 2017) a mixed picture emerged around traded services; some reported that this had increased SEMH work where others felt that this restricted their SEMH work. Where considered a barrier (Law and Woods, 2019; Zafeiriou, 2017) there were concerns that schools did not always prioritise SEMH work and that the nature of EP work was directed by schools as the 'customer'. Furthermore, similar to other findings, respondents felt that the EP role may be prioritised for learning assessments and that schools were reluctant to spend time on in-depth work for one pupil (Atkinson, Corban and Templeton, 2011; Lee and Woods, 2018). Respondents perceived themselves a costly service, noted elsewhere (Farrell et al., 2006), recognising school funding constraints potentially resulting in schools prioritising more economical mental health agencies. Nevertheless, the small number reporting trading as a facilitative factor suggested that it allowed schools with an increased awareness of the understanding and importance of SEMH to prioritise traded packages for SEMH work, consistent with comments by Lee and Woods (2017) and Zafeiriou and Gulliford (*in press*).

Respondents identified further facilitative factors noted in the literature, most frequently reporting schools' recognition of the EP contribution in the area of SEMH (Law and Woods, 2019), suggesting this was supported by the relationships EPs developed with schools (Ashton and Roberts, 2006; Atkinson, Corban and Templeton, 2011; Farrell et al., 2006). Similar to Atkinson, Corban and Templeton (2011), service factors such as a range of expertise within the EPS and a flexible approach were recognised as facilitative factors.

Particularly, a supportive service culture has been considered to promote access to CPD and supervision (Atkinson, Corban and Templeton, 2011). Authors have suggested that opportunities for CPD and training are supportive to EPs engagement within SEMH work (Atkinson, Corban and Templeton, 2011; Fee, 2011), as reported by the current sample. Good quality supervision was also reported, arguably promoting effective professional practice (Atkinson, Corban and Templeton, 2011; Fee, 2011; Squires and Williams, 2003). A small number reported supervision from external professionals, desired by EPs in previous research (Atkinson, Corban and Templeton, 2011; Squires, 2010): this may indicate a shift in practice. In contrast, a small number highlighted opportunities for training and supervision as barriers aligning with existing findings (Atkinson, Corban and Templeton, 2011).

5.1.4 Research Question four: opportunities for engaging in mental health work

Less organisational and systems level work was occurring around SEMH in comparison to work at other levels of the system, a pattern recognised more widely in the literature (DfEE, 2000; MacKay, 2002). Nevertheless, the main opportunities appear to arise through training and policy and practice work, mostly in primary settings, confirming previous research (Sharpe et al., 2016). This may be expected as respondents reported involvement most with this age phase. Given less involvement, systems level work was reported least in EYs and Post-16 and FE settings, despite suggestions for more (Dennis, 2004; Douglas-Osborn, 2017; Morris and Atkinson, 2018a; Shannon and Posada, 2007). In line with research, respondents considered the facilitation of group processes and staff support and supervision to influence their organisational work in primary and secondary settings (Andrews, 2017; Law and Woods, 2018). Findings may suggest that work at this level develops over time, hence being less frequent with age groups less worked with, or that it may not be an immediate priority for EP involvement.

A key interest of the current survey was to illuminate the potential impact of the Green Paper (DoH and DfE 2017) proposals upon the profession. Although EPs were the top professionals for MHSTs to liaise with (DHSC and DfE, 2018b), this was little reported in the current study; only eight reported involvement with Green Paper developments, with only two reporting lead roles within this. These findings indicate that EPs may not be regularly involved in wider mental health initiatives or practice beyond individual casework. To support this, greater promotion of the role in SEMH related activities through marketing or advertising has been suggested (Atkinson, Corban and Templeton, 2011): the current findings found

consultation to be the primary method for promoting the EP role in SEMH work, and potentially, the most effective. This could be promising given that the current sample reported a high level of consultation, and Zafeiriou and Gulliford's (*in press*) noting of consultation practice's efficacy in raising consultee confidence. Nevertheless, this may not sufficiently promote involvement in wider LA or government mental health initiatives and therefore consideration needs to be given to advancing the role at these levels.

A relatively small percentage (21.4%) were considered a 'Lead Professional' or were linking with other mental-health based staff. This potentially reflects findings suggesting that EPs' most likely action is referral to other agencies (Greig et al., 2019), or that EPs perceive other agencies as more able to deliver mental health support (Andrews, 2017). One respondent suggested a *potential future* role in the supervision of professionals associated with the Green Paper proposals, suggesting this is seldom occurring in practice. Similarly, despite suggestions for more supervision within EYs (Douglas-Osborn, 2017), this was limited to one report of supervision for EYs Portage workers.

Opportunities for multi-agency work were varied, triangulating existing research (Atkinson, Corban and Templeton, 2011; Greig et al., 2019), however most reported this 'sometimes'. Few qualitative examples suggested multi-agency work was less frequently encountered in practice, despite its recognised importance (DfEE, 2000; DfES, 2003). This contrasts the findings of Price (2017) who found that multi-agency work was commonly reported by both EPs and SENDCos. As noted, similar to existing research (Law and Woods, 2019; Miller, 2016), multi-agency work was a hope for future practice, illustrating the desire for a coordinated and joined-up response to supporting young people's mental health, in line with governmental agendas and policies. The findings therefore suggest a discrepancy between practice and the espoused values of such guidance and could be considered a criticism of the implementation of the *SEND Code of Practice* (DfE, 2015).

Promisingly, most felt that SEMH was a high priority in both their EPS and their locality. Nevertheless, most were unsure about mental health policies, strategies, or guidance to support them with SEMH work, suggesting they are not frequently utilised in practice: concurring with the findings of Greig et al. (2019). Although a priority for localities, albeit less, only a small number gave examples of involvement in LA mental health developments. One

possible interpretation may be again the limited recognition that EPs can contribute within this area, with some respondents suggesting LAs did not perceive this as part of the EP role.

The survey hoped to ascertain the future direction of the profession within the area of SEMH. Overall, respondents expressed a desire to engage in SEMH work more often, particularly therapeutic intervention and supporting the mental health of staff, echoing findings from Andrews (2017) and Price (2017). Perhaps unsurprisingly, similar hopes and concerns for future practice were expressed. Concerns appeared to reflect the barriers respondents currently faced and therefore suggest a need for macrosystem changes to occur to enable EPs to fully engage in effective work in this area.

The demands of statutory work were the highest concern, with some fearing the EP role may become confined to statutory assessment. Indeed, this concern has been recognised (MacKay, 2002) and understood to hinder preventative work (DfEE, 2000), echoing participants' views within the current study. Linked to this, a small number expressed concerns around the focus on academic attainment instead of wellbeing (Miller 2016; Young Minds, 2017) and governmental agendas (Andrews, 2017), affecting the type of work prioritised for EPs. Concern was expressed that the EP role within SEMH may be misunderstood or not recognised (Andrews, 2017; Greig et al., 2019; Miller, 2016; Price, 2017), therefore respondents hoped for a greater recognition of the EP contribution and the importance of SEMH. Arguably, this could lead to increased opportunities in the future for EPs within mental health work.

Concerns around a 'reactive rather than proactive role' persisted within the findings (Farrell et al., 2006). Thus, in line with Law and Woods (2019) a high number of respondents hoped for more opportunities for strategic and systems work, supporting early intervention and prevention. Similarly, the wish to support others and develop their skills was reminiscent of the 'reconstruction of educational psychology' movement (Gillham, 1978), enabling capacity building. However, a small number expressed concern around limited opportunities leading to isolated working and limited systems work within future practice. Some also suggested that the quality of training, supervision and CPD opportunities were insufficient to support EP work in this area. This perhaps does not triangulate the finding that the majority perceived initial training and supervision to be supportive overall; however it does suggest variation in

training practice. The importance of this for developing skills and knowledge was recognised, with EPs hoping for more of this in future practice.

Although the 'dominant medical-model perspective' was not reported explicitly as a barrier (Price, 2017), this was evident within the hopes and concerns for future practice. This has also been suggested to hinder multi-agency working (Shannon and Posada, 2007) offering a potential explanation for the current study's findings. Specifically, EPs expressed a hope that a 'whole-child', holistic and ecosystemic approach would be adopted in practice rather than a medical, diagnostic approach. Perhaps EPs do not consciously perceive this as a barrier despite its implications for EP practice, consistent with the proposal in the line of argument synthesis (section 2.7.9).

The various factors impacting opportunities to engage in mental health work are presented in section 5.1.3 and thus influence the findings of this research question. Similar to existing small-scale research, the current findings highlight a discrepancy between the types of SEMH work EPs were involved in, and the kinds of work they would like to carry out (Andrews, 2017; Law and Woods, 2019; Miller, 2016; Price, 2017). The desire to engage in a wider range of work has been expressed by the profession over a number of years (DfEE, 2000; Farrell et al, 2006) and appear to persist within the profession currently in relation to SEMH work.

5.1.5 Reflective summary of findings

This reflective summary aims to explore the findings in relation to the line of argument synthesis in section 2.7.9.

Data derived from this sample support the suggestion of a tension between the medical versus biopsychosocial model, proposed in the line of argument synthesis. The analysis indicated that constraints within the systems in which EPs work result in continued engagement in individual level work, potentially reflective of a within-child, medical model view (Shannon and Posada, 2007). EPs wished to be involved more systemically, working with all members of a child's ecology, utilising their expert knowledge of school systems. This is evident in the desire to upskill adults around the child and for more involvement with

families and parents, empowering the systems that the child is situated within (Zafeiriou and Gulliford, *in press*).

Data therefore triangulates the view that EP work around SEMH is commonly underpinned by theories such as attachment theory, relationship-based approaches and ecosystemic theories such as Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979). Notwithstanding system constraints, EPs are adopting a holistic approach, utilising various theories and paradigms within their approach to individual level work. Data highlights EPs as skilled practitioners in relation to consultation, supporting adults and systems around young people. Although primarily perceived an individual level activity, consultation was therefore demonstrated to impact various levels of the system, further supported by the facilitation of group processes. Interestingly, respondents reported drawing on solution-focused approaches most; the antithesis of a deficit-based, medical model approach. With suggestions that consultation and systemic work is a unique contribution (Ashton and Roberts, 2006; Miller, 2016), the level of consultation and variety of consultative skills highlighted demonstrate the distinct offering of EPs within the area of SEMH.

Although mainly engaged in individual level work, data suggested that EPs are facing system constraints impacting their ability to deliver interventions. Given EPs' skills and reported confidence, it appears that this valuable resource is seldom accessed. Thus, the barriers recognised within the evidence-base and captured within the line of argument have appeared to persist. Nevertheless, findings from the current study challenge the findings of EP 'competence', as the majority of the sample expressed confidence, skills and knowledge in the area of SEMH. Competence was expressed despite working in contrast to the medical model and facing various barriers, contrary to that suggested in the line of argument.

Examples illustrated that EPs are well placed to deliver early intervention support through work at a more strategic and systems level, although occurring less in practice. It may be seen therefore that the tension between the medical and biopsychosocial models, proposed in the line of argument, do not appear to affect EP confidence but suggest conflict in EPs' ways of working. Thus, respondents expressed a strong desire to engage in more early intervention and prevention work.

The perception of the EP role was identified as a persistent barrier, with some suggesting EPs' SEMH skills are not recognised by schools, the government, and other professionals, echoing the line of argument synthesis. This may also explain why EPs were not considered a 'Lead professional' or involved in wider mental health initiatives or LA level work often. This misunderstanding of the role is reinforced by a lack of professional representation in relation to mental health: data also demonstrated that respondents felt that the voice of the profession is absent from government guidance, despite aligning with government aims and evidence of the valuable work EPs contribute to deliver these.

Respondents reported SEMH work through the five core functions of the role, across multiple levels, indicating that SEMH work is part of everyday practice for EPs. This was supported by qualitative responses suggesting that 'EPs are always assessing and supporting SEMH' and 'every involvement concerns SEMH'. This observation raises the question around why EPs are not recognised as a well-established professional working within the field of SEMH. Arguably, this reinforces the notion that the EP contribution is unknown or seldom recognised. Indeed, it has been suggested that evidence of EP mental health intervention in a breadth of forms distinguishes it from other branches of psychology and underlines the unique contribution of EPs (Price, 2017).

Given that the barriers echo those documented over a number of years (Ashton and Roberts, 2006; Farrell et al., 2006), this suggests that the system within which EPs are operating has seldom changed to accommodate the wider, varied role EPs can contribute. The current study would argue that the EP contribution should be recognised and that the constraints upon the system in which EPs work need to be addressed to enable the delivery of valuable and preventative work more fully. Thus, there are constraints in EPs' more immediate systems such as their service and LA context, schools' funding and priorities, and also more widely, in terms of not being recognised in governmental initiatives and agendas. The service and LA context are more within EPSs immediate control and thus implications are suggested for EP practice later in this chapter. The findings appear to strengthen the line of argument which synthesises predominantly small-scale research studies, although challenge the suggestions around EPs' competence and skills.

5.2 Methodological strengths and limitations

5.2.1 Survey measure

As no current measure existed, the researcher designed the survey instrument based on literature reviewed. A pilot study ensured it was fit for purpose and the intended sample and context. Multiple literature sources supported the construction of survey questions, ensuring items appropriately covered the topic, thus enhancing content validity. Further, each question was linked to the research questions under investigation with a clear rationale for each, supporting construct validity (Robson and McCartan, 2016) (appendix 4). Developing several questions for each component issue enhances reliability and validity, representing a wider scope of the topic (Cohen et al., 2018). This may be considered a strength of the current survey as it aimed to be comprehensive, covering a range of topic areas and practice in relation to SEMH. A further strength was the mixed methods approach adopted: qualitative responses aimed to enhance validity by providing participants the opportunity to expand on their quantitative responses, allowing for triangulation (Robson and McCartan, 2016).

A number of limitations must be recognised. The high number of incomplete responses may suggest the survey was too long, potentially leading to measurement errors such as respondent fatigue (Cohen et al., 2018). Other possible measurement errors and threats to validity include participant memory and inaccurate responses, participant motivation, or social desirability (Mertens, 2015; Oppenheim, 1966). In particular, participants may have felt obliged to show agreement with the statement ‘SEMH should be part of the EP role’. Upon reflection, this question may have been better suited to a Likert scale response given that it assessed attitudes. Measuring the strength of agreement, for example, ‘strongly agree’ through to ‘strongly disagree’, may have been more informative. Inherent to surveys, a further threat to validity is self-report data (Mertens, 2015; Robson and McCartan, 2016), in which the survey may have measured what participants say they do, or would like to do, in comparison to their actual practice.

Furthermore, although question wording was carefully considered and piloted, some ambiguous questions were included: for example, the question concerning the effectiveness of promotional methods may have led to invalid results due to the way in which the question

was asked. Providing examples of qualitative response formats could have supported the instruction for extra detail for example: ‘activity, who with, at what level’. Bounded recall was not employed consistently which may have supported the accuracy of responses (Mertens, 2015), for example, how often respondents used particular interventions or delivered particular training. Additionally, temporal responses used in Likert scales, for example ‘rarely’ and ‘often’, are open to variation in their meaning (Cohen et al., 2018). Although five-point Likert scales are generally used (Robson and McCartan, 2016), four-point Likert scales were adopted to avoid giving a neutral choice, as it was assumed that respondents should be able to provide a frequency answer (Cohen et al., 2018).

The study could be criticised for not providing a clear definition of ‘SEMH’, which may have impacted on the results of the study, given that literature has suggested that EPs may construct mental health differently, and are reluctant to adopt the term ‘mental health’ (Andrews, 2017; Miller, 2016). Thus, it is difficult to ensure that respondents’ understanding of SEMH was similar to other respondents, affecting construct validity. It was hoped that this was avoided by adopting familiar terminology in line with the legislation guiding EPs within their work: the *SEND Code of Practice* (2015). Nevertheless, it is acknowledged that the *Code of Practice* (2015) could be criticised for lacking a clear definition of SEMH.

5.2.2 Sample

The study recruited a relatively large sample *(n=154)*, covering a larger geographical area than previous research. This is seen as an effort to enhance external validity by sampling those in different roles in the profession and within different service contexts to elicit any geographical and practice variations, therefore contributing valuable insight into professional practice. Findings largely replicate those from small-scale studies and provide depth through adding detail to such findings. However, criticisms could be made to the sampling strategy and lack of random sampling. Additionally, it is recognised that there were under/over-representations of particular regions, which may affect generalisability.

The rich demographic data collected aimed to increase the transferability of the findings. However, participants largely represented those in younger age groups and year three TEPs, which arguably may impact the practice reported: a higher percentage will have been trained on the doctoral course, have recently emerged from training, and will have trained at

a time when the importance of SEMH has increasingly been recognised. Furthermore, participants likely represented those with a greater interest in SEMH or perhaps more involved in SEMH work; participants carrying out less may not have been motivated to respond, thus contributing a further measurement error.

Although it is recommended to keep demographic questions to the end of the survey (Cohen et al., 2018; Oppenheim, 1966), this meant that the researcher could not identify the characteristics of non-respondents and compare this to respondents to inform the quality of response rate. However non-response is said to be less of an issue when the sample is homogenous than when the sample is varied (Cohen et al., 2018). Furthermore, technical difficulties have been identified as a disadvantage of online surveys (Cohen et al., 2018): the researcher encountered technical difficulties which may have contributed to the rate of partial responses, due to automatic submission by the software after a period of time.

5.2.3 Analysis procedure

The exploratory nature of the study is a threat to validity, restricting the causal inferences that can be made. The survey's data analysis could be criticised in that quantitative data was limited to descriptive statistics. However, descriptive statistics were conducted in line with a descriptive exploratory approach (Cohen et al., 2018; Oppenheim, 1966), and univariate analysis illuminated interesting findings. It is acknowledged that bivariate analysis exploring associations between variables would have allowed for closer examination of potential patterns or relationships within the data, however, the researcher deemed the qualitative analysis to support triangulation and add strength to the findings.

Regarding the CA, the categories on the coding frame may not be entirely mutually exclusive, potentially affecting content validity (Cohen et al., 2018) however this appears to emphasise the complexity of the EP role in the area of SEMH, and the interrelations between the core functions and types of work EPs carried out. Thus, the overlap between activities and outcomes are recognised and led to difficulties dissecting the role into discrete involvements, especially for activities which could be perceived to impact at all levels: for example, Circle of Adults whereby involvement is primarily requested around an individual young person, however as a group process, is perceived to have an impact on the system in which the young person is a part of. It was clear from responses that participants perceived

this differently. Nevertheless, this highlights the broad nature of the role and the wide reach of the EP contribution.

Furthermore, the subjective nature of the qualitative interpretation is recognised, and some questions may have been interpreted differently for example, around skills, leading to a large range of answers. This provided some difficulty at the coding stage when creating categories that did not necessarily reflect the question asked, but reflected the data given for example, qualities and values that EPs possess versus skills. Weber (1990) suggests that validity relies on the coding frame being reliable and consistent, that is, different people would code the text in the same way. The researcher sought to ensure this by discussing, reviewing and revising conceptual categories with colleagues, the research supervisor, and a fellow researcher to limit subjectivity and ambiguity, and enhance reflexivity, therefore enhancing the trustworthiness of the analysis (Bengtsson, 2016). The CA drew upon the immersion of the researcher in the field, and theory; and the qualitative nature of the processes ultimately counterbalanced the lack of formal inter-rater reliability measures.

Schreier (2012) suggests that high reliability is easily achieved with manifest content which has literal meaning and is easily identified within the data. Arguably, the majority of the data can be seen to fit this description, given that it is largely of a descriptive nature, identifying well-established EP activities. In this sense, the coding frame can be seen to have validity, as categories reflect the constructs intended to be measured, and the coding frame was largely based on the existing survey structure (Schreier, 2012; Weber, 1990). The CA is considered to have a high level of confirmability, as raw qualitative data used to generate the categories of the coding frame are presented in the Appendices for transparency.

5.2.4 Mixed methods and quality inference

The current study adopted a mixed methods design triangulating quantitative and qualitative data to provide further insight and depth to the findings. Although all participants were able to provide qualitative data, some chose not to; those who did may have held stronger views or were potentially more involved in SEMH work. Despite critics of mixed methods proposing an ‘incompatibility thesis’ (Teddlie and Tashakkori, 2009), the researcher deemed mixed methods as appropriate to answering the research questions fully, ensuring fidelity to the design and a clear description of the research process to increase dependability of the

findings. Furthermore, the study can be seen to have achieved credibility through triangulation of data sets and therefore, analytic adequacy (Teddlie and Tashakkori, 2009). Thus, the design quality of the study was well considered, appropriate to research aims, with qualitative data adding richness to the quantitative data collected.

The above limitations are likely to have impacted the internal and external validity of the survey and must therefore be considered when judging the reliability of the study's findings.

5.3 Implications of the current research

5.3.1 Implications for professional educational psychology practice

As highlighted by Law and Woods (2019), the current research provided EPs with an opportunity to reflect on their SEMH practice and application of psychological theory and knowledge to practice. As the study hoped to inform future development in mental health policy and EP practice, three overarching actions can be seen to emerge from the findings. Firstly, the current findings should be disseminated widely to ensure that the EP contribution is more fully recognised by all stakeholders that EPs work with including education settings, local authority managers and commissioners of services. Secondly, it is hoped that this will support policy makers in acknowledging the EP contribution and ensure the profession is fully and accurately represented within guidance around mental health. Finally, it is argued that there is work to be done at multiple levels to address the persistent system constraints that EPs are working within: at the EPS, LA and more widely at a governmental and policy level. As aforementioned, the current findings have identified a number of implications for EPSs.

It is hoped that the findings may stimulate discussion within EPSs around what is working well and areas for development. In this sense, the findings may support an individual service audit of facilitators and barriers to engaging in SEMH work. Senior leaders and service managers may potentially use the results to inform their service development plan within this area. EPSs may also begin to consider how to disseminate these findings with educational settings, particularly with Post-16 and FE providers or EYs settings. EPSs could reflect on the structures in place to ensure that EPs engage in a broader variety of experiences within

their role and are not constrained by statutory pressures. Interrogating allocation systems may enable equity amongst EPs and the opportunity to extend their skills in SEMH work. Furthermore, the current research did not measure the impact of EPs' varied involvement. It may be that EPSs reflect on how they are reviewing and evaluating their work around SEMH.

Findings emphasised the importance of initial training, and of CPD and quality supervision to develop competencies and enable effective professional practice. Services should ensure that this is prioritised to support professional development in the area of SEMH. It may also be helpful to ascertain the views of EPs around supervision offered within the service to inform supervision practices around SEMH. These considerations may support the development of an EPS policy to support EPs with their SEMH work. It may be that networking with other EPSs is supportive to such developments through identifying what is working well in other contexts, given the wide diversity in practice.

Regarding the types of SEMH work delivered, the findings suggest areas for focus. The findings indicate that EPSs are *offering* a wide range of interventions, which arguably suggests EPSs recognise the value of such support. Despite this, little intervention *delivery* was reported. EPSs may benefit from exploring their level of engagement in delivering interventions and any individual service factors which may prevent this. For example, this may be due to service-related factors or the interest and uptake from schools, in which EPSs may need to consider how to promote the availability and benefit of such work to schools. Overall, findings illustrated little involvement within EYs and Post-16 and FE settings. Therefore, EPSs may wish to consider ways to develop their practice with these age groups, informed by the findings of the current study and others (Douglas-Osborn, 2017; Morris and Atkinson, 2018b). It may be helpful to explore the barriers to working with these settings, as this may vary between LA contexts. Findings appeared to highlight a high level of involvement with young people either side of their secondary transition. EPSs may consider how to develop their offer around supporting transitions at a systems level.

5.3.2 Implications for future research

Given the broad nature of the current survey, a number of areas for further research are identified, allowing for an in-depth exploration of certain aspects of EP practice in relation to SEMH.

In response to the persistent finding that others may be unaware of the EP role within the area of SEMH, a wide-scale survey ascertaining the views of LA managers or policy makers may be beneficial. The survey could explore what stakeholders value about the role and what they would like to see in the future, informing EP practice within SEMH. Furthermore, it may be informative to gather the views of SENDCos or pastoral staff within EYs and Post-16 and FE settings around their perceptions of the EP role in supporting mental health. Such findings may allow for the exploration of barriers and would be informative to extending EP practice within these settings.

Findings highlighted that most felt well supported in SEMH work as a result of their initial professional training however, 42.1% felt less well supported. It would be interesting to further explore the quality and impact of initial training courses, and any geographical variations, in equipping EPs with the necessary skills and knowledge. Linked to this, closer investigation around the factors contributing to EP confidence, competence, and skills and how to minimise variation would be valuable. Given the varied involvement across the age phases within the current findings, EP confidence working with different age groups around SEMH needs may be worth exploration.

A varied picture emerged regarding multi-agency work. Further in-depth exploration of multi-agency working within different geographical locations could be informative given the current context of the mental health initiatives. Future research could explore who EPs engage in multi-agency work with, how this work arises and the barriers and facilitators. This may indicate directions for improvements in line with governmental agendas and professional desires for a coordinated response to supporting young people's mental health. Further exploration of EP work within trailblazer sites will be beneficial to understand the varied ways in which EPs are contributing to the Green Paper proposals; given a small number shared some interesting examples such as facilitating a PATH as part of the trailblazer project.

Although research around EP supervision exists, to the researcher's knowledge, the supervision of SEMH related work has not been addressed. Therefore, given the recognised importance of supervision in this study, further exploration of what makes effective supervision in the area of SEMH will be valuable.

5.4 Conclusion

This study sought to establish a stronger professional identity within the area of SEMH in light of reforms. The researcher aimed to build upon existing, largely small-scale research to investigate current EP practice and opportunities around SEMH and the factors supporting or hindering engagement within this area. Additionally, the researcher hoped to gain a deeper understanding around EPs' confidence, skills and knowledge within this domain.

Findings demonstrated that EPs are actively supporting children and young people's mental health, despite little recognition within government guidance. This suggests various other factors account for this absence of professional representation, explored through a synthesis of previous literature and an empirical study of current EP practice. The findings highlight that EPs see a continued role offering a valuable range of support at multiple levels through the five core functions of the role.

Findings have highlighted the importance of extending practice into EYs and Post-16 and FE settings. A less clear picture emerged around EP confidence and competence warranting further investigation. Linked to this, the importance of initial professional training, CPD opportunities and supervision were prominent in the findings, emphasising the significance of these for the future development of the profession. Overall, findings illustrated that EPs feel skilled and knowledgeable, offering a wide range of theoretical perspectives and application of psychological knowledge, extending the findings of previous research.

The combination of EPs' knowledge of psychological theory, child development and school contexts suggest a unique contribution. Furthermore, consultation and the notion of empowering systems around young people was commonly reported and has been

interpreted to be unique to the EP role (Ashton and Roberts, 2006; Farrell et al., 2006). EPs can be seen to support school systems more widely, through supporting young people's wellbeing in addition to staff wellbeing.

Opportunities for involvement in systems level work, projects and research were limited in the current sample. EPs would like to engage in more early intervention and prevention and work at the strategic and systems level. A small number reported liaison with the Green Paper proposals, suggesting little involvement with policy initiatives. However, it is recognised that this sample of the population may not be fully representative, thus it will be interesting to extend such findings in future research. Linked to this, the desire to deliver a coordinated multi-agency response to young people's mental health was highlighted and could benefit from further investigation.

The current findings illustrate that EPs face continued barriers to their work around SEMH and qualitative responses allowed for a deeper understanding around the impact of such complex interrelationships. Thus, the study suggests that there are issues for the profession's attention, some of which are highlighted in the implications for EPSs. Additionally, EPs face wider systemic barriers and it is argued that the profession will need to identify ways to address these, potentially through the continued efforts of professional bodies and unions such as the BPS Division of Child and Educational Psychology (DECP) and the AEP.

It is hoped the current research can be a catalyst towards change by supporting the profession to reflect on practice and developments, alongside making others more aware of the EP role and contribution within this area. Furthermore, the findings may support the promotion of the role, at a wider LA and governmental level. EPs undergo extensive government funded training to support children and young people's education and development, including their SEMH (Lyonette et al., 2019). The findings of this study illuminate the valuable knowledge and skills EPs contribute within the context of education, arguably demonstrating that mental health policy should more fully include EPs as a professional group.

The unique contribution of the current study lies in its large-scale nature, gathering views from individual EPs across a range of geographical locations. Although this could be improved it provides a holistic overview of EP practice in this area and is hopefully timely and informative to the profession. The researcher concludes that the current study has captured a range of professional practice, triangulating and extending existing research, drawing together important implications for the future of the profession.

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Burton, S. (2001). *ELSA Trainers' Manual.* London: Speechmark

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Moran, H. (2001). Who Do You Think You Are? A Technique to Explore a Child's Sense of Self Drawing the Ideal Self. *Clinical Child Psychology and Psychiatry, 6*(4), 599-604

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Burden, R. L. (2009). *Myself As a Learner Scale*. Birmingham: Imaginative Minds.

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White, M. and Epston, D. (1990). *Narrative means to therapeutic ends.* New York: W.W. Norton and Company Ltd.

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Boxall, M. (1976). The nurture group in the primary school. *Therapeutic Education, 4*(2), 13–18.

Personal Construct Psychology

Kelly, G. A. (1991). *The Psychology of Personal Constructs: Volume One: Theory and personality.* London: Routledge

Planning Alternative Tomorrows with Hope (PATH)

Pearpoint, J., O'Brien, J., and Forest, M. (1993). *PATH: A workbook for planning positive, possible futures and planning alternative tomorrows with hope for schools, organizations, businesses and families*. Toronto: Inclusion Press.

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Prince-Embury, S. (2006). *Resiliency Scales for Children and Adolescents.* Pearson Education Ltd.

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Forrest, M. and Pearpoint, J. (1996). *Solution circle: Getting unstuck a creative problem solving tool*. Retrieved from https://inclusion.com/inclusion-resources/training-tools/solution-circle/

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Therapeutic stories

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Kennedy, H., Landor, M. and Todd, L. (2011). *Video interaction guidance: A relationship-based intervention to promote attunement, empathy and wellbeing* (pp. 58–82). London: Jessica Kingsley Publishers.

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Berg, I.K. and Shilts, L. (2004). *Classroom solutions: WOWW approach*. Milwaukee, WI: BFTC Press.

Appendices

7.1 Appendix 1 – Reasons for excluding articles from the Systematic Literature Review

- Al-Khatib and Norris (2015). A family consultation service: Single session intervention to build the mental health and wellbeing of children and their families
    - Paper did not include a critical reflection on the EP role
- Roffey (2016) Building a case for whole-child, whole school wellbeing in challenging contexts
    - Paper did not focus on a critical reflection on the EP role
- Rae, Cowell and Field (2017)
    - Secondary aim to examine the EP role in providing supervision with minimal data provided. Data primarily related to teacher participants' reflections on working in an SEBD school
- Langton (2017). Adopted and permanently place children in education: from rainbows to reality.
    - Predominantly concerned adopted children/ EP role in LAC population
- Morris and Atkinson (2018). How can educational psychologists work within further education to support young people's mental health? An appreciative inquiry.
    - Focused on looking at what EPs *could* be doing (dream and design phase) rather than what they *are* doing – limited results reported at this stage
- Harvest (2017). How can EPs best support secondary school staff to work effectively with children and young people who experience social, emotional and mental health difficulties?
    - Despite the title, there appeared to be an imbalance in data presented, with a high focus on school staff views and school staff data. Findings from phase 1 EP focus group were not discreetly reported and were reported together with school staff findings. Paper appeared to focus on school staff supporting SEMH and EPs views on how school staff view and support SEMH. EP role was reflected more in discussion rather than in the findings with data as

evidence. RQ3 – findings reported where EPs could add value rather than reporting what they already do. EP views were diluted amongst school staff data; EP data was fed in to the framework of school staff data.

- Hulme (2017). How can Children and Adolescents Mental Health Services and Educational Psychology Services work together more effectively to address the mental health needs of young people in school?
    - Was not clear from research aims or research questions that the research included a main methodological focus on exploring the current EP role and contribution (although the EP role in supporting MH emerged as a key theme in the data). Study adopted a primary focus on joint working between schools, CAMHS and EPs.
- Hughes (2018). An exploration of the perceptions of adolescent mental health and multiagency collaboration over Adolescent mental health.
    - Paper did not focus on a critical reflection of the EP role in supporting MH
- Evans (2016). Primary school teachers' experiences of wellbeing. How can wellbeing be supported by schools and educational psychologists?
    - Primary focus on school staff's perception of wellbeing and the role that EPs could play rather than what EPs are currently providing

7.2 Appendix 2 – CASP guidance materials

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal
Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal
Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes
Can't Tell
No

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes
Can't Tell
No

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	

7.3 Appendix 3 – Themes identified in synthesis of included studies

	Study and evidence:					
Theme:	Law and Woods (2019)	Greig, MacKay and Ginter (2019)	Zafeiriou (2017)	Andrews (2017)	Price (2017)	Miller (2016)
Limited scope of the EP role	Other agencies' persistent views of the EP role as restricted to learning support EPs felt that a broader understanding of the EP role was being constructed and more widely recognised by schools	Authors propose there is a gap between how EPs view their role and how it is seen by wider society, particularly the government and commissioners of services		EP role not universally defined by those outside of the profession or within the profession – SENDCos viewed the EP role as the 'assessment of individual pupils'	EPs felt that constructs of their role was limited to learning however SENDCos suggested they considered EPs to have a role in mental health and to be knowledgeable and 'experts'. There was a sense from some SENDCos that EPs had a limited role in mental health and that SENDCos would typically refer for learning needs and involve EPs where there was an impact upon academic attainment.	EPs felt they needed to make schools and other professionals aware of their skill set Some clinical psychologists wanted greater clarification on the EP role and cognitive assessment was seen as a valuable aspect of the EP role
Threats to professional identity	Preventing multi-agency work					"Professional defensiveness"
Within-child focus/ impact of labelling	Labelling – "static", "within child" and potentially become a child's definition of themselves.			SENDCos viewed the EP function to focus on cognitive assessment in particular		Cognitive assessment by EPs is seen as a valuable aspect of the EP role in order to understand intellectual abilities EPs express caution with labels and language

Psychological frameworks and perspectives	Cognitive and neurobiological factors e.g. Executive Functioning, attachment and relational psychodynamic psychology, humanist approaches, e.g. Human Givens, behaviourist approaches and eco-systemic considerations of contexts and interacting factors. Solution-focussed emphasis on change		Joining theory with evidence. Solution-focussed approaches, attachment theory, self-determination theory, collaborative consultation			Interactionist, ecological paradigm, attachment theory, psychodynamic perspectives
Definition/ understanding of mental health	Externalising and internalising behaviours identified. EPs commented that behaviour (externalising) and SEMH needs are connected	*Given*		Difference in understanding of psychological wellbeing within and between different professions. Reluctance to use the word mental health due to links with medical model, preference for 'emotional wellbeing'	Biopsychosocial construction of mental health	Difficulty defining mental health however EPs adopt a social constructionist approach to mental health; influenced by a range of internal and external factors. EPs more comfortable referring to 'emotional wellbeing'
Working with others through problem-solving	Not adopting an expert role and 'giving away psychological knowledge to empower others' Helping schools and families - reframing ideas on causes for concerning behaviour and supporting problem-solving processes	Main role: as supporting others in regular contact with young person	Upskilling adults and facilitating a therapeutic relationship between the adult and child. Close collaboration with school staff and parents. EPs leading problem-solving processes to allow for safely challenging adults' perceptions with a view to helping them reframe	Change schools understanding of mental health and wellbeing – reframe discourse around behaviour to consider underlying emotional states Working with families and other professionals – joined up work enabled through consultation. One SENDCo valued the EP role in supporting	EPs were involved in multi-agency work	Collaboratively working with families and bringing different systems together.

			their perception of their concern	collaborative problem-solving with parents and other professionals.		
Working at multiple levels	Consultation, intervention with individuals and groups and systemic work, individual casework and assessment	Training for school staff, interventions with parents and carers, direct work with pupils, systemic work supporting the development of a mental health policy.		Provision of staff supervision or support groups/ peer supervision, consultation and training, direct interventions	Systemic intervention such as training and consultation. Assessment and therapeutic intervention	Whole-school preventative approaches, training and individual therapeutic work
Future practice	EPs expressed a wish to increase their use of consultation and therapeutic work and increased systemic working within schools and the LA Working more preventatively and with greater multi-agency liaison			EPs wished to support mental health of children and young people and staff	EPs wanted to have more of a therapeutic role and support teacher mental health	A desire to collaborate with clinical psychologists to provide mutually better services
Facilitators and barriers	Facilitators: good relationships between schools and EPs, perceptions of others, opportunities for multi-agency working Barriers: challenges of multi-agency working, time restrictions, differing perceptions of EP role amongst service commissioners	Barriers: time and levels of staffing, links with other agencies	Facilitator: involvement over time Barrier: traded EPSs	Barriers: time, model of service delivery limiting delivery of therapeutic intervention, pressures of statutory duties, schools assessed on academic outcomes rather that emotional wellbeing of CYP	Facilitators: knowledge, confidence and competence, consultation model and schools wanting mental health support Barriers: consultation model, preventing direct therapeutic work, time, statutory assessments, school awareness and understanding of mental health, schools' awareness and understanding of mental health	Barrier: service delivery model not allowing time for direct work, multi-agency working, school focus on academic performance

Competence	Skills needed such as empathy for adults	71% of respondents reported that their capacity in terms of knowledge and skills presented little or no barrier to meeting mental health needs	Skills identified: listening, empathising, containing, attunement, collaborative EP skills growing as a result of engaging in mental health work	EP fear of working in the field of MH – one participant felt this may be due to confidence and skills of EPs? Feeling deskilled and not practicing within this area much However, EPs were seen to hold specialist knowledge	Knowledge, confidence and competence were identified as facilitators however confidence and competence were also highlighted as barriers: competency with complex cases and confidence due to skills diminishing over time	One participant expressed not always having the skills but wanting to develop them through practice – EP skillset acknowledged as limited

Table illustrating the themes generated from included papers during the synthesis process. Text in blue highlights oppositional data in relation to themes.

7.4 Appendix 4 – Rationale for inclusion of survey questions linked to the research questions

Research Question	Survey questions to answer	Rationale for asking question
RQ 1: What is current EP practice in supporting CYP's mental health?	In the last year, approximately how many individual children and young people with SEMH needs have you had the following involvement with?	To establish how much EPs are involved in SEMH work and whether this is in the form of casework, consultation or statutory work.
	Which of the following age groups have you carried out SEMH work with? *Please provide examples of the work undertaken with each year group, at the individual, group or systemic level*	Potential discrepancies amongst reported involvements i.e. variations in reports around delivery of therapeutic work – attempt to gather a more representative, national picture
	Which of the following age groups have you carried out SEMH work with the most?	Absence of available data in the current literature and evidence base
	In which of the following areas have you contributed to SEMH work? *Please provide examples of activities undertaken and who this is with i.e. school staff, parents, others and if this is at the group, individual or systemic level*	To establish in what ways EPs are working with children and young people with SEMH needs as part of their role. The literature largely reports EP involvement in evaluating interventions. There is limited empirical research exploring EPs' contribution through other core functions of the role such as training and consultation
	Have you delivered any work to support school staff wellbeing? ***Please tick***	Suggestion from small-scale research that supporting teachers' wellbeing is currently an underdeveloped role for EPs (Rae, Cowell and Field, 2017). To identify if supervision or alternative methods to supporting staff wellbeing is occurring within EP practice across England
RQ 4: What are the opportunities for engaging in mental health work?	If you are engaging in systemic or organisational work in relation to SEMH, in what settings is this occurring? *Please give examples of the work*	To explore whether EPs are engaging in systemic work in this area and in which settings within England. Greig, MacKay and Ginter (2019) found that secondary schools were most interested in strategic work, followed by primary schools and around half of early years settings.

Research Question	Survey questions to answer	Rationale for asking question
RQ 1: What is current EP practice in supporting CYP's mental health?	Which of the following interventions are offered by you or your service in relation to SEMH?	To explore what interventions are on offer within services
	How often do you personally carry out the following interventions?	To explore which interventions EPs reported using most frequently To explore how often EPs are delivering interventions that are advertised within their service
	How often are your interventions at the individual, group, or whole-school level?	To explore at what level EPs are carrying out interventions and how often
	What SEMH-related training does your service offer?	To explore what training is on offer within services
	What SEMH-related training have you carried out? *Please state what types of training you have delivered at the following levels (group, whole-school, parent, strategic or LA, none)*	To explore what training EPs are offering and at what level
	Do you feel that SEMH work should be part of the EP role?	To gain the views of EPs' around their role within SEMH work. There is a discrepancy within the research around whether this is the role of EPs or other agencies such as CAMHS/ clinical psychologists (Atkinson, Corban and Templeton, 2011; Greig, MacKay and Ginter, 2019). Andrews (2017), Greig, MacKay and Ginter (2019) and Price (2017) reported varying views within the profession around how central mental health is to EPSs
	Would you engage in SEMH work with a child or young person where another SEMH agency is involved?	EPs have expressed a desire to work with greater multi-agency liaison (Law and Woods, 2019)
RQ 4: What are the opportunities for	How often do you typically engage in multi-agency work around SEMH?	Atkinson, Corban and Templeton (2011) illustrated that EPs feel that other services (e.g. CAMHS) are more associated with mental health

Research Question	Survey questions to answer	Rationale for asking question
engaging in mental health work?		support and joint work was variable. Greig, MacKay and Ginter (2019) reported mixed findings in relation to EPS links and communication with other agencies. Multi-agency working has been seen as a barrier (Law and Woods, 2019)
	Are you, or have you been, considered a 'Lead Professional' within any mental health work? *Please explain*	Atkinson, Corban and Templeton (2011) illustrated that EPs feel that other services (e.g. CAMHS) are more associated with mental health support
	Are you linking with any Designated Senior Leads for Mental Health, Education Mental Health Practitioners, or any other school-based Mental Health lead staff? *If so, how? e.g. training or involvement in working alongside the Green Paper proposals*	A number of EPSs reported linking with primary mental health workers (Greig, MacKay and Ginter, 2019). With the Green paper proposals and introduction of new 'Designated Senior Leads for Mental Health' and 'Education Mental Health Practitioners', exploring EPs' involvement with such professionals is pertinent to enable insight into the EP role in supporting the implementation of Green Paper proposals
	Are you involved in any mental health developments, for any ages, within your local authority, for example, representing on local multi-agency mental health forums or developing interventions? *Please explain*	A high proportion of EPSs reported EP representation on local mental health forums with other agencies (Greig, MacKay and Ginter, 2019) – key to explore if this is occurring within England
RQ 3: What factors are influencing delivery of mental health work?	Some of the following factors have been identified as barriers to EPs engaging in SEMH work. Which do you feel you are affected by? *Space is provided for you to expand on your answer if you wish*	Facilitating factors and barriers have been explored within small-scale research (Andrews, 2017; Atkinson, Corban and Templeton, 2011; Greig, MacKay and Ginter, 2019; Law and Woods, 2019; Miller, 2016; Morris and Atkinson, 2018; Price, 2017; Zafeiriou, 2017) – attempt to establish a clearer picture around the most commonly occurring facilitators and barriers on a wider scale
	Are there any factors that you feel currently support you in engaging in SEMH work?	

Research Question	Survey questions to answer	Rationale for asking question
RQ 2: What are EP's perceptions of their confidence, skills and knowledge in relation to mental health work?	How confident are you in your approach to SEMH work at the individual level, group level, whole school level and strategic/ Local authority level?	Some research has reported mixed findings in relation to EPs' confidence in SEMH work (Andrews, 2017; Price, 2017).
	Give examples of activities you are most confident to engage in	
	How confident are you in working with other agencies around SEMH?	EPs have expressed a desire to work with greater multi-agency liaison (Law and Woods, 2019) Atkinson, Corban and Templeton (2011) illustrated that EPs feel that other services (e.g. CAMHS) are more associated with mental health support and joint work was variable. Greig, MacKay and Ginter (2019) reported mixed findings in relation to their links and communication with other agencies. Multi-agency working has been seen as a barrier (Law and Woods, 2019)
	How skilled do you feel working in the area of SEMH?	Some small-scale studies have suggested that EPs may feel deskilled (Andrews, 2017; Miller, 2016; Price, 2017). To explore in a wider sample of individual EPs
	Which skills do you perceive to be the most important when working with schools around SEMH? *Give up to 2-3 examples*	Minimal discussion around contributing skills within empirical literature (Law and Woods, 2019; Zafeiriou, 2017).
	What theories or paradigms, if any, guide your practice when working in the area of SEMH?	Given the wide range of theoretical perspectives highlighted across small samples of EPs (Law and Woods, 2019; Miller, 2016; Zafeiriou, 2017) it is important to gain consensus on the most dominant theoretical perspectives and frameworks informing EP practice around SEMH from a larger sample of EPs

Research Question	Survey questions to answer	Rationale for asking question
	How well do you feel that initial professional training in educational psychology has supported you in engaging in work around SEMH?	Key to understand what may contribute to confidence, skills and knowledge in relation to a wider number of individual EPs The relationship between training, confidence and likelihood of engaging in MH work emerged as closely related concepts (Fee, 2011).
	Have you received further training or CPD opportunities around SEMH since initial training? *If so, what opportunities?*	Access to training and CPD has been identified as a facilitator to EP practice in this area (Atkinson, Squires, Bragg, Wasilewski and Muscutt, 2013). To explore opportunities for this in wider practice
	How well do you feel supported by professional educational psychology supervision around your work involving SEMH?	Access to supervision has been identified as a facilitator to EP practice in this area (Atkinson, Squires, Bragg, Wasilewski and Muscutt, 2013; Fee, 2011). Greig, MacKay and Ginter (2019) found that just over a third of respondents felt well equipped in terms of supervision. To explore in relation to a wider sample of the profession
RQ 4: What are the opportunities for engaging in mental health work?	Would you consider that SEMH is a priority in current service delivery?	Clear service vision highlighted as necessary to support EPs to engage in work around mental health (Fee, 2011).
	Would you consider SEMH is an identified strategic priority in the locality (/localities) in which you work?	Commitment from LAs to prioritise EPs working in a therapeutic way has been identified as a facilitator to EP practice in this area (Atkinson, Squires, Bragg, Wasilewski and Muscutt (2013)
	What are the principal ways in which your service promotes the EP role in SEMH work?	Price (2017) suggested that there is a dearth of research considering the impact of traded models which could have implications for EPs and their work. The author acknowledged the increase in traded services within England, highlighting this
	How effective do you perceive these promotional methods to be?	

Research Question	Survey questions to answer	Rationale for asking question
		as an area to explore. It will be key to understand how EPs are advertising their work in SEMH; both traded and non-traded contexts. Lee and Woods (2017) suggested traded services has enabled better promotion of the services on offer. Promoting the wider role to service users has been identified as a facilitator to EP practice in this area (Atkinson, Squires, Bragg, Wasilewski and Muscutt (2013).
	Does your service have a mental health policy, strategy or other service guidance to support EPs with their SEMH work? *If so, please give details*	Clear service vision highlighted as necessary to support EPs to engage in work around mental health (Fee, 2011). Greig, MacKay and Ginter (2019) found that only 1 EPS had a mental health policy or strategy, and 7 EPSs were 'in development'.
	What are your hopes for future practice by educational psychologists around SEMH?	To explore EPs' hopes and concerns for their practice in the future within this area within the context of the current government's mental health agenda
	What are your concerns for future practice by educational psychologists around SEMH?	
Demographic questions	Role (PEP, Senior EP/ Senior Prac, maingrade EP, NQEP, TEP)	To contextualise the data, assess the representativeness of the sample and allow for in-depth analysis
	Gender	
	Age	
	Years practicing as an EP (/TEP)	
	Professional training qualification in educational psychology	
	Service delivery context	
	Region of work	
	Trailblazer site?	
	Please provide your Full Time Equivalent (FTE) in the box provided. If you are a trainee, please indicate if you receive a salary or bursary.	

RQ 1: What is current EP practice in supporting CYP's mental health?

RQ 2: What are EP's perceptions of their confidence, skills and knowledge in relation to mental health work?

RQ 3: What factors are influencing delivery of mental health work?

RQ 4: What are the opportunities for engaging in mental health work?

Demographic questions **(9 variables)**

Variables (n=13):

- Current EP practice
- Competence (confidence, skills and knowledge)
- Influencing factors
- Opportunities
- Demographic variables x 9

7.5 Appendix 5 – Copy of the full survey as viewed on Qualtrics

SEMH survey

An investigation of the role of the Educational Psychologist in meeting social, emotional and mental health needs

This is an invitation to take part in a research study looking into the role of Educational Psychologists (EPs) within social, emotional and mental health (SEMH) work. The research intends to gain an understanding of the practices of EPs nationally in relation to SEMH through the following research questions:

1. What is current EP practice in supporting children and young people's mental health?
2. What are EP's perceptions of their confidence, skills and knowledge in relation to mental health work?
3. What factors are influencing delivery of mental health work?
4. What are the opportunities for engaging in mental health work?

This study forms part of my Doctorate in Applied Educational Psychology, and will be written up into a thesis and disseminated in other ways. Before you decide if you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

If you participate, you will be asked to engage in an online survey which will consist of a number of questions around EP work in the area of SEMH. The survey should take around 30 minutes and will include both fixed choice and free answer questions. You will be asked to provide some demographic information.

Participation in this study is entirely voluntary and you are under no obligation to take part. You are free to withdraw at any point before or during the study by exiting the survey. Incomplete surveys (i.e. where participants have not reached the end and pressed the submit button) will not be included at the data analysis stage. All data collected will be kept confidential and used for research purposes only. Confidentiality and anonymity will be ensured by assigning a participant code to data and data analysis will not identify any individual. Data will be stored in compliance with the Data Protection Act. As an online participant in this research, we are obliged to make you aware that there is always a potential risk of intrusion by outside agents, for example through hacking, and therefore the possibility of being identified.

If you have any questions or concerns, please do not hesitate to contact the researcher at the below email address. You can also contact the Chair of Ethics Committee at the email

address below. Please feel free to contact the researcher before, during or after your participation. Thank you for your interest in taking part in the study.

Nina Purewal Trainee Educational Psychologist

School of Psychology

University of Nottingham

Nottingham

NG7 2RD

nina.purewal@nottingham.ac.uk

Supervisor: Anthea Gulliford (anthea.gulliford@nottingham.ac.uk)

If you have any complaints about the study, please contact: Stephen Jackson (Chair of Ethics Committee) stephen.jackson@nottingham.ac.uk

Please complete this survey if you are an Educational Psychologist or Trainee Educational Psychologist **currently practising within England.**

If you work in more than one setting or role you may be prepared to complete the survey twice from the perspective of both of your roles/ contexts.

Are you aware of how to ask any questions you may have about the study?

- ○ Yes
- ○ No

Do you understand that you are free to withdraw at any time by exiting the online survey?

- ○ Yes
- ○ No

Do you give permission for your data from this study to be shared with other researchers provided that your anonymity is completely protected?

- ○ Yes
- ○ No

Do you agree to participate in this study?

- ○ Yes
- ○ No

Please provide your Full Time Equivalent (FTE) in the box provided. If you are a trainee, please indicate if you receive a salary or bursary.

_____

In the last year, approximately how many individual children and young people with SEMH needs have you had the following involvement with?

	0	1-5	5-10	10-15	15-20	20+
Consultation	○	○	○	○	○	○
Individual casework (e.g. assessment/ intervention)	○	○	○	○	○	○
Statutory work	○	○	○	○	○	○

Which of the following age groups have you carried out SEMH work with? *Please provide examples of the work undertaken with each year group, at the individual, group or systemic level*

- [ ] Early Years _____
- [ ] Key stage 1 _____
- [ ] Key stage 2 _____
- [ ] Key stage 3 _____
- [ ] Key stage 4 _____
- [ ] Post 16/ Further Education _____

Which of the following age groups have you carried out SEMH work with the most?

- ○ Early Years
- ○ Key stage 1
- ○ Key stage 2
- ○ Key stage 3
- ○ Key stage 4
- ○ Post 16/ Further Education

In which of the following areas have you contributed to SEMH work? *Please provide examples of activities undertaken and who this is with i.e. school staff, parents, others and if this is at the group, individual or systemic level*

- [ ] Consultation _____
- [ ] Assessment _____
- [ ] Intervention _____
- [ ] Training _____
- [ ] Research _____
- [ ] Other _____

Have you delivered any work to support school staff wellbeing? *Please tick*

- [ ] Supervision
- [ ] Training
- [ ] Staff support groups
- [ ] Other _____
- [ ] None

If you are engaging in systemic or organisational work in relation to SEMH, in what settings is this occurring? *Please give examples of the work*

- [ ] None _____
- [ ] Early Years _____
- [ ] Primary _____
- [ ] Secondary _____
- [ ] Post 16/ Further Education _____
- [ ] Other _____

Which of the following interventions are offered by you or your service in relation to SEMH?

- [ ] Cognitive Behavioural Therapy or CBT based
- [ ] Motivational Interviewing
- [ ] Solution Focused Brief Therapy
- [ ] Circle of Adults
- [ ] FRIENDS
- [ ] Eye Movement Desensitisation and Reprocessing
- [ ] Therapeutic stories
- [ ] Nurture Groups
- [ ] Functional Behaviour Assessment
- [ ] Circle of Friends
- [ ] Narrative Therapy
- [ ] PATHs
- [ ] Social skills intervention
- [ ] Playing and Learning to Socialise (PALS)
- [ ] Sand Play
- [ ] Video Interactive Guidance (VIG)
- [ ] Working on What Works (WOWW)
- [ ] Personal Construct Psychology
- [ ] Bereavement support

- [ ] Anger management
- [ ] Theraplay
- [ ] Emotional Literacy intervention
- [ ] Dyadic Developmental Psychotherapy (DDP)
- [ ] Other _____
- [ ] Other _____
- [ ] Other _____

How often do you personally carry out the following interventions?

	Frequently	Sometimes	Rarely	Never
Cognitive Behavioural Therapy or CBT based	○	○	○	○
Motivational Interviewing	○	○	○	○
Solution Focussed Brief Therapy	○	○	○	○
Circle of Adults	○	○	○	○
FRIENDS	○	○	○	○
Eye Movement Desensitisation and Reprocessing	○	○	○	○
Therapeutic stories	○	○	○	○
Nurture Groups	○	○	○	○
Functional Behaviour Assessment	○	○	○	○
Circle of Friends	○	○	○	○
Narrative Therapy	○	○	○	○
PATHs	○	○	○	○
Social skills intervention	○	○	○	○
Playing and Learning to Socialise (PALS)	○	○	○	○
Sand Play	○	○	○	○
Video Interactive Guidance (VIG)	○	○	○	○
Working on What Works (WOWW)	○	○	○	○

Personal Construct Psychology	○	○	○	○
Bereavement support	○	○	○	○
Anger management	○	○	○	○
Theraplay	○	○	○	○
Emotional Literacy intervention	○	○	○	○
Other	○	○	○	○
Other	○	○	○	○
Other	○	○	○	○

How often are your interventions at the individual, group or whole-school level?

	Frequently	Sometimes	Rarely	Never
Individual level	○	○	○	○
Group level	○	○	○	○
Whole school level	○	○	○	○

What SEMH-related training does your service offer?

- [ ] Emotion Coaching
- [ ] LEGO-based therapy
- [ ] Attachment Training
- [ ] Trauma
- [ ] Resilience
- [ ] Anti-bullying
- [ ] Anxiety
- [ ] Emotional Literacy Support Assistants (ELSA)
- [ ] Restorative approaches
- [ ] Working with puppets
- [ ] Bereavement and loss
- [ ] Cognitive-behavioural approaches
- [ ] Mindfulness
- [ ] Nurture approaches
- [ ] Nurture Groups
- [ ] Self-esteem
- [ ] Social skills
- [ ] Anger management
- [ ] Self harm

- [ ] Other _____
- [ ] Other _____
- [ ] Other _____

What SEMH-related training have you carried out? *Please state what types of training you have delivered at the following levels*

- [ ] Group _____
- [ ] Whole-school _____
- [ ] Parent _____
- [ ] Strategic or Local Authority _____
- [ ] None

Do you feel that SEMH work should be part of the EP role?

- ○ Yes
- ○ No
- ○ Unsure

Would you engage in SEMH work with a child or young person where another SEMH agency is involved?

- ○ Yes
- ○ No

How often do you typically engage in multi-agency work around SEMH?

- ○ Frequently
- ○ Sometimes
- ○ Rarely
- ○ Never

Are you, or have you been, considered a 'Lead Professional' within any mental health work? *Please explain*

- ○ Yes _____
- ○ No

Are you linking with any Designated Senior Leads for Mental Health, Education Mental Health Practitioners, or any other school-based Mental Health lead staff? *If so, how? e.g. training or involvement in working alongside the Green Paper proposals*

- ○ Yes _____
- ○ No

Are you involved in any mental health developments, for any ages, within your local authority, for example, representing on local multi-agency mental health forums or developing interventions? *Please explain*

○ Yes _____

○ No

Some of the following factors have been identified as barriers to EPs engaging in SEMH work. Which do you feel you are affected by? *Space is provided for you to expand on your answer if you wish*

☐ Time constraints _____

☐ Levels of statutory work _____

☐ Competing work demands (please state) _____

☐ Lack of opportunities _____

☐ Trading _____

☐ Provision from other mental health agencies (such as CAMHS) _____

☐ Other _____

☐ Other _____

☐ Other _____

Are there any factors that you feel currently support you in engaging in SEMH work?

_____

_____

_____

_____

_____

How confident are you in your approach to SEMH work at the individual level, group level, whole school level and strategic/ Local authority level?

	Confident	Somewhat confident	Neither confident nor unconfident	Somewhat unconfident	Unconfident
Individual level	○	○	○	○	○
Group level	○	○	○	○	○
Whole school level	○	○	○	○	○
Strategic/ Local authority	○	○	○	○	○

Give examples of activities you are most confident to engage in

○ Individual level _____

○ Group level _____

○ Whole school level _____

○ Strategic/ Local authority _____

How confident are you in working with other agencies around SEMH?

- ○ Confident
- ○ Somewhat confident
- ○ Neither confident nor unconfident
- ○ Somewhat unconfident
- ○ Unconfident

How skilled do you feel working in the area of SEMH?

- ○ Very Skilled
- ○ Skilled
- ○ Unsure
- ○ Somewhat skilled
- ○ Not skilled

Which skills do you perceive to be the most important when working with schools around SEMH? *Give up to 2-3 examples*

_____

_____

_____

_____

_____

What theories or paradigms, if any, guide your practice when working in the area of SEMH?

_____

_____

_____

_____

_____

How well do you feel that initial professional training in educational psychology has supported you in engaging in work around SEMH?

- ○ Very well
- ○ Well
- ○ Unsure
- ○ Somewhat
- ○ Not well

Have you received further training or CPD opportunities around SEMH since initial training? *If so, what opportunities?*

_____

_____

_____

_____

_____

How well do you feel supported by professional educational psychology supervision around your work involving SEMH?

- ○ Very well
- ○ Well
- ○ Unsure
- ○ Somewhat
- ○ Not well

Would you consider that SEMH is a priority in current service delivery?

- ○ High priority
- ○ Somewhat a priority
- ○ Don't know
- ○ Low priority
- ○ Not at all a priority

Would you consider SEMH is an identified strategic priority in the locality (/localities) in which you work?

- ○ High priority
- ○ Somewhat a priority
- ○ Don't know
- ○ Low priority
- ○ Not at all a priority

What are the principal ways in which your service promotes the EP role in SEMH work?

- ☐ Brochure
- ☐ Leaflets
- ☐ Website
- ☐ Through consultation
- ☐ Other _____

How effective do you perceive these promotional methods to be?

	Very effective	Somewhat effective	Don't know	Low effectiveness	Not at all effective
Brochure	○	○	○	○	○
Leaflets	○	○	○	○	○
Website	○	○	○	○	○
Through consultation	○	○	○	○	○
Other	○	○	○	○	○

Does your service have a mental health policy, strategy or other service guidance to support EPs with their SEMH work? *If so, please give details*

○ Yes _____

○ No

○ Unsure

What are your hopes for future practice by educational psychologists around SEMH?

_____

_____

_____

_____

_____

What are your concerns for future practice by educational psychologists around SEMH?

_____

_____

_____

_____

_____

Role *(please give details of any specialisms in the space provided)*

- ○ PEP _____
- ○ Senior EP/ Senior Practitioner _____
- ○ Main grade EP _____
- ○ Newly Qualified EP _____
- ○ Trainee EP _____

Gender

- ○ Male
- ○ Female
- ○ Prefer not to say

Age

- ○ 25-29
- ○ 30-34
- ○ 35-39
- ○ 40-44
- ○ 45-49
- ○ 50-54
- ○ 55-59
- ○ 60-64
- ○ 65+

Years practising as an EP. If you are a Trainee EP please state which year you are in

_____

Professional training qualification in Educational Psychology

- ☐ Masters
- ☐ Doctorate

Service delivery context

- ○ Local authority traded
- ○ Local authority part-traded
- ○ Local Authority non-traded
- ○ Private company
- ○ Social enterprise
- ○ Private practitioner
- ○ Any other? Please specify _____

In which region do you work?

- ○ North West of England
- ○ North East of England
- ○ Yorkshire and The Humber
- ○ West Midlands
- ○ East Midlands
- ○ East of England
- ○ London
- ○ South West of England
- ○ South East of England

Do you work in an area located within a Trailblazer site for the Mental Health Green Paper proposals?

- ○ Yes
- ○ No
- ○ Don't know

7.6 Appendix 6 – Pilot response feedback and action taken

Pilot participant	Online survey completed?	Survey evaluation form returned?	Feedback points	Action taken
PEP	Y	Y	Q. Which of the following age groups have you carried out SEMH work with? *Please provide examples* – **expand to explain what examples are being requested**	Amended instruction: *Please provide examples of the work undertaken with each year group*
			Q. Have you delivered any work to support school staff wellbeing? Please tick – **no possibility of a 'no' answer**	Included a 'none' tick box option
			Q. Do you feel that SEMH work is part of the EP role? – **Further definition of response options needed (universal, targeted and specialist), and what is meant by the question**	Amended question wording to 'Do you feel that SEMH work <u>should be</u> part of the EP role?' – amended response options to Y, N, unsure
			Q. Would you engage in SEMH work with a pupil where another SEMH agency is, or should be, involved? – **Could get a different answer from 'is' than 'should be', question conflates the two positions**	Amended wording to reflect 'is' and removed 'should be'
			Q. How often do you typically engage in multi-agency work around SEMH? – **not sure what the 'typically' adds to this question**	No action taken
			Q. Are you linking with any Designated Senior Leads for Mental Health or any other school-based Mental Health lead staff? If so, how? - **Many LAs do not yet have these roles (Designated Senior Leads for Mental Health). should /could that be a question: does your LA have Designated Senior Leads for Mental Health?**	No action taken – option for respondents to respond 'no'. DSLMH is unique to individual schools not authorities
			Q. How skilled do you feel working in the area of SEMH? – **response options: 'somewhat' is more than 'unsure', 'unsure'**	

			should be the final category. Does not fit readily in the continuum  Q. How well do you feel that initial professional training in educational psychology has supported you in engaging in work around SEMH? - **Presumably this will be influenced by how many years practice the EP has – the more, the more that post-qualification CPD will be important.** <u>Additional comments:</u> You might need to clarify whether or not the EP holds a specific brief – e.g., if a specialist in SEMH, the EP will have worked with far more; if (as is my case) the EP is a PEP, s/he might work with far fewer cases at all & possibly none of them being SEMH. The survey has no back-button, so no ability to check or clarify previous answers. This felt a rather long survey. I was beginning to wish I had reached the end by the question 'How skilled do you feel working in the area of SEMH?'. Especially as many of the questions towards the end were more challenging – theories underpinning our work, for example!	Amended wording to reflect 'somewhat skilled' and keep 'unsure' as a midpoint Years practicing will be collected in demographic data Explored in demographics Back button added No action taken – all respondents answered this question and this was not highlighted as a wider viewpoint within feedback
Member of AEP Executive	N	Y	Some EPs work across different settings/services so you might want to allow for that, in asking for total FTE and ask if it's split	Included invitation on information sheet to complete two surveys

			across different employers/different contexts..? and if they work in different contexts you might ask them to fill in different surveys?	from the perspective of their two roles/ contexts if they wish
			Q. In the last year, approximately how many cases with SEMH have you had involvement with? – **'casework', medical connotations, use of 'individual CYP'? 'SEMH who is causing concern'?**	Amended wording
			Q. Which of the following age groups have you carried out SEMH work with? *Please provide examples* – **explain if you are referring to individual or group work?**	Amended instruction to invite individual, group and systemic work
			Q. In which of the following areas have you contributed to SEMH work? *Please provide examples of activities undertaken and who this is with i.e. school staff, parents, others* – **explain if you are referring to individual or group work?**	Amended instruction to invite individual, group and systemic work
			Q. What SEMH-related training does your service offer? - **Does "nurture" mean training on how to set up nurture groups or developing nurturing approaches/schools? You've mentioned nurture groups earlier and here it's just nurture…**	Included options for nurture groups and nurture approaches
			Q. Would you engage in SEMH work with a pupil where another SEMH agency is, or should be, involved? – '**CYP' instead of 'pupil'?**	Amended wording
			Q. How often do you typically engage in multi-agency work around SEMH? - **Is it worth asking if the EP works within an area that has "trailblazer" status and, if so, is the local EP service involved in developing new ways of working/testing out the Green Paper proposals…? Any input to the training of the new EMHPs (Education Mental Health Practitioners)?**	Trailblazer status in demographic questions. Amended question around multi-agency work with DSLMH to include EMHPs and gave examples of training/ working alongside the Green Paper proposals
			Additional comments:	

			Age groups – 60-64 and 65+ “independent practitioner” - all EPs provide independent professional advice – “private” or “freelance” may be more helpful	Amended age groups Amended in demographic section
Senior EP	Y	N		Positive general feedback received: survey was clear and easy to complete
EP with SEMH specialism	Y	Y	Q. In which of the following areas have you contributed to SEMH work? *Please provide examples of activities undertaken and who this is with i.e. school staff, parents, others* - **I would probably have an “Other” box, to allow for flexibility in other activities beyond school delivery –or otherwise specify in the question that this question is to do with service delivery at schools only.** Q. Are you, or have you been, considered a ‘Lead Professional’ within any mental health work? Please explain - **Perhaps would be helpful to explain/define who a ‘Lead Professional’ is, since it is in brackets.** Q. Barriers - **My understanding of “time” and “competing work demands” is the same. Possibly “levels of statutory work” falls under the same category as well, only it’s more specific. “Opportunities” sounds a bit vague.** Q. Confidence - **You have used “individual”, “group” and “whole-school” level before –I would think it would be better if the same words were used throughout the survey (e.g. either**	Inclusion of an ‘other’ box No further feedback around this – question answered by all pilot participants Amended wording of options: ‘time constraints’, ‘lack of opportunities’ and included text boxes next to each option to allow for an expanded answer should respondents wish to give more detail Amended question wording from ‘systemic’ to ‘whole school level’ to match response options.

			"whole-school" or "systemic"). You also used strategic/Local Authority above –perhaps it can be included here too. **Suggestion to move question around 'how skilled EPs feel' before asking how confident they feel to work with other agencies in mental health** <u>Additional comments:</u> Possibly to look into how EPs become involved in SEMH cases, e.g. through statutory work, commissioned casework etc? Where are the opportunities for our involvement? And are there missed opportunities?	Added in 'Strategic/ Local authority' as a response option Questions not moved as they are arranged in blocks i.e. one block for questions around confidence and one block for questions around skills Amended first question around casework to elicit where EPs may become involved in SEMH cases
Maingrade EP	N	Y	Q. In the last year, approximately how many cases with SEMH have you had involvement with? – **SEMH needs. What is involvement? Need for italicised information on what involvement would constitute? (would an anonymous conversation about a challenging case with a SENDCo/ teacher count? Only official referrals?)** Q. If you are engaging in systemic or organisational work, in what settings is this occurring? *Please give examples of the work* - **Add 'in relation to SEMH' to make it clear** Q. What SEMH-related training have you carried out? Please provide examples – **Clarity on wording 'Please state what types of training you have delivered at the following levels'** Q. Do you feel that SEMH work is part of the EP role? – **Do you feel that SEMH work <u>should</u> be part of the EP role. At which levels?**	Amended wording to reflect 'SEMH' needs Involvement captured through matrix grid with responses for consultation, individual casework (assessment/ intervention) and statutory work – to gain the numbers of each Amended wording Amended wording Amended question wording to 'Do you feel that SEMH work <u>should be</u> part of the EP role?' –

			Q. Are you involved in any mental health developments, for any ages, within your local authority, for example, representing on local multi-agency mental health forums? *Please explain* – **add another example: for example, 'or developing interventions'** Q. Barriers – **'Lack of opportunities'? (Schools that don't trade/ trading budget), Time – not enough time for each piece of work? Comment box next to each with 'please expand' to allow for specificity with each factor** Q. What are the principal ways in which your service promotes the EP role in SEMH work? Q. How effective do you perceive these promotional methods to be? – **rating scale against each method?** <u>Additional comments:</u> Question numbers to be visible/ progress bar	amended response options to Y, N, unsure Amended to include example Amended wording of options: 'time constraints', 'lack of opportunities' and included text boxes next to each option to allow for an expanded answer should respondents wish to give more detail Amended response option to reflect a matrix grid response Added a visual progress bar
Maingrade EP	Y	Y	Q. How often do you personally carry out the following interventions? – **add DDP?**	DDP added
Y3 TEP	Y	Y	Q. Would you engage in SEMH work with a pupil where another SEMH agency is, or should be, involved? – **Space for a comments box?** Q. Does your service have a mental health policy, strategy or other service guidance to support EPs with their SEMH work? *If so, please give details* – **include a 'don't know' box?**	Comment box not added to limit qualitative data gathered – question amended (see above) Included a response option 'unsure'

7.7 Appendix 7 – Ethical approval

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SJ/tp

Ref: S1194

Friday 26th July 2019

Dear Nina and Anthea,

Ethics Committee Review

Thank you for submitting an account of your proposed research "An investigation of the role of the Educational Psychologist in meeting social, emotional and mental health needs".

That proposal has now been reviewed and we are pleased to tell you it has met with the Committee's approval.

However:
Please note the following comments from our reviewers;

Reviewer One:

-Approved as is

Reviewer Two:
Minor Revision

- Would also be useful to note and reflect on how long the survey is likely to take and whether there is any incentive for taking part.

- On points 27 and 29 in the ethics checklist, the data is described as confidential and then anonymous. Please clarify which the data will be.

- Within the recruitment letter, how long the survey will take to complete is still blank, make sure that this information is added.

- Within the information sheet, information about the types of questions and responses has been left blank, this needs updated.

Final responsibility for ethical conduct of your research rests with you or your supervisor. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society and the University Research Ethics Committee. If you have any concerns whatever during the conduct of your research then you should consult those Codes of Practice. The Committee should be informed immediately should any participant complaints or adverse events arise during the study.

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Independently of the Ethics Committee procedures, supervisors also have responsibilities for the risk assessment of projects as detailed in the safety pages of the University web site. Ethics Committee approval does not alter, replace, or remove those responsibilities, nor does it certify that they have been met.

Yours sincerely



Professor Stephen Jackson
Chair, Ethics Committee

7.8 Appendix 8 – Participant recruitment letter

Dear Colleague,

My name is Nina Purewal and I am a Trainee Educational Psychologist (TEP) at the University of Nottingham. I am conducting research into the Educational Psychologist (EP)'s role within the area of social, emotional and mental health (SEMH).

I am hoping to gather information through a web-based survey regarding current educational psychology practice and the factors that may influence this area. I am interested in the responses of all qualified EPs and of TEPs, whether SEMH is a specialism or a less encountered area of practice. Further information about the study can be found on the introductory page of the survey.

I hope that you feel you would like to participate in this study. Please use the link to the survey, provided below, or you can paste this into your browser. The survey should take no more than 30 minutes to complete. If you encounter any difficulties, please do not hesitate to contact me.

https://nottinghampsych.eu.qualtrics.com/jfe/form/SV_cTJHoVUJCCHZlLn

I would also be grateful if you were able to distribute this email and link to other EP colleagues.

If you have any questions regarding the research, please do raise them with me or my supervisor, contact details below.

Thank you very much for your time.

Kind Regards

Nina Purewal

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7.9 Appendix 9 – Descriptive statistics to show the number of individual children and young people EPs have been involved with and the type of work (consultation, individual casework and statutory work)

	Consultation	Individual casework (e.g. assessment/ intervention)	Statutory work
N	149	150	153
Median	15-20	10-15	5-10
Mode	20+	20+	5-10

7.10 Appendix 10 – 'Other' options EPs provided around supporting staff wellbeing analysed by content analysis

Other ways EPs support staff wellbeing		
Subcategories	**Frequency *(N)***	**Illustrative quotes**
Group processes	9	Force field analysis to gather views of helping and hindering factors of staff's well-being I delivered a group 'problem-solving' session for a pupil in Year 3. We were meant to brainstorm strategies once I had gathered information. Staff said that they felt it was therapeutic - this was not my initial aim but a by-product of the group session.
Supervision	7	Case supervision and practice. Virtual School Both individual supervision and ELSA group supervision
Informal support	7	Regular discussion with staff about the importance of their emotional health and well-being. Informal supervision and emotional support to individual staff
Systemic approaches	6	Involved in developing a tool to support school staff auditing the emotional health and wellbeing of the whole of the school community. Joint systems work
Critical Incidents and bereavement support	6	Critical incident - working with staff for children and staff wellbeing Bereavement counselling, critical incident support
Consultation	5	Support offered at SENCo cluster consultations

		Consultation with school staff around general issues of concern SENCO network meetings held half termly we do a regular staff wellbeing slot
Practice development	3	Not in the last 12 months but the year before I provided VERP for primary school staff (team of 3 teachers).
Training	3	Not directly but I do a section on staff well-being in my emotion coaching training
Coaching	2	Coaching drop in sessions
To other professionals and settings	1	Ongoing support for care and education staff within a residential school

7.11 Appendix 11 – 'Other' interventions offered by EPs/ EPSs analysed by content analysis

Other interventions offered		
Subcategories	**Frequency *(N)***	**Examples of interventions** (Frequency of individual interventions *N*)
Wellbeing interventions	53	• ELSA (7) • Emotion Coaching (6) • Lego Therapy (5) • Acceptance and Commitment Therapy (ACT) (5) • Mindfulness (4) • Drawing and Talking (3) • SCERTS (2) • Dialectical Behaviour Therapy (DBT) (1) • Seasons for Growth (1) • Exam stress (1) • Talking Therapy (1) • Play-based therapy (2) • DNA-V (2) • Build to Express (1) • Circle Solutions (1) • We Eat Elephants (Live Life to the Full) (1) • Therapy Dog (1) • Team of Life (1) • Social Thinking curriculum (1) • Zippy's Friends (1) • Guided Imagery (1) • Rewind Technique (1) • Zones of Regulation (1) • Narrative approaches (1) • Attachment KCA (Kate Cairns) (1) • Human Givens (1)
Skill development interventions	13	• Sort it Out problem-solving programme (1) • Aggression Replacement Training (1) • Living Life to the Full Young Person (1) • Resilience Groups (1) • Transition Groups (1) • Derbyshire Behaviour Box (1)

		• The Social Skills Improvement System Classwide Intervention Program (1) • Developmentally appropriate games (1) • Assertiveness Training (anti-bullying) (1) • Play Partners session (written by an EP) (1) • Rock and Water (1) • Selective Mutism intervention (1) • I can Problem Solve (1)
Systemic approaches	7	• Bespoke training (1) • FLOURISH programme (1) • TaMHS programme (1) • MAPS (1) • Forest Schools (1) • Thrive (1) • Solihull Approach (1)
Interventions with adults	4	• Group consultation • ACT for staff wellbeing • Video Enhanced Reflective Practice (VERP) • Circle of Adults
Family work	4	• Systemic Family Therapy • Early Behaviour Support (EBS – Bespoke individual parenting intervention • Multi-family Groups • Watch, Wait, Wonder
Not explicitly offered	3	• VIG is the only one from the above list that we explicitly advertise as offering • We do not offer interventions directly • None of these programmes are explicitly offered but individual EPs in the team may offer them if it is something that is part of their skill set and they have capacity.
Coaching	3	• Pupil Coaching • Coaching Psychology • Coaching

Flexibly offered	2	• *We are flexible in offering these services but VIG is the only one from the above list that we explicitly advertise as offering • Would not like to put the approach that I take into a box but I use elements of some of the approaches that you list
Delivered as part of training requirements	2	• Also MI, CBT and SFT have to be done for Uni • We do not offer interventions directly, although I have been able to work with schools more closely as part of my Uni training
Barriers faced	4	• Trained in Sand Play and VIG - not delivered as too costly in traded service • I am not sure what colleagues offer - I am now very part-time and there have been a lot of changes in our service over the last two or three years • New service so no uniform "packages" of training currently. Probably more available and being implemented but I'm not involved in them or seen them • We are not a traded service.

7.12 Appendix 12 – Descriptive statistics to show how frequently EPs carry out the interventions offered by their EPS

Intervention	*N*	Median	Mode
Cognitive Behavioural Therapy or CBT based	149	3	3
Motivational Interviewing	142	3	3
Solution Focused Brief Therapy	147	3	3
Circle of Adults	143	3	4
FRIENDS	135	4	4
Eye Movement Desensitisation and Reprocessing (EMDR)	136	4	4
Therapeutic Stories	142	4	4
Nurture Groups	141	4	4
Functional Behaviour Assessment (FBA)	145	2	2
Circle of Friends	141	3	4
Narrative Therapy	142	4	4
PATHs	141	3	4
Social Skills intervention	143	3	4
Playing and Learning to Socialise (PALS)	137	4	4
Sand Play	138	4	4
Video Interactive Guidance (VIG)	140	4	4
Working on What Works (WOWW)	138	4	4
Personal Construct Psychology (PCP)	146	2	2
Bereavement Support	143	3	4
Anger Management	141	3	4
Theraplay	140	4	4
Emotional Literacy Intervention	143	3	4

Key: **1 =** Frequently **2 =** Sometimes **3 =** Rarely **4 =** Never

7.13 Appendix 13 – Descriptive statistics to show how often EPs' interventions are delivered at the individual, group or whole-school level

	Individual level	Group level	Whole-school level
N	152	151	149
Median	1	2	3
Mode	1	2	3

Key: **1 =** Frequently **2 =** Sometimes **3 =** Rarely **4 =** Never

7.14 Appendix 14 – 'Other' training offered by EPSs/ EPs analysed by content analysis

Other training offered		
Subcategories	**Frequency *(N)***	**Examples of training** (Frequency of individual training *N*)
Interventions	30	• ACT (2) • Mindfulness (2) • Motivational Interviewing (4) • Zippy's Friends (2) • Apple's Friends (2) • VIG (2) • Zones of Regulation (1) • Digital Resilience (1) • Peer Support/ Mentoring (1) • 123 Magic (1) • Narrative Approaches (1) • Emotional Wellbeing Plans (2) • Therapeutic Play (1) • Attachment based mentoring (1) • Behaviour Box training (2) • Therapeutic Stories (1) • Positive Play (1) • Person-centred Planning (1) • Coaching Psychology (1) • Circle of Friends (1)
Raising staff awareness and understanding around topics	19	• Selective Mutism (1) • Complex Trauma and ACEs (1) • ADHD related training (2) • Protective Behaviours (1) • Listening to Children, relationships between young people (1) • Transitions (1) • Emotionally based school avoidance (1) • Adolescent Brain (1) • Babyroom Project (1) • Safe Spaces and Classroom Toolkits (1) • Understanding and managing challenging behaviour (1) • Positive Psychology (2) • Acceptance and Commitment

Whole-school (systemic)	7	Therapy for staff wellbeing (1) • Understanding and preventing self-harm (1) • Keys to Happier Living (1) • ASC and Mental Health (1) • Domestic Abuse (1) • Thrive (1) • Mental health and wellbeing (1) • Mental Health First Aid (1) • Solihull Approach (2) • Staff Wellbeing (1) • Cherish your Team (1)
Needs led training	3	NQT training Individual EPs may make specific training related to requests from schools We don't have a formal package of interventions as such, they tend to be bespoke to the school

7.15 Appendix 15 – Examples of EP activities for SEMH across the individual, group and systemic levels within the Early Years

Early Years	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Consultation	23	Consultation level, helping schools to better understand the child's needs and implementing strategies Consultations in children's centres/ pre-school settings with parents and support staff
	Statutory assessment	12	Statutory assessment EHCNA
	Observation	9	Observation
	Assessment	6	Play-based assessment Functional Behaviour Analysis
	Around challenging behaviour	4	Some of these children have been experiencing heightened levels of anxiety and have demonstrated challenging behaviour as a result. FBA linked to challenging behaviours - biting / pinching
	VIG	4	Video interaction guidance to support the building of relationships between parent and child Video Interaction Guidance with EYs pupils with parents/carers and/or nursery practitioners
	Supporting settings	3	Planning transition to primary Co-working with specialist teachers

	Around emotional and communication difficulties	3	Reception child with social communication difficulties, reception child with emotion regulation difficulties Usually regarding separation anxiety
	Support for parents	2	Individual parenting intervention Support for parents
	Around children's early life experiences	2	Adopted child who has experienced neglect
Group level	Training and group processes	2	Consultative group work with adults around the child. Training to an EYFS stage staff group in school
Systemic level	Training	4	Emotion Coaching training Early years behaviour training to Early Years staff
	Policy and practice development	3	Whole school policy and practice work Contributing to ASD pathway
	Circle of adults	2	Circle of Adults

7.16 Appendix 16 – Examples of EP activities for SEMH across the individual, group and systemic levels within Key Stage 1

Key Stage 1	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Consultation	41	Consultation re: individual children
	Assessment	27	Gaining pupils views through tools such as scaling, MEP cards, strength cards Cognitive assessment e.g. EYBAS -3
	Statutory assessment	18	Work has mainly been individual assessment as part of the statutory process
	Observation	9	Observations
	Intervention and therapeutic work	9	SFBT, MI – individual level Individual Build to Express sessions
	Individualised Plans	5	Avoiding Overwhelm personalised plans Multi-element plans
	VIG	4	I have also completed VIG with pupils in key stage 1 and their parents
	Around emotional difficulties	3	Y3 boy with emotion regulation difficulties Individual work around anxiety
	With those at risk of exclusion or disengaged with education	3	Pupil at risk of exclusion – direct work with pupil and family Individual casework to support disengagement
	Around trauma	2	Y2 boy with history of early trauma and difficulty with emotional regulation Work with individual CYP who have experienced domestic violence and or

			other trauma
	Multi-agency meetings	2	Multi-agency meetings TAC/TAF meetings
	Around challenging behaviour	1	Young girl in Year 1 who had been displaying behaviour such as hurting other children, screaming and refusing to complete work
Group level	Group consultation with adults around the child	4	Group consultation, circle of adults to support inclusion Reflective teams with key adults
	Training	2	Training to Y2 to support transition into Junior school. Training to staff groups in school
	Intervention	1	Team of life group intervention
Systemic level	Training	13	Training to schools on a wide range of issues such as attachment, emotion coaching, polyvagal theory I provided whole school training to a special primary school around trauma, attachment, adverse childhood experiences and PTSD.
	Whole-school policy and practice work	9	I have worked with schools to implement whole school approaches and many of my schools now use zones of regulation throughout the school. Whole school support re: staff bereavement

7.17 Appendix 17 – Examples of EP activities for SEMH across the individual, group and systemic levels within Key Stage 2

Key Stage 2	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Consultation	39	Bookable consultations (self-contained problem-solving 1hr session through consultation) SEMH consultations
	Assessment	35	Work has involved individual assessment work using narrative/PCP-based approaches such as tree of life, ideal self, and some solution-focused brief therapy and scaling activities Resiliency scales
	Statutory assessment	20	A large amount of my work in KS2 has been statutory assessment work
	Interventions and therapeutic work	23	Lego-based therapy Some individual 1:1 work with children doing narrative therapy and CBT
	Observation	8	Observation
	Individualised plans	7	Developing an Emotional Wellbeing plan Secondary transition support
	Multi-agency meetings	6	Contributed to a consultation with other agencies, staff and parents. TAF/TAC meetings
	Around emotional difficulties	6	Low self-esteem, anxiety A child looked after in Year 5 who was struggling with managing his emotions

	With disengaged learners	3	Risk of perm-ex - violent behaviour towards adults other children
	Around trauma and attachment	3	Mainly for children who are looked after, or who have experienced early childhood trauma.
	Around EBSA	2	School refusal due to anxiety
	Support for parents	2	Listening to parents
	Around self-harm	2	Therapeutic work with a CYP who exhibits self harming behaviour
Group level	Group consultation and staff supervision	15	Circle of adults, MAPS, group problem solving The generation of support groups using the Solutions Circle Framework (linked to empathy, active listening and collaboration as identified variables underlining emotional well-being through these models).
	Intervention	8	Therapeutic Story Writing groups Circle of Friends
	Support for parents	4	Home visits/attachment parenting program
	Training	3	Training to Y6 to support transition into Secondary school Training for key staff team re attachment and trauma
Systemic level	Training	22	Emotion Coaching training Whole school training on areas such as attachment, de-escalation, staff wellbeing
	Whole-school policy and practice	12	Intensive support for schools as part of a specialist team for SEMH. Whole school work - wellbeing survey

7.18 Appendix 18 – Examples of EP activities for SEMH across the individual, group and systemic levels within Key Stage 3

Key Stage 3	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Consultation	36	Individual consultation
	Assessment	30	MALS Questionnaire / Self-image profile/ Belonging Scales Becks, Resiliency Sales
	Statutory assessment	19	Statutory work
	Intervention and therapeutic work	14	Tended to be on individual level using similar tools (PCP, SF, principles from behavioural psychology) Individual work using ACT
	Around emotional difficulties	8	Difficulties around anxiety, emotion regulation and behaviour management, LGBTQ+, emotional literacy difficulties, self-esteem and self-image issues High anxiety and suicidal ideation
	Around EBSA	6	I'm also working with secondary schools to help them support children with EBSA Anxiety based school refusal- particularly with pupils on the Autism Spectrum
	Those excluded or at risk of	4	A lot of statutory assessments for children who have either been permanently excluded or are at risk of PEX Individual casework with pupils who have been excluded due to 'challenging behaviour'
	Observation	4	Observation
	Individualised plans	4	Personal Education Plan (PEP) meetings Developing an Emotional Wellbeing plan

	Multi-agency meetings	4	Joint formulation with team around the child Multi-agency problem solving panels
	Around difficult home life	2	Casework with pupils who are adopted, LAC or who have difficult home circumstances
Group level	Group consultation and problem-solving	12	Circle of adults, PATH, MAPS I am running solution circles within a mainstream secondary school targeted at pupils who are often receiving internal exclusions.
	Staff supervision	2	Staff supervision groups
	Training	2	CBT training
	Intervention	1	Group intervention using CBT
Systemic level	Training	18	I have delivered some training in the area in secondary schools, however this has required further prompting/time for the school(s) to be receptive to it. Trained staff in interventions, such as Precision Teaching to help improve pupil's basic skills
	Whole-school policy and practice work	10	Working with secondary school supporting them to develop SEMH provision within school Systemic - recommendations for teacher practice

7.19 Appendix 19 – Examples of EP activities for SEMH across the individual, group and systemic levels within Key Stage 4

Key Stage 4	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Consultation	28	Anonymous consultation to support post-16 planning for pupil with cognition and learning needs and ASD
	Assessment	18	SEMH direct assessment work with young people Questionnaires such as Beck Youth/ Resilience Scales
	Statutory assessment	15	Statutory assessment
	Interventions and therapeutic work	9	Solution-Focused Brief Therapeutic sessions Individual work on a weekly basis delivering CBT for 6 weeks
	Around emotional difficulties	7	Girl with ASD who was experiencing high levels of anxiety. Year 10 boy who was struggling with his emotions and behaviour in school
	Observation	6	Lesson observations
	Around EBSA	4	ASD and anxiety- school non-attenders in a special school Around social anxiety and school refusal
	Multi-agency meetings	4	TAF/TAC meetings Multi-agency meetings
	Individualised plans	3	An Emotional Wellbeing plan

	Around at-risk populations	2	Greater increase in PEX work Working with CYP who are being groomed/working county lines
Group level	Group consultation and problem-solving	8	Y11 pupil with ASD planning next steps using PATH Circle of adults, MAPS, group problem solving
	Staff supervision	2	Staff supervision groups Discussion to support ELSA re bereavement
	Intervention	2	Whole class sessions for SEMH needs around exam time
	Training	2	Training to staff groups in school
Systemic level	Training	11	Ongoing project in SEMH school providing workshops and training to staff of emotion coaching and PACE (playfulness, acceptance, curiosity and empathy) to help support YP challenging emotions and behaviours
	Whole-school policy and practice work	8	Use of an audit tool for alternative provision to support belonging and reintegration

7.20 Appendix 20 – Examples of EP activities for SEMH across the individual, group and systemic levels within Post-16 and FE settings

Post 16 or Further Education	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Statutory assessment	9	My work with this age group has been solely statutory assessments, where I have used PATHs and other person centred tools to help them work towards a desired goal.
	Around emotional and mental health difficulties	8	SEMH needs at this stage have been largely related to anxiety Pupils with mental health difficulties in preparation for post 16 education.
	Around transition	4	Individual casework including help to acquire for university support Transition to college or the work place and support for ensuring the YP can cope and their needs are understood
	Intervention	4	8 sessions of CBT with a YP in year 12
	Assessment	4	Cognitive assessment e.g. BAS3 PCP activities such as strength cards /MALS Questionnaire / Self-image profile/ Belonging Scales
	Consultation	4	Consultation work with supporting adults for YPs with severe learning difficulties or complex cases
	Observation	2	Some observations where possible
Group level	Consultation	2	Consultation and multi-professional work via EP input into the virtual school
Systemic level	-	3	Systemic work in SEMH provision

7.21 Appendix 21 – Examples of EP consultation practice across individual, group, and systemic levels

Consultation	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	With school staff	64	With school staff, pastoral leads, mentors, teachers, HOY Regularly: consultation with SENCOs, class teachers
	With parents and carers	46	Individual consultation with parents
	Type of consultation: joint home-school	37	I tend to hold home-school consultations so that all parties are able to problem solve together Collaborative problem solving with parents and staff
	With other professionals	20	Other professionals e.g. parent support advisors LA officers, EWOs
	With social care	10	Social care professionals
	Type of consultation: Multi-agency meetings	9	Multi-disciplinary team Group consultation with parents, school staff and external agencies such as behaviour support, family support worker, paediatric consultant
	With the young person	8	Consultation with children/young people Occasionally the child themselves
	Purpose of consultation: Providing feedback and developing	6	Contributed feedback of Pupil Voice and DA during a consultation with setting staff, parents and other agencies Unpicking needs and identifying pro-active and reactive strategies to manage needs.

	strategies and next steps		
	Purpose of consultation: Advice and support	5	Advice re which assessment and possible intervention In particular supporting pre- and post-secondary school transition
	Purpose of consultation: Review meetings	3	Post EHC, with headteachers and school staff who wish to make sure they have fully implemented all recommendations and need to know where to go next with the young person.
	Purpose of consultation: supporting others' understanding	3	Support teachers/parents to understand the impact of SEMH on learning and engagement
	With CAMHS	2	With CAMHS
	Type of consultation: Person-centred meetings	2	Big Picture meetings Person-centred meetings
	Type of consultation: Bookable or Drop-ins	2	Bookable consultations with school staff and parents Drop in sessions within schools for a number of teachers
	Type of consultation: Co-constructing plans	3	Parents and school staff including emotional well-being plans
Group level	Consultation and group processes	16	Group supervision using a Solution Circle format Circle of Adults/PATH
	Joint consultations with groups of staff	5	Consultation sessions with staff (individual and small-group basis) Regular group consultations with SENCo clusters

	Joint consultations with school staff, parents and carers	4	Group consultation with school staff and parents
	Joint consultations with other professionals	1	Group consultation when part of a team around the child.
Systemic level	-	2	Some systemic work with SENCos

7.22 Appendix 22 – Examples of EP assessment practice across individual, group, and systemic levels

Assessment	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Assessment of pupil views	84	Discussions with children using Personal Construct Psychology and Solution-Focused Approaches Individual assessments using scales/ questionnaires such as Becks inventory's, emotional literacy checklists.
	Observation	19	Also observations, how is the child presenting in the class in response to various things. Observation for baseline data such as frequency/severity of behaviour
	Statutory work	15	Statutory assessment only due to service restrictions
	Approaches to assessment	14	Play/ games-based assessment Functional Behaviour Analysis
	Working with school staff	12	Discussions with staff Gathering teacher views using Solution-focused questionnaire
	Learning assessment	12	Young person-cognitive assessment, dynamic assessment Dynamic assessment to highlight strengths
	Working with parents	11	Family interviews Consulting with parents/ carers
	Purpose of assessment:	7	Using published and informal means to understand SEMH needs

	assessment of needs, strengths and recommendations		Assessment of needs/strengths and recommendations
	Purpose of assessment: Analysis of data	5	ABC analysis Analysis of questionnaire information
	Purpose of assessment: Formulation of individual needs	5	Psychological formulation of current SEMH needs for individual casework CBT formulation
	Consultation	5	Consulting with parents/carers/social workers, teaching staff, support staff, pupil.
	Working with other professionals	3	Assessment accompanied by key workers and occasional joint assessment with colleagues e.g. sensory impairment team
	Around a variety of needs	3	Commissioned work for young people with anxiety, attachment difficulties, social skills
	Purpose of assessment: Assessment of emotional literacy	2	Assessments of emotional literacy using emotion photo cards
	Purpose of assessment: Pre- and post-therapeutic work	1	Pre/post therapeutic work
Group level	Whole-class	2	Group (class dynamics)
	Approaches	1	Functional behavioural assessment- at a group level working with staff.

Systemic level	Whole-school policy and practice work	4	Whole school behaviour walks (systemic) Pupil focus groups (group /systemic)

7.23 Appendix 23 – Examples of EP intervention practice across individual, group, and systemic levels

Intervention	Subcategories	Frequency *(N)*	Illustrative quotes
Individual level	Interventions and therapeutic work for young people	59	Solution focused intervention, cognitive based therapy intervention, motivational interviewing Play therapy, e.g. sand tray, narrative work, therapeutic story writing
	Indirect advice and support	22	Working with staff on an individual and group level to support the development of interventions Collaboratively co-constructing recommendations with school staff and parents.
	Intervention with staff	12	Video Interaction Guidance (VIG) with either the young person and their parent/carer or the young person and a member of nursery or school staff. ELSA supervision
	Support for parents	6	VIG with parents and children in primary mainstream, Individual parenting programme through Sure Start centre Drop ins for parents
	Assessment as intervention	2	Using the theoretical frameworks and tools outlined above to carry out assessment and inform intervention for YP
	Individualised plans	1	Factfile to share with teachers, transition plan, multi-element plan
Group level	Intervention for young people	20	Group support to manage anxiety around exams

			Individual and group-based interventions using techniques such as Therapeutic Story Writing and Cognitive Behavioural Therapy approaches
	Staff support and group problem-solving approaches	10	Circle of Adults, Force Field Analysis with Virtual School Team
			Co-delivering with school staff - Zippy's Friends and Zones of Regulation
	Whole-class work	7	Whole class work using WOWW
			Whole classes
Systemic level	Training	5	Staff training on interventions
			ELSA supervision and training
	Whole-school support	3	Critical Incidents
			School based interventions such as emotion coaching
	Circle of Adults	1	Circle of Adults

7.24 Appendix 24 – Full list of training delivered at the group level

SEMH related training EPs delivered at the group level		
Subcategories	**Frequency *(N)***	**Examples of training** (Frequency of individual training *N*)
Intervention approaches	93	• ELSA (23) • Nurture groups (5) • Lego-based therapy (10) • Mindfulness (6) • Motivational Interviewing (3) • SFBT approaches (4) • Emotion Coaching (12) • Anger Management (2) • Social Stories and Therapeutic Stories (3) • CBT approaches (8) • Social Skills (3) • Escape from Exclusion (Tina Rae, 2004) (1) • Circle of Friends (1) • Therapeutic story writing (2) • Zippy's Friends (1) • Narrative approaches (3) • Emotional Literacy (1) • Zones of Regulation (1) • Using Functional Behaviour Assessments and Multi-element Plans (2) • VIG (1) • ACT (1)
Around mental health and emotional wellbeing	24	• Emotional wellbeing and Emotional Development (2) • Anger management (1) • Resilience (3) • Anxiety (12) • Mental Health and wellbeing (1) • Mental Health First Aid (1) • Self-harm (1) • Supporting SEMH needs (2) • Supporting our own wellbeing (1)

Attachment and trauma informed	18	• Attachment (10) • Trauma-informed (2) • Attachment and trauma-informed (6)
Raising staff awareness and understanding around topics	15	• Selective Mutism (1) • Self-esteem (3) • Aspects of Autism Education Trust (AET) Tiers 1 and 2 (1) • Emotionally-based School avoidance (3) • Managing Challenging Behaviour (1) • Exam Stress (1) • ADHD (2) • Adolescent Brain (1) • Anti-bullying (1) • Harmful Sexual behaviour (1)
Practice development	9	• SEN practice (1) • Managing challenge (1) • Solihull Approach (2) • Restorative Approaches (4) • Academic Resilience Approach (1)
Bereavement loss and Critical Incidents	8	• Loss and Bereavement (7) • Critical Incidents (1)
Group Process	5	• Solution Circles (2) • Circle of Adults (2) • Process Consultation (1)

7.25 Appendix 25 – Full list of training delivered at the whole-school level

SEMH related training EPs delivered at the Whole-school level		
Subcategories	**Frequency *(N)***	**Examples of training** (Frequency of individual training *N*)
Intervention approaches	72	• Mindfulness (6) • Emotion Coaching (36) • ELSA (4) • Social skills and Emotional Literacy (2) • Anger Management (1) • Nurture approaches (4) • CBT approaches (2) • SFBT approaches (2) • Lego based therapy (5) • Motivational Interviewing (2) • Zippy's Friends (1) • Zones of Regulation (2) • Circle of Friends (1) • Sort It Out (1) • We Eat Elephants – Living Life to the Full (1) • Peer Mentoring (1) • 1,2,3 Magic (1)
Attachment and trauma	55	• Attachment (33) • Trauma-informed (9) • Attachment and trauma-informed (13)
Mental Health and Wellbeing specific	37	• Anxiety and stress (10) • Mental Health and wellbeing (8) • Resilience (13) • Self-harm (3) • Emotional literacy (2) • Mental Health First Aid (1)
Raising staff understanding and awareness around topics	18	• PACE (1) • ADHD (5) • Foetal Alcohol Syndrome (1) • Autism and SEMH needs (1) • Emotionally-based school avoidance (1) • Relationship-based approaches to supporting young people (1)

		• Supporting LGBTQ+ pupils (1) • Teenage brain development (1) • Supporting Developmental Conditions (1) • Quality First Teaching (1) • Sensory Processing (1) • Human Givens (2) • Keys to Happier Living (1)
Whole-school approaches	13	• Restorative Approaches (8) • Anti-bullying pledge (1) • Emotionally Friendly schools (2) • Solihull Approach (1) • Sandwell Wellbeing Chartermark (1)
Bereavement and loss	8	• Bereavement and Loss
Understanding and managing behaviour	6	• Understanding functions on behaviour (2) • Managing challenging behaviour (1) • De-escalation (2) • Promoting Positive Behaviours (1)
Staff Wellbeing	6	• Staff wellbeing (5) • Staff support groups (1)

7.26 Appendix 26 – Full list of training delivered with parents

SEMH related training EPs delivered with parents		
Subcategories	**Frequency *(N)***	**Examples of training** (Frequency of individual training *M*)
Parenting approaches and interventions	18	• Emotion Coaching (11) • Mindfulness (1) • Cognitive behavioural approaches (1) • PACE (1) • VIG (3) • Human Givens (1)
Raising awareness and understanding around emotional and mental health difficulties	13	• Anxiety (6) • Overcoming your child's worries (1) • Understanding SEMH needs of your child (2) • Managing anger with your child (1) • Bereavement (2) • Grief and Loss (1)
Raising awareness and understanding needs	12	• Attachment and trauma (6) • Selective Mutism (1) • Foetal Alcohol Syndrome (1) • Behaviour training for children with ASD (1) • Strategies to support ADHD (1) • Girls with Self-harming and ASD (1) • Healthy Minds (National Autistic Society) (1)
Workshops and parenting support	9	• Parent workshops around behaviour which challenges (1) • Transition at Y2 and Y6 with an SEMH focus (1) • Family systemic (1) • Confidence building (early years) (1) • Understanding Behaviour and Communication (1) • Behaviour management (1) • School attendance (1) • Making sense of the Teenage Brain (1)

		• Workshop on managing children with multiple learning disabilities with SEMH concerns (1)
Parenting courses	5	• Incredible Years Parenting Courses (1) • Triple P Teen Courses (1) • Triple P 1:1 Courses (1) • Mellow Parenting (1) • Attachment centred parenting (1)
With foster carers and adoptive parents	4	• 18 week attachment course for adoptive parents, foster carer & Special Guardian training • Foster carer and adoptive parents • Foster carers & some adoptive parents • Foster carer training in emotion coaching
Participation in group processes	1	• MAP, PATH

7.27 Appendix 27 – Full list of training delivered at the strategic or LA level

SEMH related training EPs delivered at the strategic or LA level		
Subcategories	**Frequency *(N)***	**Examples of training** (Frequency of individual training *N*)
Mental health and wellbeing	26	• Mental Health and Wellbeing (1) • Anxiety and Depression (1) • Mental Health First Aid (2) • Whole School Approach to Children's Mental Health (1) • Emotional Wellbeing Plans (1) • Managing Mood (adolescent/teenage brain) (1) • Self-Harm (3) • Resilience (11) • Anxiety (3) • Emotional Literacy (1) • Session for trainees at university on SEMH and supporting parents (1)
Intervention approaches	23	• Restorative Practice (3) • Emotion Coaching (6) • ELSA (9) • Motivational Interviewing (2) • De-escalation/ Anger management (1) • Sort It Out (1) • Lego Therapy (1)
Attachment and trauma	12	• Attachment (5) • Trauma-informed (4) • Attachment and trauma-informed (3)
Raising awareness and understanding around topics	7	• ADHD awareness (1) • Human Givens (2) • Emotionally based school avoidance (2) • Domestic Abuse (1) • Selective Mutism (1)
To other services and groups of staff across schools	7	• Training to other LA colleagues such as SALT, PHYSIO, Learning Support • Capacity Building across all primary and secondary schools • Group of social workers

		• Groups of head teachers/SENCOs • Designated safeguarding leads • Session for trainees at university For social care services
Bereavement, loss and critical incidents	5	• Grief and Loss (1) • Bereavement and Loss (2) • Grief and loss training and critical incident management to groups of head teachers/SENCOs (1) • Critical Incidents (1)
Staff support	4	• Staff support groups (1) • Coaching framework delivered to group of social workers (1) • Graduated Response (1) • Person centred planning (1)

7.28 Appendix 28 – 'Other' examples of EPs' involvement in SEMH work, analysed by content analysis

Other examples of SEMH work		
Subcategories	**Frequency *(N)***	**Illustrative quotes**
Policy and practice development	10	Beginning work on supporting new alternative provision with policies, transition of pupils in, day to day practice of staff etc. Systemic practice with Designated Leaders at [City] College
Supervision and support	8	Staff supervision (individual level and small-group problem solving); ELSA supervision Supervision for staff and virtual school
Systemic projects	7	Sandwell whole school approach to emotional wellbeing Co-running our County's TaMHS Programme in terms of overseeing the work and recruiting schools into the programme.
Collaborative work	2	Collaboration with other professionals (e.g. CAMHS)

7.29 Appendix 29 – Descriptive statistics to show EPs' confidence in their approach to SEMH work across the different levels at which they work

	Individual level	Group level	Whole-school level	Strategic or local authority level
N	154	154	154	154
Median	2	2	2	2.5
Mode	2	2	2	2

Key:

1 = Confident

2 = Somewhat confident

3 = Neither confident nor unconfident

4 = Somewhat unconfident

5 = Unconfident

7.30 Appendix 30 – Table to show range of further training and CPD opportunities EPs had engaged in

Further training and CPD opportunities around SEMH		
Subcategories	**Frequency *(N)***	**Examples of training and CPD and illustrative quotes** **(Frequency of individual interventions *N*)**
Intervention approaches	147	• VIG/ VERP (10) • Narrative (8) • CBT (21) • Emotion Coaching (24) • FRIENDS (4) • SFBT (12) • MI (16) • Lego-based approaches (2) • Therapeutic story writing (6) • Therapeutic stories (2) • ACT (8) • SCERTS (3) • Drawing and Talking (1) • PCP (5) • FBA (4) • DDP (3) • Circle Solutions (1) • DBT (1) • Sand Play (2) • Mindfulness (3) • Art Therapy (1) • ELSA (2) • Human Givens – Guided Imagery (1) • Nurture Group qualification (1) • Build to Express training (1) • Theraplay (1) • Working with Puppets (1) • Hypnotherapy (1) • Watch, Wait, Wonder (1) • Single Session Therapy (1)
Attachment	18	• Attachment (9) • Kim Golding Attachment training (1) • Attachment and Trauma (1) • Sensory attachment intervention (1)

		• Attachment and early development (1) • Attachment trauma and adolescence (1) • Neuroscience and attachment/ trauma (1) • Patricia Crittenden attachment training (1) • Kate Cairns associates Attachment Friendly Schools (2)
Yes but unspecified	17	Many - I have been an EP for 34 years and there have been many opportunities to develop skills in assessment and intervention in relation to SEMH needs Training courses Input or joint working with CAMHS and clinical psychologists (5) Shadowing colleagues (5) Interest groups on Mindfulness
Joint working with others as CPD opportunities	16	A huge amount of training and working with different agencies. Working with CAMHS & Social Care to support fostered and adopted families and children for 4 years Yes, joint working with EP colleagues, Psychiatrists, Clinical Psychologists Liaison with other professionals involved in specific cases (ie. clinical psychologist) (2)
Person-centred planning and graphic facilitation	15	• PATHs (9) • MAPs (2) • Circle of Adults (3) • Big Picture training (1)
Trauma	15	• Trauma (5) • ACEs, Trauma and Loss (1) • Trauma and Loss (1) • Trauma-informed schools (1) • Trauma-informed practice (2)

		• Developmental trauma (1) • Adverse Childhood Experiences (ACEs) (3) • Bruce Perry Neuro approach (1)
Systemic approaches	13	• Restorative approaches (5) • PACE (1) • THRIVE (1) • Academic Resilience Training (2) • Compassion in Schools (1) • Solihull Approach (2) • Sandwell Wellbeing Chartermark (1)
Psychology approaches and frameworks	12	• Systemic theory (1) • Resilience (4) • Positive Psychology (1) • Coaching Psychology (2) • Supervision and emotional fatigue (2) • Reflective Practice (1) • Human Givens (2)
Training to raise awareness and develop knowledge of specific topic areas	11	• Emotionally-based school avoidance (3) • Self-harm training (3) • Eating disorder training (2) • Approaches to supporting SEMH for trans students (1) • 'Loose the Booth' training (1) • Sexuality and Gender conference (1)
Still in initial training/ recently finished initial training	11	Still in initial training Not yet but I only finished my initial training in July so I haven't yet had a chance
No	10	None! No
Anxiety	7	• Anxiety (4) • Anxiety in schools conference (1) • Exam-based anxiety approaches (1) • Anxiety in Autism training (1)

Bereavement, Loss and Critical Incidents	6	• Critical Incident support (2) • Bereavement (2) • Trauma and bereavement support (1) • Loss training day (1)
Parent training and family approaches	6	• Tuning into Kids (1) • Family First training (1) • Reducing parental conflict (1) • Parenting programmes (1) • Systemic Therapy (1) • Family Therapy (1)
Through experience	4	Trained to be an EP 20 years ago when it was a 1 year Masters course. Every thing I know and use now was developed and learnt as a qualified EP. Everyday is a further opportunity to understand that all cases and all work has an SEMH aspect
Mental health specific training	3	• Mental Health Practitioner via CAMHS (1) • Mental Health First Aid (1) • CYP-IAPT options (1)
Training around behavioural approaches	3	• Team Teach (1) • De-escalation training (1) • Bill Rogers (1)
Safeguarding topics	2	• Signs of Safety (1) • County Lines and level 3 safeguarding courses (1)

7.31 Appendix 31 – Table to show full list of activities EPs' were confident to engage in at the individual level

Activities EPs are confident to engage in at the Individual Level		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Interventions	82	CBT type work, PCP work, solution focused work CBT approaches, ACT approaches, drawing and talking
Assessment	52	Assessments, hypothesis development Assessment of resilience, self-esteem, personal constructs Personal construct psychology, solution focused scaling, brief functional assessment questions
Consultation	20	FBA guided consultation Consultation
Listening to young people and gathering their views	15	Voice of child, building a rapport with hard to reach young people leading to them engaging in the sessions with you Co-production and pupil voice work
Supporting school staff and families	8	Supporting adults to understand SEMH needs and how these might be supported. Parental support/ training
Identifying need and planning	7	Identifying need and ways forward in discussions with the child/young person, parents and staff; and supporting their interventions through Plan Do Review cycles Planning interventions
Group Processes	6	Circle of Adults and PATHs / Person Centred Planning

		Intervention (if ever I got the opportunity but rarely do)
Barriers faced	6	I would feel confident engaging in direct interventions such as CBT approaches/MI/SF however seems these opportunities are more difficult to find in the sense school want assessment not intervention.
Casework	5	Working 1:1 with pupils
Observation	5	Observation
Triangulating views from others	4	Gain pupil views, parental views, teacher views, triangulate information
Around a variety of needs	3	Working with children with high level SEMH needs. I also feel confident to discuss these children with staff (e.g. children who are self-harming) and make recommendations
Bespoke planning for young people	3	Emotional wellbeing plans to support change
Project work and evaluation	2	Evaluation Project work

7.32 Appendix 32 – Table to show full list of activities EPs' were confident to engage in at the group level

Activities EPs are confident to engage in at the Group Level		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Intervention	69	Friendships and social skills work, loss and change groups Lego Groups CBT based group work
Group consultation	38	Solution-focused group consultation using large sheets of paper and taking a more visual approach Solution circles with staff to provide supervision around SEMH.
Training	29	Training for groups of parents ELSA training Training LSAs in ACT, mindfulness
Supervision	12	Peer supervision ELSA supervision
Support for staff to deliver interventions	4	Helping support staff to plan group sessions, e.g. by holding a workshop, or running the sessions together to begin with
Supporting staff capacity	4	Teacher coaching
Planning	4	Supporting planning and school intervention Planning ELSA work
Barriers faced – lack of opportunities and time	4	I feel confident in my ability to deliver interventions, such as therapeutic story writing, despite having few opportunities to utilise this.
Assessment	2	Class dynamic assessments

7.33 Appendix 33 – Table to show full list of activities EPs' were confident to engage in at the whole-school level

Activities EPs are confident to engage in at the Whole-school Level		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Training	89	ELSA training, trauma Training in SEMH issues e.g., attachment/bereavement
Policy and practice development	19	Discussion of behaviour policies and their impact Audit, planning, evaluation
Consultation and group processes	15	Circle of Adults and PATHs to support a wider organisational change around SEMH needs Using tools such as Force Field Analysis
Interventions	5	Emotion Coaching/ PACE principles Mindfulness
Involvement in projects	5	Organisational projects
Approaches EPs take	4	Appreciative Inquiry Solution-oriented working
Staff supervision and staff wellbeing	4	Supervision around SEMH Staff Wellbeing
Supporting staff to understand needs and implement provision	4	Supporting staff to understand underlying needs Provision mapping
Barriers faced – confidence and lack of opportunities	3	N/A I would feel "confident" in I feel able and willing to carry out work at a whole school level such as delivering training and using approaches such as Circle of

	Adults and PATHs to support a wider organisational change around SEMH needs but have not had any opportunities to do so

7.34 Appendix 34 – Table to show full list of activities EPs' were confident to engage in at the strategic or LA level

Activities EPs are confident to engage in at the Strategic or LA Level		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Training	30	Training for children's service staff e.g., anger management/de-escalation, motivational interviewing, solution focused approaches Mindfulness, Emotion Coaching
Supporting project work	17	Participation in project work Supporting the LA with implementation of the Wider Inclusion Strategy Contribution to LA-wide initiatives to develop a strategic response to meeting SEMH needs
Policy and guidance development	10	Developing behaviour policy guidance & systems for graduated approach Local area training and policy development
Multi-agency liaison	11	Liaising with other professionals regarding strategic work Building support networks within the profession and organisation to help us to do our work well
Barriers faced	11	I feel able and willing to deliver training but have had very limited opportunities to do so Not confident
Research	5	Undertaking research to evaluate interventions/ identifying areas of need
Within service contribution	4	Contribution to working groups
Consultation and supervision	3	Consultation Supervision

Involvement in strategic decision making	3	Attending LA decision-making groups
Contribution of a psychological perspective	3	Supporting development of work by sharing psychology and evidence
Problem-solving with others	2	Holding group consultation and problem-solving sessions with staff such as a PATH

7.35 Appendix 35 – Full list of skills reported by EPs as important when working in the area of SEMH

Important skills when working with SEMH		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Interpersonal skills	78	Good interpersonal skills Building rapport and relationships with staff, parents, young people and other professionals. Listening in an attuned way to stake holders, including young people skilfully using tools Understanding and having empathy with the student, parent and teachers Strong, trusting relationships with staff and families
Consultation skills	45	Organisational consulting skills Unpicking - not just accepting set assumptions Critical friend Techniques to help shift perceptions where necessary e.g. reframing, presenting a different understanding of the child in light of information gathered Consultation and reflection skills
Communication skills	43	Communication and listening skills Active listening skills Communication - being able to communicate SEMH needs in a way which is understandable to others

EP qualities and values	35	Clear communication in the psychology that is being shared so that this is understood, relevant and able to inform practice Reflective practitioner Staying calm/not rising to the level of panic that schools may feel around a particular issue Professional resilience Promoting inclusivity and a sense of belonging (avoiding exclusion) You are aware of power, difference
Therapeutic skills	27	Therapeutic alliance focus (listening, unconditional positive regard etc) Containment of emotions of students, staff and families Helping school staff feel that they have a role and that they have the skills to help the child/family (rather than "eek, mental health, not my area").
Problem-solving skills	23	Facilitation skills to support problem solving so schools feel that they can move things forward Being able to support formulation of the young person's situation to help increase understanding for the young person, staff and family
Knowledge and understanding of mental health needs	20	Understanding of the wider impact of SEMH difficulties on learning and development Knowledge of SEMH and an awareness that behaviour is an effect rather than a cause.
Being collaborative	20	Value collaboration. See key staff as experienced and value partnership.

		Ability to work with all those involved (parents, school staff, other agencies) Collaboration (to develop a shared understanding/ working hypothesis development with stakeholders)
Knowledge of psychological theory and research	18	Understanding of key theories / concepts that underpin SEMH e.g. resilience, sense of belonging etc Knowledge of assessment and intervention, knowledge of evidence-based practice
Application of theoretical approaches	13	Application of theory/models to guide thinking/ formulation Application of Positive Psychology/ Solution Focused
Taking a holistic approach	12	Taking a holistic approach to look at all the factors that may be affecting mental health Understanding the influence of wider context factors on children's development, and facilitating interventions that take these into account
Facilitating change	11	Developing relationships so that shared objectives can be developed and change facilitated. Using tools, such as strength based methods like well-being plans, to help people to feel empowered to effect change and shift attitudes towards the difficulty
Being flexible	10	Knowledge and understanding of a variety of approaches to mutually appreciate what would work best for the setting/child/stakeholders Ability to be flexible and adapt to the young person's needs
Assessment skills	10	Careful use of appropriate and sensative pre- and post-measures.

Confidence and competence	8	Skilled at assessing difficulties Understanding own competence Not shying away from potentially difficult topics Confidence
Knowledge of how to provide support	7	Good understanding of different strategies and 'tools' - good understanding and awareness of LA offer to support SEMH Being able to signpost to different resources/services
Supervision skills	7	Supervision skills
Perspective taking	6	Listen and accept different perspectives including young person and parent
Empowering young people to have a voice	6	Supporting the CYP to explore and express their views and perceptions
Skills in delivering training	6	Training - a great space to support staff to take the time out to reflect, learn something new and think about how they will take this forward in practice
Being strengths-focused	5	Identifying strengths and what is working
Understanding of school context	5	Understanding of context and other pressures on schools
Experience	5	Previous work experience in CAMHS Experience
Knowledge of child development	2	Coherent model of children's emotional development
Observation skills	2	Observation

7.36 Appendix 36 – Full list of reported theories guiding EP practice in the area of SEMH

Theories guiding EP practice in the area of SEMH		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Attachment and trauma theories	75	Trauma and attachment theory Attachment/ brain development Childhood adversity and trauma, attachment theory Attachment theory and related concepts (e.g. Circle of Security, Coventry Grid, VIG)
Solution-focused approaches	34	Solution focused practice
Personal Construct theory	31	Personal Construct Psychology; behaviour always makes sense to the person who is exhibiting them and understanding where they are coming from and their construct of the world supports to understand the behaviour.
Ecosystemic theories	30	Holistic- Brofenbrenner Consultation - multi factor consideration Systemic perspectives Interactionist perspective Ecosystemic theory and the interactions between the systems
Behavioural theories	28	Functional behaviour theories Social Learning Theory
Cognitive-behavioural theory	28	Cognitive-behavioural theory 5 Ps Formulation
Humanistic theories	25	Humanistic psychology- unconditional positive regard

		Maslow’s Hierarchy of Needs
Positive Psychology and strengths-based approaches	20	Positive Psychology
		Strengths-based
		Relational approaches
Relationship-based theories	19	Attunement and VIG interaction principles
		Emotion Coaching
		Resiliency Framework
Resiliency theories	14	Growth Mindset
		Narrative therapy and the importance of the stories we hold about ourselves.
Narrative approaches	12	Narrative approaches
		Problem identification, analysis and solving approaches
Frameworks and models	10	Consultation processes to guide people through emotive discussions
		Social Model of Disability
		VIG
Intervention-based approaches	10	ACT
		Mindfulness
		Motivational interviewing and 'rolling with resistance'
Theories of change	9	Prochaska and DiClemente's trans-theoretical theory of change
Self-determination theory	7	Self-determinism/motivational theory - idea of autonomy, authenticity, confidence, competence etc
Cognitive theories	7	Attribution theory

		Concept of self-fulfilling prophecies
Psychodynamic theories	6	Psychodynamic theories
Emotional wellbeing approaches	5	Models of Anxiety and emotional regulation
Developmental theories	4	Child development Understanding of SLCN needs and how this can impact on behaviour Theory of Mind and the development of empathy
Emotional literacy approaches	2	RULER anagram for emotional literacy (Recognise, understand, label, express, regulate).

7.37 Appendix 37 – Reported paradigms guiding EP practice in the area of SEMH

Paradigms guiding EP practice in the area of SEMH		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Behavioural	17	Behavioural Psychology Behaviourism
Humanistic	13	Humanistic Psychology
Systemic	9	Systems Psychology Ecosystemic
Cognitive	7	Cognitive Psychology
Psychodynamic	7	Psychodynamic
Social constructionism and social constructivism	7	Social Constructionism Social constructivist- how people assimilate new constructions of reality into their own thinking
Neuropsychology	5	Neuropsychology Neuroscience
Developmental	4	Developmental Psychology
Social	3	Social Psychology
Eclectic	2	This can vary broadly based on the needs and circumstances of the individual, for example, when in SLD Sp School a behaviourist approach is taken, to view function of the behaviour. Various theories and approaches are used, e.g. attachment theory, ecosystemic and psychoanalytic, along with developmental psychology, to name a few. In my view, as the term 'SEMH' covers such a broad range of difficulties and needs it is not straightforward enough to address by using just one theoretical stance, paradigm or approach.

Critical Realist perspective	1	Critical realist perspective

7.38 Appendix 38 – Table to illustrate barriers to engaging in SEMH work – EP responses to the 'other' barriers option

Barriers to engaging in SEMH work: 'Other' barriers EPs faced		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Service factors and LA context	7	Working in a LA means that you assess and support SEMH on a wider level, but do not deliver intervention yourself. Within my authority, there is an expectation of ta specific type of EP work (traditional/cognitive assessment based) making it hard to be creative in relation to SEMH work Other EPs taking the lead within the service.
Role restrictions	7	Knowledge - As a TEP I am still picking up and learning new skills and domains. SEMH is probably not an area of strength for myself so I'm working on it.
Perception of EP role by others	6	Some parental barriers such as misconceptions about our role and the nature of our involvement. For example fear of medical view / diagnosis / pathologising I think sometimes school staff see our role as learning and somehow think that this is separate to behaviour. This can mean that cases aren't referred to an EP when that would be very appropriate.
Training	5	Lack of CPD opportunities to develop skills in other area I am not sufficiently trained to do therapeutic work with high risk cases
Policy and guidance	5	OFSTED criteria reinforces schools' focus on academic achievement and has limited their investment in support for pupils with SEMH. There are also some school behaviour systems that make it challenging to reach

		pupils with SEMH because they are quickly excluded and sent to other provisions.
Lack of collaboration between agencies	3	LA services working more in isolation as they move to a more traded model, not as much co-working as before
No barriers experienced	2	None of these apply. We are not within local authority constraints and therefore can work in a preventative way with schools and other organisations to implement timely and appropriate interventions etc.
Confidence and skills	2	Lack of confidence/expertise to lead 'therapy'
Supervision	2	Adequate in-depth and appropriate clinical supervision to support therapeutic work
Link between behaviour and mental health not well understood	2	School staff lack the understanding of the links between wellbeing and behaviour (in general - not all school staff) so that means that they often do not invest enough time on the pupils with SEMH and worry too much about learning.

7.39 Appendix 39 – Table to illustrate barriers to engaging in SEMH work – Time constraints

Barriers to engaging in SEMH work: Time constraints		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Need for longer term involvement in SEMH work	12	Often SEMH work can take longer at all level e.g. engagement with student Carrying out ongoing work beyond 1 or 2 sessions Sometimes feels like you cannot fully explore SEMH needs
Impact on intervention delivery and direct work	9	Limits the amount of direct intervention work Can recommend interventions but not deliver
Contributing factor: Trading services and cost	6	Traded service, schools can't afford time spent on intervention Linked to trading issues and schools not always wanting to continue prioritising
Contributing factor: Workload	4	My caseload is 100-150 children and young people in any given year
Contributing factor: Statutory demands	4	Demands of statutory work
Contributing factor: Service context	3	Often within the consultation model of service delivery, we only have time for an initial consultation, some information-gathering work with the young person and a review consultation
Contributing factor: staffing capacity	2	Our service is currently understaffed which focuses work on statutory processes and capacity for intervention is limited

7.40 Appendix 40 – Table to illustrate barriers to engaging in SEMH work – Levels of statutory work

Barriers to engaging in SEMH work: Levels of statutory work		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Increased demand	14	This work has increased by about 60% in our service and therefore impacts on what else we can engage with Overwhelming number of statutory requests
Priority over other work	5	We primarily carry out statutory work so this means most work is at an individual level. This makes it difficult to fit the traded SEMH work in
Impact on type of work involved in	4	Interferes with preventative work Affected my numbers of individual I can support, or group work done
Impact on time and quality of work	2	Impact on time left available to complete more in depth SEMH work and training at an organisational level.

7.41 Appendix 41 – Table to illustrate barriers to engaging in SEMH work – Competing work demands

Barriers to engaging in SEMH work: Competing work demands		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
School priorities	11	Schools are more likely to want to use our time for an assessment which can contribute to a referral for an EHCNA assessment than using our time to complete a piece of therapeutic work Schools focus on cognition and learning and less interested in SEMH work Other professionals offer SEMH things so schools tend to prioritise casework for me. Schools identifying individual casework as priority and reluctance to dedicate time to whole school or wider initiatives when we are the only professionals who can do the EHCP advice bit.
Statutory assessment	9	SLAs used by schools as a path to statutory assessment High level of statutory work means that there is little flexibility within the EP role; statutory demands often mean that we are not able to use our full skill set
Impact of trading	5	With schools being the customer it is very much dictated by them. Traded time from schools means therapeutic work often side-lined for assessment-based work
Managing additional tasks	4	Protecting time for planning and prepping therapeutic work e.g. CBT and protecting regular slots in your diary for delivery while navigating other work demands can be tricky
Role responsibilities	2	Management responsibilities

7.42 Appendix 42 – Table to illustrate barriers to engaging in SEMH work – Lack of opportunities

Barriers to engaging in SEMH work: Lack of opportunities		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
School priorities and funding	15	The opportunities we get vary depending on our contact school and what services they choose to buy in Individual casework is often requested for assessment purposes Schools not able/willing to prioritise and buy it in
Restricting the type of work EPs are involved in	5	Lack of opportunities to work at group/ systemic level Very little opportunities for multiagency work
Perception of EP role by others	4	Some school staff continue to view the EP role as solely related to learning needs and outcomes, hence pupils with SEMH needs are not discussed as they are perceived to not meet threshold for EP involvement because they are academically able Not seen as EPS role by LA
Service context	3	Within my current service (as opposed to other services I have worked in), there is not much in the way of specialisms or expertise in SEMH, this means the opportunity to do creative SEMH is limited - especially since I am still training and acquiring new skills/approaches

7.43 Appendix 43 – Table to illustrate barriers to engaging in SEMH work – Trading

Barriers to engaging in SEMH work: Trading		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
School priorities	19	Limited hours and schools prioritising numbers of children rather than ongoing pieces of work Traded model supports sometimes, as schools can request our support. At other times it is a barrier, where schools do not see mental health as a priority
Restrictions on EP activity	14	Schools rarely engage in systemic or group work or therapeutic intervention work and often request only individual assessments Reduced the amount of joint-school-family consultation work in particular
School funding and resources	10	Schools do not seem to have the funds or prioritise the funds for direct intervention. Schools don't always prioritise or have the money for EP input, especially for therapeutic work and systemic work
Cost	8	Other services are cheaper than EPs, therefore schools are more likely to purchase intervention elsewhere SEMH work typically requires more involvement than a one off session and so is more costing to schools.
Time and capacity	5	We cannot accommodate the requests for SEMH work we receive Schools can only buy in a small amount of time so there is a lack of time to complete long term SEMH work.
Being commissioned	2	Requirement to find a funding stream can sometimes be difficult

7.44 Appendix 44 – Table to illustrate barriers to engaging in SEMH work – Provision from other mental health agencies

Barriers to engaging in SEMH work: Provision from other mental health agencies		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Limited multi-agency working	9	Perhaps a lack of joined-up working between CAMHS and EPs There are lots of other agencies around, including CAMHS but can sometimes feel there are often is not as many opportunities for joined up working
Barrier to children and young people accessing support	7	Not so much a barrier for an EP becoming involved, but is definitely a barrier for the CYP trying to access the support However, equally I am aware of many children who are on a very long waiting list for CAMHS and feel this is where we can step in to provide support and possibly reduce the need for some referrals to CAMHS.
Capacity and skills of other agencies	6	Other agencies may be better placed to work with the child such as counsellors or CAMHS Often other agencies can offer support and time needed to coordinate support
EPs not considered or prioritised	5	CAMHS are in every school so we rarely receive referrals for SEMH that are not statutory and this is disappointing Sometimes SEMH is considered to be a 'specialism' of others when I feel we are well placed to contribute to the work
Role boundaries	4	Personally I find it hard to know where EPs stand in relation to CAMHS and do worry about 'stepping on their toes' or doing work that is not in our remit. Often CAMHS will say not our job and you know it's beyond your own training

		Not a problem previously but MH Trailblazers may impact on traded work as schools will have access to free support
Cost	4	Many different people are qualified to deliver work on anxiety and we are a very expensive resource!

7.45 Appendix 45 – Table to illustrate facilitators to engaging in SEMH work

Facilitative factors to engaging in SEMH work		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
School awareness of EP contribution	16	Having established relationships with schools which has led to a fuller understanding of the EP role and what the EPS might be able to offer in terms of supporting YP with SEMH needs, and staff in supporting YP. Schools are very positive about the EP role in SEMH work, often reporting that the EP formulation as pivotal it making sense of the communicative function of the child's behaviour and underlying SEMH needs and how these interact in the school environment
Supervision	15	Time for supervision Supervision enable me to feel safe in taking on SEMH work that I might not have done in the past.
Schools with increased awareness and understanding of the importance of SEMH	13	Schools generally understand the importance of this issue even if they find it difficult to enable the level of work that is needed. Some schools want to use their traded packages for SEMH related training/therapeutic work
CPD, attendance at training events and conferences	13	CPD training often focused on supporting SEMH needs Training and conferences
LA support	12	Recognition within the Local Authority, that EPs are valuable contributors to this area of work The LA has a good understanding of what we can offer.

Relationships with other professionals and multi-agency work	12	A desire among professionals to work together, even if the systems are less willing to accommodate this! e.g. informal discussions with staff in SEMH team Multi-agency meetings that use a person centred approach and are outcome focussed.
Relationships with schools	12	When EPs can build relationships with schools and establish trust and rapport with SENDCos, teachers and support staff I feel that it is a crucial role for the EP, who has a presence within schools and relationships with staff, to upskill school staff and share knowledge so that they can understand the emotional needs being communicated through behaviours.
Support from senior leaders	12	Excellent lead EP and SEPs Our principal is pushing for us to be a more proactive service in tackling this need
Delivering training and project work	11	Opportunities for attending/delivering training on SEMH topics. Opportunities for being involved in projects (e.g. ELSA) which have a strong emphasis on SEMH. Time allocated to work with other agencies such as the youth offending team and to work on research projects such as exclusions
High levels of need	10	Schools see high levels of SEMH need and dwindling services to help meet it A lot of demand for involvement for cases which do not meet CAMHS thresholds
Promotion and communication of work	9	A culture of promoting SEMH work and supporting SEMH needs in the service We are fully traded and undertake a broad range of work in schools, including a lot of SEMH work. It is my personal opinion that you can create any type of work in schools if the need is present, you just need to

		communicate its purpose and demonstrate its value
Knowledge, skills and experience within the team	9	Wide knowledge base of colleagues within service Having a range of skills and experience within the EP team to draw upon
Service reputation and being valued	9	The EPS has a good reputation based on the work done. Time given to this work, and acknowledgement from out directors of the value of EPs in delivering SEMH work.
Service priority and commitment	8	A commitment from my own EPS service to this work SEMH is a service priority and a great area of need in the LA I work within
Service ethos and culture	8	Open, collaborative approach at service Proactive & creative EP service A culture of promoting SEMH work and supporting SEMH needs in the service
Specialist roles	7	Having a Mental Health lead within the team I am supported within my current role to have 0.6 of my position in a specialist role to support C/YP with SEMH needs.
Supportive service and team	7	Support from the team
Initial training	6	Good training at university so that I feel confident in SEMH Being a TEP means that I'm offered therapeutic opportunities more so than some qualified EPs in the team might typically be, to support the development of those skills/competencies

Trading	6	Traded model supports sometimes, as schools can request our support. At other times it is a barrier, where schools do not see mental health as a priority
EPs skills and knowledge	6	My own skills Knowledge base
Virtual school funding and opportunities	6	Large Virtual School commission means that there are more opportunities for work in relation to SEMH, often involving therapeutic work. Some work that I have completed has also been funded by the virtual school which has helped to get rid of a funding barrier.
Flexibility of the service	6	Flexibility within the service to explore own interests. Not constrained by levels of statutory work. Supportive service who value a range of approaches and are not prescriptive
EPs interest and motivation	4	I have a strong passion for working with pupils with SEMH and have never found an issue with being able to complete this work. And motivation of EPs to engage in MH work
Working outside the LA	4	I am directly employed by a MAT and therefore have increased flexibility in how I use my time. I'm not constrained by trading or statutory work.
Supportive systems within the service	4	Opportunities to participate in working groups Monthly therapeutic team meetings
Policy and guidance	3	The code of practice raising the area of mental health.

7.46 Appendix 46 – Table to show examples of EPs who had been considered a Lead Professional within mental health work

Examples of EPs who have been a 'Lead Professional' within mental health work		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
To fill the gap for other services	8	Taking the lead on assessment and intervention for YP with SEMH where other services not directly involved e.g. CAMHS, or counselling service I would only lead the case up until point of referral.
Through a variety of roles	7	I lead for mental health for our service in the authority Assistant PEP for SEMH and lead for schools wellbeing service
Around a variety of needs	4	Mostly with children with anxiety and/or emotional-based school refusal
At school's request	4	School frequently rely on EP as lead professional in mental health work and really value our input and support
Through LAC casework	3	In casework where a YP has SEMH needs, is Looked After, but no other agencies are actively involved
Alongside others	2	I write the clinical service plans for young people within the integrated site alongside mhp [mental health practitioner]
Through working with parents	2	Mellow Parenting programme
Through delivering training	2	Provide the mental health first aid training on behalf of the LA via public health
Through supporting staff	2	Heading up working groups in schools around SEMH

7.47 Appendix 47 – Table to show responses given for 'other' promotional methods

Other ways EPSs promote the EP role in SEMH work		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Conference	7	Presentations at local events e.g. SENCo conference Upcoming conference on mental health and learning
Planning meeting	5	Face to face planning meetings with SENCo
Multi-agency working	5	Local Inclusion Forum Team Meetings (multi-professional problem-solving / solution focused meetings with local SENCOs bringing cases or areas of concern. (professionals include specialist teachers, SALT, EWO, Early help...). We are trying to engage with other agencies and help them understand our role and opportunities for MA working.
None	4	We don't do any active form of promotion for the EPS
Word of mouth	4	Word of mouth between schools, high reputation
Training events	4	Training sessions
Working with schools	3	Regular communications with schools (headteacher updates)
Unsure or unaware	3	Am not aware of any deliberate attempts to promote this work
Traded offer	3	Traded platform called Revolution
Service guide or brochure	2	Mental health brochure listing interventions/training/support
Training package or menu	2	Offering a training menu

Newsletter	2	Our email newsletter
Through ensuring SEMH is a service priority	2	Ethos and strategic priorities
SEMH panel	1	SEMH panel
Emails	1	Emails
LA events	1	Local authority events
LA local offer	1	Local Authorities' Local Offer

7.48 Appendix 48 – Data relating to the effectiveness of promotional methods

Table 7.1: Table to show percentage of EP ratings of different promotional methods employed

Promotional method	Percentage of respondents				
	Very effective	Somewhat effective	Don't know	Low effectiveness	Not at all effective
Brochure	3.9%	24%	0%	13%	3.2%
Leaflets	4.5%	22.1%	0%	11.7%	3.9%
Website	7.1%	15.6%	0%	11%	6.5%
Through consultation	39%	42.9%	0%	1.9%	0%

When asked to rate the effectiveness of the above promotional methods EPs reported that consultation as the most effective (Table 7.1). The survey enabled respondents to select which promotional methods they would like to rate, consequently, this meant that each promotional method had a different number of respondents and were not rated by the entire sample (further information around numbers for each can be found in the descriptive statistics table below). On the whole, EPs providing an 'other' promotional method rated these as 'very effective'. Eighteen participants did not provide any data for this question.

Promotional method	*N*	Median	Mode
Brochure	68	2	2
Leaflets	65	2	2
Website	62	2	2
Through consultation	129	2	2
Other	37	2	1

Key:

1 = Very effective

2 = Somewhat effective

3 = Don't know

4 = Low effectiveness

5 = Not at all effective

7.49 Appendix 49 – Table to illustrate examples of reported EPSs' mental health policies, strategies or service guidance

Examples of mental health policy, strategy or service guidance		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Roles to support EPs with their SEMH work	5	As SEMH specialist seniors we provide information and capacity building opportunities to other EPs. We have a clinical lead
EPS policies and guidance	5	Various policies e.g. around risk management Supervision
Guidance for schools	4	Promotion of SEMH Audit and Quality Mark process in order to support school staff in meeting SEMH needs better and building inclusion across the LA Emotionally friendly schools project
Mental health strategy – EPS focus	3	Service development plan Big focus on wellbeing in the team
Development groups	2	Whole service study days and interest group follow up also predominantly about SEMH
Being guided by the LA	2	Strategic policy of the LA guides the service plan overarching the work we offer
In progress	1	In progress

7.50 Appendix 50 – Examples of systemic or organisational work around SEMH within Early Years settings

Systemic or organisational work around SEMH in Early Years settings		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Project and policy development	3	Behaviour policy, education mental health practitioner support and project implementation
Training	3	Emotion coaching training for nursery settings
Supervision and support for staff	1	Portage supervision

7.51 Appendix 51 – Examples of systemic or organisational work around SEMH within primary settings

Systemic or organisational work around SEMH in Primary schools		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Training	30	Emotion Coaching ELSA training, Attachment training
Whole school approaches or policy development	17	Whole school behavioural change work - moving to relational approaches to behaviour Supporting SLT to launch work from attachment aware schools training, use of emotional wellbeing audit tool for whole school to identify ways to build staff resilience
Group processes	15	PATH used for staff resilience Circles of adults, force field analysis, MAPS
Supervision and staff support	13	ELSA training and supervision Supporting a primary school to implement emotion coaching principles via a staff working party group
LA project work	11	Education mental health practitioner support and project implementation A 4 year project to develop SEMH in a designated area of the authority
Consultation and meetings	4	Team around the child Consultations
Parent support	2	Parent workshops on mindfulness, emotion coaching

7.52 Appendix 52 – Examples of systemic or organisational work around SEMH within secondary settings

Systemic or organisational work around SEMH in Secondary schools		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Training	21	Staff training around SEMH, predominantly internalising needs such as anxiety (including exam anxiety), self-injurious behaviours Restorative approaches training for senior staff
Whole-school approaches or policy development	14	Using Solution Circles, working with SENCO to look at how we can support mental health through PSHE curriculum, considering adaptations to behaviour policy with SENCO to support pupils ELSA, Solihull
Projects and research	12	Research around what is important in school for secondary pupils as part of our Ethnic Minorities working group, working with youth workers and school staff with the findings Mental health champions project
Group Processes	11	Force Field Analysis/workshop sessions with a designated group of secondary school staff to develop the school-wide response to managing challenging behaviour Group problem solving
Supervision and staff support	9	Training and supervision for staff in my SEMH special school Staff training and consultations
Developing provision for vulnerable groups	3	Development of new provision to support CYP with emotionally based non-attendance issues
Parent interventions	1	Parent interventions

7.53 Appendix 53 – Examples of systemic or organisational work around SEMH within Post-16 and FE settings

Systemic or organisational work around SEMH in Post 16 or Further Education settings		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Training	4	Trauma Informed practice at Post 16 Emotional Health and wellbeing to 3 post 16 colleges Academic Resilience Approach (ARA); ELSA; MHFA Training

7.54 Appendix 54 – 'Other' examples of systemic or organisational work around SEMH

Other examples of Systemic or organisational work around SEMH		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Across various settings with various professionals	8	Integrated therapeutic residential school for 8-16 ASC advisory service Holding an 'Anxiety in schools' conference
Policy and practice development	8	LA guidance in collaboration with schools to develop a city-wide graduated response good practice guidance in relation to SEMH County wide project work in relation to EBSA
Through consultation	2	In all through consultation and action planning- always include aspects which address families or schools approach to SEMH on the greater and individual child level
Training	3	ACE ambassador training within the local authority, I have helped to put together the training presentation for ACE ambassadors and am delivering it to people from a range of services.

7.55 Appendix 55 – Table to show examples of EPs' links with school-based mental health lead staff

EPs' links with school-based mental health lead staff		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
As part of the Green Paper proposals	8	Yes I attend the Trailblazer steering group and may have a future role in supervision of the MHP EP link to CAMHS trailblazer
With school-based staff	7	Ongoing work with MH leads from schools - including in TaMHS accreditation work - designed to recognise and celebrate (and hence, also promote more of) good practice re MH work in schools. Pastoral support teams in high schools who have a role in SEMH
Through projects	7	Mental health champions project linked to the future in minds initiative EPs commissioned to deliver whole school approach at secondary schools and post 16
EPs with additional mental health responsibilities	6	Project co lead for EMHPs Education, health and wellbeing coordinator for a mental health partnership NHS trust funds work within the service
Through training and supervision	5	Planning of training and delivery of training and supervision of staff Training for schools in the LA, nurture resilience project and nurturing practitioners (our version of ELSAs)
With CAMHS and other mental health professionals	5	Our EPS works closely with our CAMHS around EBS non-attendance Supporting the development of the MHTs in the local area

Through multi-agency working	4	I link with key professionals involved, not necessarily to do with green paper proposals Through multi-agency panels
Through individual casework	3	As part of usual individual casework
Developing links	2	Links just beginning to be established

7.56 Appendix 56 – Table to show examples of EP involvement in LA mental health developments

EP involvement in LA mental health developments		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Project and development work	16	Development of an Intensive support team to support schools with high profile YP to reduce permanent exclusion Liaison with CAMHS Universal Provision Workers to develop toolkit/strategy as part of a LA-wide project aimed at supporting SEMH needs in primary and secondary schools
Part of specific programmes	9	Developing interventions - ELSA lead Mental Health in Schools link programme
Joint working	5	Integrated mental health pathway with CAMHS
Research	4	LAC work and research Research thesis exploring relationship between students and teachers using PCP based intervention
EPs as a representative	3	EPS rep at bimonthly meeting of CYP Mental Health Partnership
Training	3	I am involved in develop and administering training to ACE ambassadors within the local authority.
Part of Green paper proposals	2	Within my LA I am facilitating a paths session for the trailblazer project

7.57 Appendix 57 – Table to show examples of EPs' hopes for future practice

Hopes for future practice for EPs around SEMH work		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Collaborative working	33	To be working collaboratively with schools and other support services to support pupils with SEMH needs. I think we need to liaise more closely with other agencies (e.g. CAMHS) and bridge across to mental health leads in schools
Strategic and systemic work	32	More opportunities for system, group, preventative and intervention work More time for strategic involvement in this area, not constrained by statutory assessment pressures and traded agenda As a profession, we are more involved in working preventatively (e.g. strategic/whole school level to promote social and emotional well-being) rather than reactively (e.g. when young people have significant SEMH needs which have led to exclusion)
Recognition of EP contribution	28	Recognition of the contribution and value that EPs can offer To be seen as integral, key pieces of the jigsaw by schools and by government. To be valued for our skills and application of psychology around SEMH
Supporting others and developing their skills	26	Inclusive vision allied to developing the skills of those around the child in the community, rather than becoming therapists or deskilling those around the child. To provide training to staff in the area of SEMH To support school staff with their wellbeing

Supporting early intervention and prevention	21	To increase involvement in school-based group interventions e.g. anxiety management, resilience groups, to be delivered by EP alongside school staff A move towards a stronger role in prevention, rather than intervention, for EPs To be involved in prevention and early intervention work as well as more complex work.
SEMH is understood and recognised as important	21	I would really like us to make SEMH just as important as cognition and learning in our work. I think we need to continue to produce holistic formulations that take into account both SEMH and academic/cognitive aspects of a child's functioning. Schools having a better understanding of SEMH and more flexibility to provide opportunities and provision that makes time for growth in this area for all students - not just when they are in crisis. That it is seen as of critical importance by all EPs as it can often be a secondary factor in other cases
EP role in direct intervention	18	More involvement in direct intervention with with individuals, groups and whole schools. Being more involved in SEMH work, delivering individual interventions Less focus on individual CBT work
Increased supportive factors	16	EPs have good quality supervision of the work delivered in this area Time to fulfil this role meaningfully and effectively. Not constrained by statutory assessment pressures

		Further support and funding from Local Authority
Opportunities to continue to develop skills and knowledge	15	To develop my skills and knowledge around this area so that I can carry out more individual work with children. Training and CPD around SEMH to continue to enhance knowledge and skill
Holistic ecosystemic approach vs medical diagnostic approach	15	I hope that we will be able to contribute the importance of a 'whole child' and eco-systemic approach to new developments that deflect from the within child clinical approach. I hope our profession can be part of championing the concepts within he power-threat-meaning framework to understanding young people's SEMH needs compassionately and in context. I hope we can change the discourse around SEMH to consider all factors affecting young people and effect change at different levels
Working with families	13	Multi-agency work around children and families in a preventative way Working with communities and families to develop internal support systems. Working with families to support them with children who may have SEMH needs. Development of work as an EP with Parents/ Carers
Increased opportunities	12	I really hope that we can become more involved in supporting SEMH needs, particularly mental health needs More opportunities to work over an extended period of time within schools and with staff To expand beyond majority of focus of KS1 to KS3, expand to early years and post 16.

EP contribution to national policies, strategies and guidance	11	We will guide national strategies That there will be a top-down shift that enables the introduction of policies that enable creative, early-intervention work around SEMH. For example, how can local authorities start to implement practices/procedures that prioritise/allow for multi-agency work around children and families in a preventative way? Greater role within the green paper proposals Training to designated mental health leads
EPs feel confident and well-trained	10	That all EPs feel confident in their abilities to support YP with SEMH needs and feel their training has equipped them to support these YP EPs to feel more confident in supporting SEMH needs, to have an understanding of therapeutic work and how we can work with others/ when it is appropriate for us to carry this out.
Promotion of inclusion	5	That we retain a unique inclusive vision
EPs as evidence-based practitioners	3	Ensuring that psychology used draws upon recent developments in research.
Advocating young peoples' needs	3	To be a voice for vulnerable young people, to reframe negative stereotypes and behaviour in ways that are supportive and understanding of young people's needs and for this to continue into their adult lives. (e.g. so attachment explanations do not become "personality disorder" explanations in adulthood.)
Less of an assessor role	3	To reduce the number of assessments in this area and use consultation more frequently

7.58 Appendix 58 – Table to show examples of EPs' concerns for future practice

Concerns for future practice for EPs around SEMH work		
Subcategories	**Frequency *(N)***	**Illustrative Quotes**
Demands of statutory work	42	That EP's work with SEMH will be squeezed out with the dual factors of the increase in MH trained staff working in schools and the ever increasing quantity of statutory assessment work, that only EPs can provide. Within our service there is a concern that our role could become more focused on statutory work, with less opportunity to focus on SEND Support work. That we will continue to be overrun with statutory work and not be able to do any early intervention/preventative work That our role is reduced to only statutory work Time for more complex or ongoing therapeutic work is reducing due to statutory demands.
Funding	24	Lack of funding in schools (and general economy) to have further detrimental impact on SEMH. Reduced capacity both within our service and within schools due to financial and curriculum constraints Schools don't prioritise budgets towards psychological services.
Impact of traded	20	Trading can be a barrier especially at a time when health is providing increased support in schools for free. May not be deemed a priority by schools and that traded time means EPs are not always able to work with children who have SEMH as schools can dictate the focus of EP work

Quality of training, supervision and opportunities for CPD	19	Time - particularly in traded services Increased trading can lead to less children having access to EP and SEMH services I worry that SEMH issues are not adequately covered in EP training and then we don't get to work with these issues enough once qualified, so we could become deskilled as a professional group. Supervision, time pressures, ongoing training, Confidence
EP role misunderstood or not recognised	15	I am concerned that the role of EPs and their unique contributions to support children SEMH needs is not well understood by health and educational professionals. We may be overlooked by politicians and those making key decisions about who can offer support to schools around SEMH. Professionals not having a clear understanding of the EP role and our expertise in SEMH.
Time and resource constraints	14	That resources will constrain, and that families and individuals will not get the support that they need. As an EP not having sufficient time and resources for effective working. Workload and funding pressures reducing opportunities to engaging in a range of SEMH work
Focus on a clinical diagnostic approach	9	The medical model of "diagnose and treat" Only that a more clinical approach will be taken if only CAMHs are involved in Futures in Mind programme.
Lack of systemic approaches	9	That statutory demands will lower the amount of systemic work EPs can do in general; affecting our ability to effectively intervene and support SEMH needs.

		A focus on individual casework instead of increasing staff capacity and confidence in supporting SEMH needs
Reactive role rather than proactive role	9	That we continue to be responding when it has already reached crisis level and often only through statutory work. If we were able to make a difference early on, such as through early intervention, many of these assessments might not be needed. Just being a reactive service
National curriculum pressures and focus on academic attainment	8	Competing demand- league tables, attainment and the perception of what makes a ‘good teacher’ is not always in line with SEMH support for the most vulnerable pupils Curriculum mismatch
Access to other services	7	Other services are cheaper limiting EP involvement. That EP's work with SEMH will be squeezed out with the dual factors of the increase in MH trained staff working in schools
Increasing focus on exclusions	7	The government not supporting policies that discourage permanent exclusion That there is a wider political movement towards exclusion in line with keeping up academic performance within schools. For example, the government supporting policies like expanding alternative provisions recently. I feel like this is combined with a rhetoric that children with SEMH needs are 'unsafe'. And could potentially contribute to dubious practices like off-rolling.
Isolated working	7	Increasingly working in isolation due to time/financial constraints - less joint work That multi-agency working and access to our services can be a 'minefield' to parents and professionals outside of the schools we already have a good relationship with.

		That we get stuck in a therapeutic role!
Lack in variety of work	6	I hope that we do not get pigeonholed into learning and/or statutory work
Increase in SEMH needs	6	The increasing number of younger children with SEMH needs SEMH needs grow under austerity
Categorising need vs holistic approach	5	I am very concerned about the perception of splitting needs into categories. We should be thinking holistically about the person, not meeting one particular need, which is only described as that category because someone else has described it so. We should be seeing and working with a person, not with how someone else has described them on paper. That would be poor practice, and should be gently challenged, so that the person who has fallen into that trap moves away from thinking of people as having needs in certain categories, and into working and relating to people as people
Lack of other services causing greater demand on EPs	4	I worry that we will be the only ones left who can offer anything around SEMH, as other services are cut so hard they can only work with children in crisis.
SEMH is less of a priority	4	It will become less of a priority Teachers SEMH needs are ignored to breaking point
Wellbeing of adults	4	LA EP burnout due to statutory demands and excess workload - see recent BPS survey of 6000 EPs interviewed about pressures of the job
Conflicting policy	3	That there is not a clear national vision on how to support SEMH needs. So many policies seem to conflict which makes it hard for schools to respond to SEMH needs.