Facilitators and barriers to the provision of therapeutic interventions by school psychologists

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Abstract

There is growing concern internationally about the prevalence of mental health problems among school-aged children and their access to specialist services. School psychologists (SPs) may be one group of professionals well-positioned to support the well-being of children and young people, due to their position as applied psychologists working within educational settings and their capability to deliver therapeutic interventions. This research considers findings from a large scale, United Kingdom (UK)-wide survey of the views of SPs ($N = 455$) about facilitators and barriers to the provision of therapeutic interventions to children and young people. Principal Components Analyses of ranked questionnaire responses yielded three components: The role of the SP; training and practice; and support and psychology service context. Quantitative findings were then triangulated, using qualitative responses from the survey. Greater direction and clarification of the role of the SP as a provider of therapeutic interventions is recommended, particularly given the diverse roles undertaken by SPs and competing demands, particularly from assessment activities.

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The World Health Organisation (WHO) (2003) acknowledges the significant impact of failure to recognize and address mental health problems in children, noting that 'The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive' (p. 2). In the same document, caution is expressed about the 'medicationalization' or even 'psychiatrization' of mental health problems, particularly when these occur as part of normal life or normal psychosocial development. The WHO (2003) quotes 2000 World Health Report figures indicating that up to 20% of children and adolescents worldwide suffer from a disabling mental illness. Similar prevalence statistics have been cited both in the UK (Meltzer, Gartward, Goodman, & Ford, 2000) and the United States (US) (Suldo, Freidrich, & Michalowski, 2010).

Reasons why young people experience these difficulties may be complex and multi-faceted. For example, Lee, Hong, and Espelage (2010) considered how the high incidence of youth suicide in South Korea might be influenced by a range of factors, from individual, familial, peer, and school factors, through to broader ecological influences, including cultural beliefs and values. Similarly Prever (2004) identifies both risk and resilience factors, including protective factors which can be implemented at a school-level as preventative measures against mental health difficulties.

However, despite the level of concern around children's emotional well-being, the delivery of therapeutic services is often fragmented and inadequate and there remains a significant level of unmet need amongst the child and adolescent population. In the UK, only a small proportion of children and young people experiencing mental health problems receive any form of specialist help, with estimates of those who do receive help ranging between 10% to 21% (Davis, Day, Cox, & Cutler, 2000). Similar issues in accessing child and adolescent mental health services are also recognized in the US (Perfect & Morris, 2011; Suldo et al., 2010).

SPs as providers of school-based mental health interventions

School psychologists (SPs) are applied psychologists who routinely work in educational settings and are well-positioned to provide a flexible range of support (Atkinson, Bragg, Squires, Muscutt, & Wasilewski, 2011; Miller, DuPaul, & Lutz, 2002; Suldo et al., 2010). The interest internationally in the role of school psychologists in supporting mental health is not a new phenomenon. For example, a content analysis of articles published in this journal identifies a steady stream of published articles relating to 'intervention in mental health services to develop

social and life skills' over the past two decades (Little, Akin-Little, & Lloyd, 2011). These include exploration of the contribution SPs can make to the emotional well-being of students at an individual level (e.g., Cohen & Mannarino, 2011), group level (e.g., Yeo & Choi, 2011), or systemically, working through school-based professionals (e.g., Nastasi, Overstreet, & Summerville, 2011).

Yeo and Choi (2011) note, however, that while internationally SPs are occupied in diverse roles, some activities including assessment limit the scope for involvement in delivering what they term 'frontline psychological services' (p. 617). Similarly, they note that in some countries, including Singapore where their research was conducted, the ratio of SPs to the number of children can further preclude involvement in wider roles. This problem is not recent. Murphy (1994) in seeking to develop brief therapy practices in schools recognized that SPs' time was extremely limited particularly to develop longer term therapies, in light of large caseloads and competing priorities.

While historically in the UK there was an emphasis on therapeutic provision within school psychology practice, the focus shifted following legislation in the 1980s and 1990s which placed a statutory duty on SPs to contribute to the assessment of children with special educational needs. However, in recent years there have been a number of calls for therapeutic work to be expanded within SP practice (Farrell et al., 2006; MacKay, 2007; Scottish Executive, 2002). Despite this, small-scale research into the role of the UK SP undertaken by Ashton and Roberts (2006) identified that school special educational needs co-ordinators (often the main point of contact for SPs) did not specify therapeutic intervention as an aspect of work which was valued, raising the question of whether it is seen by schools as a key function of the SP's role.

SPs as providers of therapeutic interventions

Recognizing the need for better access to mental health services in the US, Suldo et al. (2010) sought to establish why SPs were not providing adequate levels of support. They used a qualitative design to ascertain what school-based mental health services were provided by SPs and the facilitators and barriers to the delivery of these services. Findings indicated SPs were engaged in a range of activities, including individual and group counselling, crisis intervention services, consultation and behavioural assessment, and intervention. Barriers to the provision of effective support included problems with using the site for school delivery, insufficient support from department and district administration, and insufficient training. Enablers included sufficient department/district support, sufficient time and integration into the school site, and sufficient training. Factors such as school caseload, relationships with school personnel, and personal characteristics were seen as both facilitators and barriers.

Squires and Dunsmuir (2011) were interested in the facilitators and barriers faced by trainee SPs in attempting to deliver Cognitive Behavioural Therapy (CBT) in school settings. They constituted focus groups with tutors and trainees

at two UK training centres delivering the three-year doctoral programme which leads to professional registration. They found that individual trainee factors (such as confidence, motivation, and previous experience) as well as training and supervision could act both as barriers and facilitators to the provision of CBT. They also reported challenges with working in school settings, which ranged from protecting time and case identification, to logistical issues such as pupil attendance and finding a space to work.

Atkinson, Corban, and Templeton (2011) reported on the outcomes of two small scale studies using interviews and focus groups to explore some of the issues faced by trainee and qualified SPs in delivering therapeutic interventions. They found that schools were not always aware that SPs could provide therapeutic input and that where this was available it was often limited by time available to schools. This study seeks to provide a more systematic picture of the facilitators and barriers to therapeutic provision by SPs in the UK.

Method

All SPs working within the public sector in local authorities (LAs) within the four countries of the UK: England, Northern Ireland, Scotland, and Wales, were invited to complete an online or postal version of a questionnaire asking for information about their use of therapeutic interventions [School psychologists in the UK are referred to as educational psychologists (EPs). EPs have a peripatetic role across schools and the community, working with the 0- to 19-years population. Throughout this article, the term SPs is used, to include UK-based EPs, as well as other members of the international school psychology community]. Details of the questionnaire were distributed by post, via the UK's leading professional bulletin and on the main UK forum for school psychologists.

An overview of the complete questionnaire and descriptive findings from the research can be found in Atkinson, Bragg et al. (2011). Within the questionnaire, the following descriptors of therapy were used: (a) Therapy—'The treatment of mental or psychological disorders by psychological means' (*Oxford Dictionaries*, 2011); (b) Therapeutic work may involve the direct intervention of a psychologist with an individual child or a group of children. Equally it is applicable to the wider role of supporting others who work with children on a daily basis (MacKay & Greig, 2007, p. 4).

As part of the questionnaire, SPs were asked specifically about facilitators and barriers to SP involvement in therapeutic intervention. SPs were provided with lists of ten statements which had previously been derived through small scale research by Templeton (2010). Respondents were asked to rank the statements from 1 (for the most important facilitator/barrier) through to 10 (for the least important). Facilitators and barriers presented in the questionnaire are presented in Table 1 below.

SP respondents were additionally asked to provide qualitative feedback about their individual use of therapeutic interventions and the way in which their LA

Table 1. Enabling factors and barriers to SPs' use of therapeutic interventions.

Enabling factors	Barriers
Access to training	Access to supervision
Autonomy	Historical context for SP work
Management support	Lack of practice
Peer support	Lack of training
Personal interest in therapeutic intervention	Limitations of service time allocation model
Recent legislation supports broadening of SP role	Not best use of SP time
Schools valuing their relationship with the SP	Other priorities identified via stakeholders
Schools valuing therapeutic intervention	Service capacity
Service culture offers flexibility in the model of working	Service remit and ethos
Supervision	Stakeholders do not identify SPs as providers of therapeutic intervention

psychology service engaged in therapeutic work. These data provide opportunities for a mixed methods approach, by which qualitative data can be used to triangulate quantitative findings. Descriptive statistics relating to responses can be found in Atkinson, Bragg et al. (2011).

Findings

Principal Components Analysis (PCA) was used to ensure an empirical summary of the data set. This procedure was deemed appropriate given the suitably large data set ($N = 455$). Sphericity, according to the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy equalled 0.861 (a value greater than 0.6 on a scale of 0–1 is considered significant) indicating that factor analysis would be appropriate. Inspection of the correlation matrix revealed coefficients greater than 0.3, again indicating PCA to be viable. Kaiser's criterion (any factor with an eigenvalue of 1 or above) suggested five potential factors worthy of further investigation. Catell's Scree test clearly ruled out the inclusion of factor 5, while a sharp incline in the chart indicated that the first two factors definitely be retained, capturing 38% of variance between them. A small kink in the graph suggested that factors 3 and 4 might still be worth exploring. The first four factors accounted for 50.5% of variance.

Varimax rotation using Kaiser Normalisation, selecting the two key components, revealed an overlap of variables. The procedure was therefore repeated with three components. Overall variance explained by the three factors remained at 44.5%, with component 1 accounting for 16.16%, component 2 for 15.26%, and component 3 for 13.1%. The Oblimin Rotation, however revealed a correlation between components 1 and 3 (a value above 0.3 indicates a correlation). As the

Varimax Rotation assumes that factors are not related, it was therefore appropriate to use the Oblimin Rotation. In the Pattern Matrix (Table 2 below), items above 0.4 (bold) are considered to load strongly with, and therefore to describe, a factor.

Items in component 1, labelled 'role of the SP' relate to how the SP's role is understood and/or determined by commissioners and stakeholders. Component 2, described as 'training and practice' identifies items which link to the development of and opportunities for therapeutic practice. The third component is categorized as 'support and psychology service context'.

The three components revealed through this analysis resonated with previous findings that emerged from a quantitative survey (Atkinson, Bragg et al., 2011) as well as from the qualitative phase of the research. Each of these components will

Table 2. Pattern Matrix for the Oblimin Rotation.

	Component		
	I	2	3
Facilitators—schools valuing relationship with SP	**0.741**	−0.110	−0.134
Facilitators—schools valuing therapeutic intervention	**0.727**	0.002	−0.122
Barriers—other priorities identified via stakeholders	**0.644**	0.083	0.097
Barriers—stakeholders do not identify SPs as providers of therapy	**0.624**	−0.003	0.032
Barriers—historical context for SP work	**0.544**	−0.164	0.141
Barriers—not best use of SP time	**0.401**	−0.328	0.259
Facilitators—service culture offers flexibility in model of working	0.368	0.059	0.206
Facilitators—autonomy	0.360	−0.280	0.152
Facilitators—recent legislation supports broadening of SP role	0.356	−0.266	0.224
Barriers—lack of training	−0.050	**−0.873**	−0.033
Barriers—lack of practice	0.117	**−0.778**	−0.028
Facilitators—access to training	−0.008	**−0.536**	0.033
Barriers—access to supervision	−0.113	**−0.520**	0.465
Facilitators—personal interest in therapeutic intervention	0.203	**−0.403**	−0.044
Facilitators—supervision	−0.313	−0.284	**0.723**
Facilitators—management support	0.001	−0.074	**0.708**
Facilitators—peer support	0.087	−0.252	**0.568**
Barriers—service capacity	0.162	0.196	**0.522**
Barriers—limitations of service time allocation model	0.199	0.196	**0.459**
Barriers—service remit and ethos	0.273	−0.188	0.358

Extraction Method: Principal Component Analysis. Rotation Method: Oblimin with Kaiser Normalization. Rotation converged in 18 iterations.

now be explored further, with reference to the qualitative feedback from the questionnaires. This is undertaken to triangulate themes derived from the PCA and to offer additional insight into these facilitators and barriers to therapeutic provision.

Role of the school psychologist

SPs identified that schools valued not only direct therapeutic intervention to children and young people, but the application of therapeutic interventions within consultation, critical incident response, groupwork, parenting support, research projects and training. However, stakeholders did not always identify SPs as providers of therapy; in particular those working for child and adolescent mental health services (CAMHS) did not readily identify SPs in this role.

> I have had recent issues with CAMHS professionals who did not consider it appropriate for me to offer CBT to a child with [Post Traumatic Stress Disorder] PTSD (they did not offer it either). There is a greater need for those who offer therapeutic support to liaise and clarify who might offer what in what circumstances.

Although most of the responses indicated that it was health, rather than school-based professionals who did not recognize the role of the SP as therapeutic provider, a number of SPs acknowledged issues related to schools prioritizing therapeutic intervention work in light of competing demands, particularly for assessment and statutory work. One respondent reported that 'Some other SPs use therapeutic interventions but generally they have little time for individual and group work, due to high demand for statutory assessments'.

Statutory duties placed on SPs may significantly impinge on their potential to work therapeutically. In the UK, performance indicators for SP work are often based around the completion of statutory work within declared timescales, meaning that it may need to take precedent over other activities. One SP noted: 'I suspect our ambivalence to engage more with working therapeutically is linked back to wider issues and influences concerning what an SP should do and what [LAs] see as the most essential activities'.

It was, however, widely recognized that, given the prevalence of children and young people with mental health needs, schools and families value therapeutic input and there is demand for it.

Although, the questionnaire did not advocate for increased use of therapy, it should be recognized that not all SPs would relish a greater role in therapeutic delivery and may even see it as impinging on their ability to provide other services to support children and young people. Survey responses noted that some SPs did little or no therapeutic work and that others did not see it as a priority. This is particularly important to acknowledge, given that the respondent sample was self-selecting and therefore may be biased towards SPs with a positive predisposition towards the delivery of therapeutic interventions.

Training and practice

What is clear from the survey responses is that a number of UK SPs have significant additional counselling or therapeutic skills in a range of therapeutic approaches including: CBT, eye movement desensitization and reprocessing (EMDR), family therapy, gestalt therapy, human givens therapy, hypnotherapy, mindfulness, motivational interviewing, narrative therapy, parent child game, play therapy, solution focused brief therapy, systematic psychotherapy, and video interactive guidance. In a number of cases, SPs are additionally accredited by professional bodies such as the British Association for Counselling and Psychotherapy (BACP). Some SPs reported that they have undertaken this training in a previous role, for example as a counsellor or mental health provider.

However, training can also prove a barrier to the provision of therapeutic interventions. A number of SPs reported that the training received was inadequate, particularly in helping them develop the higher order skills involved in therapy, for instance: 'Lack of adequate training by SPs means that therapeutic approaches are often seen as a "fixing kit" rather than a complex relationship building process'.

Even where SPs felt they did have sufficient access to training, it was recognized that it was not always easy to find opportunities to practise or consolidate these skills. One SP observed that, 'I am a qualified hypnotherapist but now rarely get the opportunity to use the full range of my skills', while another noted: 'There are many counselling needs identified, but little time or opportunity to practise counselling'.

Another issue was access to effective supervision to consolidate skills learnt in training and develop professional practice in relation to therapeutic intervention. Concerns were expressed that supervisory structures were insufficient to enable them to effectively deliver therapeutic interventions, for example, 'Supervision is a major obstacle, as the frequency is not sufficient and some of the content has placed an unfair burden on my supervisor'. Another voiced the opinion that:

> I think that lack of clear and informed supervision as a tool is quite dangerous. There should be two kinds of supervision, (1) by therapists *per se* skilled in the [therapeutic intervention], and (b) by more experienced SPs skilled in the general practice of school psychology.

Countering this was evidence from a number of SPs that interest in therapeutic interventions led to significant personal attempts to prioritize the delivery of therapy as part of their casework. These included: undertaking research in therapy as part of their initial training; protecting time for delivery of therapeutic interventions within time allocation; prioritizing therapeutic interventions as part of their continuing professional development; undertaking therapeutic work within their own time (e.g. unpaid overtime, trainee study days); and in two cases, even paying for their own supervision. A number of respondents mentioned that therapeutic principles underpinned their work as an SP, for example: 'Therapeutic approaches

inform all aspects of my work on a daily basis, that is using the theories under-pinning therapeutic approaches to inform consultations and discussions with parents, staff and pupils'.

Support and psychology service context

As well as supervision, management and peer support were seen as integral to the delivery of therapeutic interventions. One respondent noted:

> I have been fortunate to work for a [school psychology service] that values therapeutic interventions and the individual skills of each SP. It would not be possible to carry out the range of work that I do without this whole service ethos.

SPs reporting management and peer support indicated that in addition to super-vision this could be through a number of avenues, including strategic planning for therapeutic interventions, training and accreditation, support to pursue areas of interest, collaborative working, protected time, and opportunities for research into therapeutic interventions.

There was, however, widespread concern that in many cases, service capacity and/or the service time allocation might limit opportunities for therapeutic inter-vention. SP respondents reported that despite a perceived need for and a willing-ness to deliver therapeutic interventions, there was either not time available, or that the preferred model of service delivery did not allow for therapeutic interventions, for example: 'I have found it increasingly difficult to work directly with children in a therapeutic way as the focus of SP work in my context has moved increasingly towards consultation'.

There was also an indication that SPs might signpost schools to other thera-peutic providers, rather than delivering the therapeutic interventions themselves.

The availability of time to deliver therapeutic interventions was seen as a sig-nificant issue for many of the SP respondents. Problems included: Time to under-take ongoing work, rather than just a single session; a lack of flexibility to enable intensive support where required; competing priorities (e.g. statutory work which has to be completed within timescales); a limited number of school visits; schools' willingness to pay for ongoing work via a traded services model; and having only a small number of SPs available to deliver therapeutic interventions (In the UK, the funding system is becoming less centralized, with budgets being increasingly dele-gated to schools. While previously SP services were delivered centrally from within the LA, psychology services are increasingly entering a 'traded' model, where work is directly commissioned and paid for by schools).

Discussion

Quantitative analysis using PCA indicated three themes which might be significant in SPs' use of therapeutic interventions, which have been triangulated by

qualitative data from the questionnaire. The first component of 'role of the school psychologist' resonates with the findings of Suldo et al. (2010) who reported that school personnel in the US were not always supportive of counselling or unaware that SPs could provide mental health services, perceiving that their role was primarily to do with testing. Furthermore, they identified that many SPs' delivery of mental health services was inhibited by a sometimes overwhelming demand for psychoeducational assessments. Conversely, it is interesting to note that in Estonia, where there are no standardized tests due to the small size of the country, the most common activity undertaken by SPs is individual counselling (Kikas, 2007).

Atkinson, Corban et al. (2011) found that in the UK the historical remit for SP work contributes to the perception that SPs are primarily concerned with educational matters. There is also much variation in practice; Squires and Dunsmuir (2011) discuss the heterogeneity of SPs' professional territory and how this varies according to the psychological service context and the schools the SP serves. These variations are even more significant when considered within an international context and when bearing in mind the influence of social, cultural, and economic factors and local and national priorities (Jimerson, Oakland, & Farrell, 2007; Woods, Bond, Tyldesley, Farrell, & Humphrey, 2011).

Atkinson, Bragg et al. (2011) found that while therapeutic interventions were most commonly used in individual direct therapeutic work, they were also used within assessment, as part of consultation, in groupwork, and in training. Furthermore, 60.5% of SP respondents identified their use in working through others. This resonates with suggestions made by Reinke, Stormont, Herman, Puri, and Goel (2011) and Yeo and Choi (2011) that a key role for SPs is involving or supporting teachers in the delivery of interventions for promoting mental health, through the dissemination of specialist knowledge and expertise.

Pugh (2010) and Perfect and Morris (2011) call for a re-emphasis on mental health and therapeutic interventions during the training of school psychologists, but alongside this there may be a need to promote greater awareness of the therapeutic functions of the SP. Given the competing pressures described by Yeo and Choi (2011), Pugh (2010) cautions that 'Failure to embrace a wider therapeutic role will increasingly result in the limited commissioning of only statutory and assessment services' (p. 397).

Consistent with findings of this research, Suldo et al. (2010) identify a theme of insufficient training; incorporating insufficient content knowledge, applied experiences and a confidence in one's ability to provide subsequent services. US SPs in the study also reported a dearth of opportunities to practise clinical interventions, with corresponding feelings of insufficient skill development and uncertainty during practice. Despite this, findings from this research indicate an interest amongst many SPs to develop their therapeutic skills, supporting the observations of Perfect and Morris (2011) and Suldo et al. (2010) that SPs desire greater involvement in providing therapeutic support.

As in this study, previous research has indicated problematic access to therapeutic supervision, particularly in relation to the specialist skills around a particular counselling modality (Atkinson, Corban et al., 2011; Squires & Dunsmuir, 2011). Given international reports of difficulties in accessing supervision generally (Jimerson et al., 2006) the provision of therapeutic supervision may provide additional challenges. One way to promote skill development and supervision within the profession may be to find better ways of harnessing and utilizing the skills held by experienced therapeutic practitioners working as SPs. These might include: Setting up SP networks or interest groups; peer or group supervision, particularly where colleagues have accessed similar training; and pairing of SPs or services to share expertise and provide support either through direct contact or virtual media. It may also be useful to develop mutually beneficial links with partners from other mental health support providers. In particular, technological advances such as email or contact via virtual interfaces, such as Skype, may offer access to practitioners in countries or contexts where therapeutic supervision is less accessible.

Time and competing demands are significant factors in SPs' ability to deliver effective therapeutic interventions. This may be particularly true in countries where there is a smaller ratio of SPs to children and where competition for SP time is even greater. Again, these findings resonate with those of other studies (Atkinson, Corban et al., 2011; Squires & Dunsmuir, 2011; Yeo & Choi, 2011). Additionally, Suldo et al. (2010) cited a barrier to mental health provision in the US as insufficient support from department or district administration, particularly where the conceptualization of SP practice was not broad enough to encompass the SP's role in promoting mental health and wellbeing. In countries where the SP role is less established, there may be even greater challenges in finding governmental or district support for the provision of therapeutic services. There is overlap here with component 1, 'the role of the SP' and to this effect, a clearer governmental perspective on SPs' role in supporting mental health is likely to be advantageous.

Suldo et al. (2010) concluded that systems-level factors, rather than person-centred factors appeared to provide the greatest barriers to delivery of mental health services. Certainly this research suggests that there appears a will amongst SPs in the UK to respond to the needs of the growing number of children and young people recognized as having mental health needs. However, like Suldo et al.'s (2010) research, this study might also conclude that simply the reduction of barriers or the greater enabling of facilitators may be insufficient to redefine SPs as a providers of therapeutic interventions and that departmental/district level factors including role assignments and expectations need to be addressed. This suggests that in the absence of strategic developments in SP service delivery, SPs may be limited in their capacity to respond flexibly to the needs of children and adolescents. These issues may be particularly pertinent in countries and contexts where the SP role is less established or less flexible; perhaps due to smaller numbers of SPs, less established multiagency links, or greater demands for SPs to engage in assessment activities.

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