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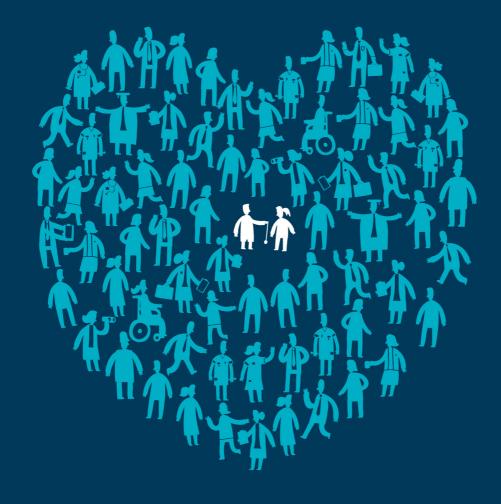
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**Children's Workforce
Development Council**

How do school counselling and therapy services undertake participation activities in a way that meets the ethical requirements of therapeutic practice?

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Catholic **Children's** Society (Westminster)

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Janis Griffiths

How do school counselling and therapy services undertake participation activities in a way that meets the ethical requirements of therapeutic practice?

Abstract

This study explores how organisations providing counselling and therapy services within schools undertake participation activities, and the ways in which ethical considerations might have affected the choice of methods. It primarily focuses on the participation of children and young people in improving the quality of services. The research aimed to gather potential models of involving children and young people in the development of services.

Two semi-structured interviews and one focus group took place, gathering data from five services providing therapeutic services in schools in London or the South East. The research found that while participative practice is inherent in the day-to-day delivery of therapy and counselling, it is still in development at an organisational level. The need for standardisation of approach at an organisational level clashed with the therapist and counsellors' need to consider an ethical approach and the individual needs of clients. Specific challenges related to collecting the views of young children were noted in the interviews.

The study concludes that devising a prescriptive approach that is delivered identically in every case is not appropriate. Every method used must be differentiated for different ages and developmental stages, and a level of flexibility in its implementation must be allowed. This flexibility will allow the therapist or counsellor to adapt the approach in situations where its delivery may conflict with ethical principles.

Janis Griffiths
Catholic Children's Society (Westminster)
020 8575 0282
janisg@cathchild.org.uk

Introduction and aims

This study explores how organisations providing counselling and therapy services within schools undertake participation activities, and the ways in which ethical considerations might have affected the choice of methods. It primarily focuses on the participation of children and young people in improving the quality of services.

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Context

School Counselling

Emotional disturbance can have a significant effect on the educational capacity of a child (Lee, Tiley and White, 2009), and therapeutic services have been developed as a key part of many schools' pastoral care systems. Although, as many as one in five children and young people may suffer from a mental health difficulty, a significant proportion do not get access to mental health support (Fox and Butler, 2009), and school counselling and therapy services based on the school site can provide a simple and easily accessible route to early intervention. Further to this, under the extended services agenda of the Department for Children, Schools and Families (DCSF), schools are now expected to provide a range of community services within their premises, including 'swift and easy referral' to other services (DCSF, 2008).

Jackson and Polat (2006) found that 50 per cent of schools expected their counsellors and therapists to be appropriately qualified and accredited through a professional body. Amongst providers of therapy and counselling to schools this is considered a basic good practice requirement and some services provide placements for trainees on appropriate courses who are also accredited as a trainee with a professional body.

Ethical Frameworks

Discussing ethics for research with children, Allen (2005) highlights that there are three levels of ethics: regulatory, institutional and those of the individual practitioner. These levels could also be applied to the ethical frameworks that apply to therapeutic practice.

- At a regulatory level professional bodies such as the British Association of Counsellors and Psychotherapists (BACP) and Play Therapy UK (PTUK) provide ethical frameworks that their members must adhere to.
- At an institutional level policy and procedure is developed based on the organisation's ethical approach and a management-level interpretation of the ethical framework.
- On an individual basis the practitioner applies his or her own ethical viewpoint in their delivery of therapy/counselling.

From a legislative perspective, there is currently no statutory basis for counselling and 'guidance from professional associations is aspirational rather than mandatory in form (BACP, 2001)' (Jackson and Polat, 2006, p7). The Health Professionals' Council is currently consulting on putting in place statutory regulation for counsellors and psychotherapists.

However ethical guidance underpins the training, theory and practice of therapists and professional bodies have recourse to remove accreditation from individuals if ethical principles are not adhered to appropriately. Cowe and Pecherek (1996) identify that although the law does not ensure therapists and counsellors behave ethically, there are some areas covered by ethical principles in which legislation may apply. For example the Children Act (2004) contains a legal duty of care to share information to safeguard the child from harm and abuse. This limits the extent to which confidentiality can be guaranteed to young clients (Jackson and Polat, 2006).

Therapists working with children and young people can belong to a range of professional bodies and each produces their own ethical framework. This report uses the ethical frameworks from BACP (2010) and PTUK (2002) as its reference. These are broadly similar, and are based on a set of underpinning values including a respect for human rights. These values inform a set of core principles that include:

- fidelity of the counsellor/ therapist
- respect for the self-determination or autonomy of the client
- "non-maleficence", or doing no harm to the client
- beneficence, or a promoting the client's well-being
- justice, incorporating the fair and impartial treatment of all clients and the provision of adequate services.

On occasion different ethical principles may compete, for example a conflict around whether to break confidentiality may arise from conflict between the principles of autonomy and ensuring the welfare of the child (Nelson Agee, 2004). The ethical frameworks also set out a series of personal moral qualities that the therapist or counsellor should foster within themselves (PTUK, 2002, and BACP, 2010).

Participation of Children
'Participation is the process by which individuals and groups of individuals can influence decision-making and bring about change' (Participation Works, 2008, p.9.).

The child's right to express their views on matters that affect them is included in Article 12 the UN Convention for the Rights of the Child. Children of all ages, abilities and backgrounds have a right to participate (Participation Works, 2008). Participative practices have grown out of human rights based practice, movements promoting the treatment of service users as active, engaged consumers rather than passive recipients, and changes in how the competencies of children are viewed (Kirby, Lanyon, Cronin and Sinclair, 2003).

There is no legal requirement to involve children and young people in *all* decisions that involve them, however there is legislation that requires the participation of children in particular circumstances, such as requirements under the Children Act (2004) to consult with children involved in child protection enquiries or children in need assessments (Health and Social Care Advisory Services (HASCAS), 2008).

Participation incorporates a wide range of different approaches across varying degrees of involvement. Participation can refer to involvement in decision-making at a policy level, organisational level, and at an individual level. Kirby et al (2003) describe two main models that describe the various levels of active engagement, including:

- Hart's 'ladder of participation' which shows the levels of engagement as rungs on a ladder. Criticism of this model is that a ladder suggests that the 'top rung' is most desirable, and that certain levels of engagement are more desirable than others;
- Shier's 'pathways to participation' which can be used to identify which particular levels of participation are appropriate for a specific task.

Kirby et al (2003) identify that:

In recognising participation rights, adults must take on a different role from simply being protectors and providers. This requires working **with** children and young people rather than working for them; understanding that accepting responsibility **for** someone does not mean taking responsibility **away** from them. (Kirby et al, 2003, p.26, their bold)

Ethical frameworks can be seen as supportive of participation in that they:

- are based on human rights
- require the counsellor or therapist to respect the clients ability to autonomy, i.e. to make decisions for themselves.

Smith and Thomas (2010) identify that participation is 'inextricably linked with equality and social justice' (2010, p.357). In ethical frameworks the principle of Justice incorporates providing equality of opportunity and access to therapy/counselling services. Participation in the development of services at an organisational level can contribute to equality of service provision, in that it potentially enables the service to better meet the needs of the range of clients.

HASCAS (2008) states that, despite user involvement in decision-making being high on the agenda of Child and Adolescent Mental Health Services (CAMHS), there has been slow progress to implement it widely.

Methodology

The planned methodology was to interview between three and five coordinators of school-based therapeutic services. Seven organisations were approached to take part, and four were successfully engaged. Although it was originally planned to undertake individual interviews, an opportunity to interview several coordinators at a local network meeting resulted in:

- two semi-structured interviews with individuals
- one focus group based around an existing provider network.

Five individuals from four organisations were interviewed:

- A service manager at a Child and Adolescent Mental Health Service (CAMHS) responsible for managing several educational psychologists and co-managing a project providing early intervention (tier 2) mental health services in one London borough
- The coordinator of a therapy and counselling service run by a small voluntary sector organisation. The project runs in around 30 schools in one London borough

- Two people in coordination roles, responsible for a therapy and counselling service run by a local arm of a national charity. This runs in primary and secondary schools in the south east of England. The geographical area covered by their service extends across a unitary authority and a council area, and includes both urban and non-urban areas
- One coordinator managing a voluntary counselling and therapy service covering around 40 schools in several London boroughs and the south east.

An interview schedule was created, offering a series of questions and potential prompts grouped by themes to help structure the interviews. The same series of questions and prompts were used as a basis for both the interviews and focus group. Interviews take place across a continuum of formality (Grebenik and Moser, 1962, cited in Bell, 1993). The more standardised, the easier it is to collate and quantify responses (Bell, 1993). Given the intention to keep the research on a small scale, a semi-structured approach was chosen to provide the flexibility and freedom to explore areas in more depth or investigate other emerging themes.

After initially collecting information on the organisations' services, the first section of the questions then focused on the method by which services gathered children's views. The questions focused on participation activity at organisational level, with prompts focused on participation through:

- facilitating children giving feedback on their opinions of strengths and weaknesses of the service and how it could be developed
- enabling children to inform staff on the impact the service had on them.

The final section of the interview moved on to consider how ethical requirements were taken into consideration and affected the approach the organisation had taken to participation.

In practice, the semi-structured approach meant that conversation moved freely between the two sections, and additional themes were covered that were not included in the initial schedule.

A strength of focus groups is that they enable participants to not only share information but to compare their contributions, serving not only to highlight differences or a consensus in opinion, but also to help uncover the reasoning behind views held by participants (Denscombe, 2007). As such running a focus group was well suited to the aims of the research, helping to unveil the ethical reasoning behind using particular approaches.

In one-to-one interviews the fact that the researcher was also a practitioner was helpful, as this enabled the use of examples from her own practice to exemplify questions or to prompt practitioners to discuss particular issues more deeply.

Interviews were recorded on tape and transcribed, complemented by field notes. Limitations of the recording equipment meant that the focus group was recorded via notes taken during and immediately after the interview. These records of the interviews were then reviewed against themes set out in the interview schedule, in addition to analysis to identify other common themes not anticipated prior to the interview activities.

Participants were informed that their organisations and identity would be kept anonymous in the report, to encourage them to discuss issues and ethical decisions freely. They were informed of the purpose of the approach, and how the information from the interview would be used prior to agreeing consent, via an information sheet, and were able to withdraw consent for taking part at any time.

The research focused on a very small number of practitioners, therefore it is subject to limitations, as the findings cannot be assumed to be widely applicable to other similar services. Although the services are broadly similar, one participant had management responsibility for services which also included educational psychologists, and this data has been included in the findings.

Findings

Approaches to participation
The participants' organisations were at varying stages of developing their participative practice.

One service had an established, formal system of gathering children's views and enabling children to input on the progress they had made in therapy. This approach used a questionnaire to gather information on the children's experience of the service, and a series of scales completed before and after the therapy to gauge changes in the emotional state and level of difficulties experienced by the child.

In order to gain support from their team of counsellors and therapists, the organisation was flexible about how the information was collected, encouraging therapists and counsellors to use creative methods to collect information in a way that suits the individual child.

When it came to gathering feedback on how the services were delivered, most other services had template evaluation forms that they provided to their therapists and counsellors. In these cases their completion was not mandatory, nor was the information systematically collated by the services. However two services were in the process of developing more standardised ways of collecting the views of children and young people. Potential approaches in development included:
- using staff within the school, such as the Special Educational Needs Co-ordinator (SENCO) to collect evaluation forms from the child or young person shortly after the intervention
- periodically implementing focus groups to inform service evaluation and development
- developing standardised evaluation forms for use at the end of the intervention.

Services used a range of measurement tools in assessment of the child. The three services solely providing therapy and counselling described using tools that assess the level of emotional difficulty before (pre-) and after (post-) an intervention. Such tools monitor and evidence changes in the client's symptoms of emotional ill-health, by rating specific behaviours, emotional states and other symptoms, enabling a comparison of the score before and after therapy. These are usually presented as a paper or online questionnaire, and there are several clinically recognised tools that have been evidenced to provide a reliable measure.

For one service the completion of the pre- and post- intervention measures were left to the therapist's discretion, and for the other two it was a required element of the service delivery. Measurement tools included clinically recognised scales and measures developed by the services themselves.

One organisation used Goodman's Strength and Difficulties Questionnaire (SDQ), a quantitative measure of a child's strengths and difficulties taken before and after an intervention to help measure the impact made to the child. The Goodman's SDQ has versions that can be completed by the parent, teacher and child. This organisation encouraged staff to use the self-assessment version alongside those collated from parents and teachers. However, the service identified limitations to its use with some children, including the form being inappropriate for use with the younger age range. In fact, the Goodman's SDQ is not validated for use with children younger than 11 (Goodman, 2001, cited in Lee, Tiley and White, 2009).

One service had used TEEN CORE (more recently known as YP CORE), a self-completed pre- and post- intervention measurement tool designed for use with children and young people aged 11-13 years (Fox and Butler, 2009). However they had felt that the content focused on concerns more relevant to 'higher tier' services, rather than to their early intervention focus. In addition, they could not apply it to their work with children in Primary schools as the content was not suited to be completed by younger children. The service now used alternative, non-clinical measures based on a series of scales. Children and young people could self-assess their emotional state before (pre-) and after (post-) therapy using these scales.

When undertaking statutory assessments of children, the educational psychology service used a specific form designed to gather the child's perspective. The educational psychologist, or a member of the school staff, completed this form through discussion with the student, and the child or young person's views were included in the subsequent report produced by the educational psychologist.

All the forms provided by the organisations for children and young people were actively designed to be child-friendly. For example, the majority used smiley faces as a visual prompt to help indicate degree of satisfaction.

In several interviews discussion arose around the purposes of collecting views from children and young people. Reasons put forward included fulfilling monitoring requirements, ensuring data was available to help secure funding, and gathering information that would help to improve the service for the clients. One participant felt that children and young people's views on their own would not greatly affect how the service was delivered, whilst others felt that identifying patterns of what didn't work well would cause them to make changes. The organisation with an established approach described that they took the information from children into account alongside information from other stakeholders to identify changes to service delivery.

The uses to which the resulting information was used varied from collating the data to provide management and monitoring information to inform the service, through to expecting the therapist or counsellor to make use of the information but not undertaking any formal review. There was a consensus that self-assessment and evaluative feedback

from children and young people would not be used as a management tool to monitor an individual therapist or counsellor's work.

In two interviews it was noted that there was a level of participation inherent in the work done by therapists, counsellors and educational psychologists. For example, therapists and counsellors provided therapy in client-led ways, and were expected to gather and act on the thoughts and feelings of the child or young person throughout the process, whilst for educational psychologists it was standard practice to include children and young people's views in assessments.

Standardisation
The issue of standardisation emerged as a key theme raised across all the interviews. All services agreed that a prescriptive approach that required information to be gathered in the same way on every occasion was not practicable. It was acknowledged across all interviews that there was a tension between providing data systematically enough to sufficiently quantify the service's impact and quality on an organisational level, and the need for flexibility to gather views in a manner that would meet each client's individual needs.

A prescriptive approach would, in some cases, cause the ethical principles of the therapeutic work to be violated. One example given was that if a child was very distressed in a final session it may become harmful to them to insist they complete a feedback questionnaire and thus break the principle of non-maleficence.

The services worked with a wide range of children and young people of all ages and abilities. All participants identified that it was also necessary to adapt approaches to make it meaningful according to a child's age or developmental stage.

This differentiated approach took into account the level of autonomy children and young people were able to take at their developmental stage. For example in one service an older child would complete a written feedback form independently and seal it into an envelope without the counsellor or therapist seeing it, while a younger child would be assisted to complete the form. In some cases the therapist or counsellor would act as a scribe for the child. In three interviews specific mention was made of how it was particularly challenging to find meaningful ways to collect the views of very young children.

Authenticity of response
Mixed views were presented about the authenticity of the response that was given when children and young people could not give their views in a way that was confidential or autonomous.

Due to their developing understanding and abilities, children and young people may need support to complete evaluations and impact measures. Several interviewees commented that where a counsellor or therapist gathered the child or young person's views, this might result in an inauthentic response. Reasons for this included:

- children and young people not wanting to jeopardise their relationship with the therapist or counsellor
- seeking to please the therapist or counsellor by giving an overly positive assessment of the provision of the service

- inequalities resulting from the power dynamics within the relationship between therapist or counsellor and child
- views gathered at the end of the therapy being affected by the child or young person's negative feelings about ending.

Since younger children were much more likely to require support to complete any evaluation exercise, it was suggested by interviewees that their responses would be particularly vulnerable to these effects. One interviewee had identified an online tool using animation and speech to enable young children to give their views without an adult, but this was too costly for a small organisation.

Action taken to mitigate against the therapist's potential influence included one service considering using school staff such as the SENCO to gather information, and other services enabling older children to seal their response in an envelope and post in their forms if they wished. The difficulties in securing private space in school, as well as in supporting younger children to give their views were recognised by the services.

Conversely, one interviewee commented that in order to gain accurate information a relationship of trust was needed, particularly regarding sensitive assessment information. Another participant identified that in many cases an 'honest' response would be given to the therapist or counsellor involved in gathering the views of the child or young person.

With regards the pre- and post- intervention measures it was noted by several participants that the child or young person's emotional state could be affected by situations outside of the therapy such as the family situation or life events, and that this could in turn affect the outcome of the measure and thus its usefulness in assessing the impact of the work being done.

The conflicting responses around whether the therapist's involvement in supporting children to give their views would result in an 'authentic' response seemed to stem from the individualistic nature of the work. As each child responds in a unique way to the therapeutic intervention, so the impact of the therapist being involved in the evaluative process will vary from child to child. What was agreed by all interviewees was that several aspects of therapy, including the presence of strong emotions (especially as the therapy ends), the emotional pull of the therapeutic relationship, and the level of trust required to share openly, had the potential to affect the views a child might give.

Conclusion

A common basis in human rights means that counselling and therapy approaches and participative practice align in many aspects. Ethical principles, including respecting the autonomy of the client, contribute to placing participative practice as very much inherent in the day-to-day delivery of therapy and counselling.

At an organisational level, however, many services within this study are still developing ways in which they collect children's views on the quality of the service and the impact it has on them. Reconciling the need to gather children and young people's views in a way that can inform the evaluation of the service with the need to respect the individual's needs and circumstances in the therapeutic space is challenging. An area of particular challenge is finding ways to include younger children's views, due to the increased

reliance on adults to support the gathering of information and a lack of affordable measures specifically designed for the age range. The sector would benefit from the development and/or sharing of tools to do this effectively, ethically, and affordably.

Devising a prescriptive approach that is delivered identically in every case is not appropriate. Any method must be differentiated for different ages and developmental stages, and a level of flexibility in its implementation must be allowed. This flexibility will allow the therapist or counsellor to adapt the approach in situations where its delivery may conflict with ethical principles.

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