Equity, Excellence & Empowerment through Psychology

SOUTH AYRSHIRE COUNCIL EDUCATIONAL PSYCHOLOGY SERVICE

Therapeutic Intervention Policy

May 2020

Contents

An Introduction to Therapeutic Interventions

The involvement of educational psychologists (EPs) in therapeutic intervention has attracted much attention over the last few years both nationally and internationally (Mackay, 2007; Suldo et al 2010; Yeo & Choi 2011). MacKay (2007) suggests that educational psychologists (EPs) are a key therapeutic resource for children and young people, especially in educational contexts such as schools and argues for a renewed focus on therapy within educational psychology practice.

EPs, as applied psychologists with knowledge of both child and adolescent development and educational contexts, are well placed to deliver therapeutic interventions in schools. Indeed an online survey completed by more than 450 EPs working in England, Northern Ireland, Scotland and Wales revealed that 90% of EPs, that responded, used therapeutic interventions as part of their current practice, in a variety of educational settings, with children and adults (Atkinson et al, 2011).

The rise in young people with mental health concerns has also been well documented in recent times (Suldo et al 2010). A Ipsos Mori Survey published in 2015 advised that pupils were most likely to have poorer mental health (as assessed through SDQ scores) if they stayed in Stirling or South Ayrshire as opposed to some other local authorities. Whilst there are many competing demands on an Educational Psychology Service, South Ayrshire Psychological Service recognises the importance of therapeutic intervention with young people and acknowledges the value of this service held by young people, parents, schools and associated professionals. It also supports EPs in delivering one of our core functions, in our 5 core functions, namely that of intervention.

South Ayrshire Psychological Service would use the following definition of therapeutic intervention:

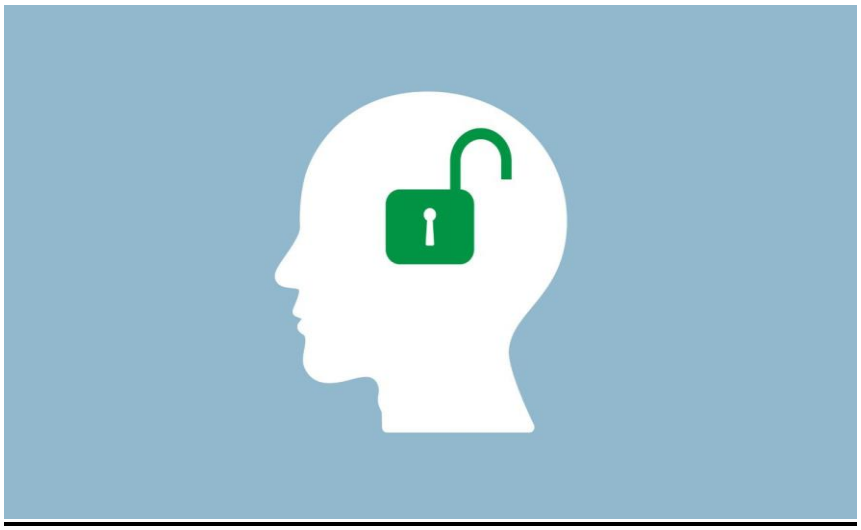
Therapeutic work may involve the direct intervention of a psychologist with an individual child or a group of children. Equally it is applicable to the wider role of supporting others who work with children on a daily basis (MacKay and Greig, 2007).

The definition recognises that as well as direct work with children and young people, therapeutic interventions can be used in groupwork, consultation and assessment and also at a systemic level through training or developing the skills of others. Indeed therapeutic interventions can be used within different contexts and at different levels. As such South Ayrshire Psychological Services strongly encourages all Psychologists to be involved in therapeutic interventions. Training and enhancement of skills is encouraged at all levels by all staff. Furthermore, staff are encouraged to ensure that all interventions are subject to rigorous evaluation of their effectiveness to ensure that the best services are provided to our young people.

This paper includes a description of three such therapeutic interventions that the service offers namely CBT, EMDR & VIG. These are not exhaustive but aims to give an overview of services that can be provided by the service.

South Ayrshire Psychological Service

Cognitive Behaviour Therapy Team



South Ayrshire Psychological Service

Cognitive Behaviour Therapy (CBT) Team

1. Introduction

Cognitive Behavioural Therapy (CBT) is one of the therapeutic interventions that is being delivered through South Ayrshire Council Educational Psychology Service.

CBT practices can form part of a range of multi-level preventative interventions ranging from universal to specialist supports. To ensure that interventions are appropriate, they must be tailored to the child or young person's needs. CBT practices can be delivered at three levels: universal (whole class supports) targeted (designed for at-risk groups) and specialist interventions (delivered to individuals that require higher levels of support from professionals with further training). It is proposed that the CBT Therapeutic team will deliver support at a specialist intervention level.

There are many universal school based CBT. In the UK, *FRIENDS*, a classroom-based universal group CBT programme, was found to be effective in schools (Stallard, Skryabina, Taylor, Philips, Daniels, Anderson & Simpson, 2014 and Stallard et al, 2008), although effectiveness is dependent on the facilitator. *Living Life to the Full* (Williams, 2009) is another example of a universal CBT programme that can be facilitated within the classroom. Examples of more targeted CBT programmes may be the *Low Intensity Anxiety Management* (LIAM) programme (NES), Living Life to the Full (Williams, 2009) or the Humunculi Approach (Greig & MacKay, 2013). However, both programmes can be utilised at a universal or targeted level depending on the needs of the child or young person. Interventions at a universal and targeted level can be discussed with your link Educational Psychologist.

When considering CBT as an appropriate intervention for a child or young person thought should be given to the individual and the multiple systems surrounding them that play a significant role in the shaping and maintenance of the challenges they are experiencing. It is important to bear in mind the interacting risk and resilience factors that surround a child or young person when identifying appropriate supports.

CBT is a talking therapy with a robust evidence base for impacting positively on anxiety (Ottie, 2011), depression (Driessen and Hollon, 2010) and trauma (Cohen, Mannarino and Kliethermis, 2012). Specific examples of the research on the efficacy of CBT in young people can be seen in the table below.

Authors	Outcomes
Muris, Meesters and Van Melick (2002)	Reduced anxiety and depression in young people aged between 9 and 12 years.
Sukhodolosky, Kassinove and Gorman (2004)	Meta-analysis of 40 previous studies indicates that CBT is effective with children between the ages of 7 and 15 with anger management difficulties. Children with moderate anger management difficulties seemed to benefit the most.
Squires (2001)	Improved self-regulation and classroom behaviour.
Stallard, Skryabina, Taylor, Philips, Daniels, Anderson & Simpson (2014)	Found that FRIENDS, a classroom-based universal group CBT programme to be effective in schools in reducing anxiety symptoms.
Humphrey and Brookes (2006)	Anger Management for secondary pupils at risk of exclusion

2. What is CBT?

CBT is a process of supporting individuals to develop new ways of processing information. It is different from other types of therapies as it focuses on the immediate challenges that an individual may be experiencing. It is directive in nature and allows for the development of skills that allow the individual to gain an objective and true perspective of their current situation.
CBT is founded on the three main assumptions:

- Feelings and behaviours are directly affected by the way a person thinks.
- Negative patterns of thinking can bring rise to emotional distress.
- Altering negative thought patterns can reduce emotional distress.

(Hofmann, Asnaani, Vonk, Sawyer & Fang, 2012)

The aims of CBT are to help the individual recognise physiological responses to a range of feelings, to help the individual clarify their thoughts and beliefs in situations that they are finding challenging and to develop a range of coping skills. The sessions will involve support from the psychologist to identify and modify negative and unhelpful thoughts and to evaluate outcomes that will impact on change.

3. How is CBT delivered?

- CBT sessions typically last for an average of 8 sessions and are mainly focussed on the 'here and now' as opposed to past experiences.
- The sessions will take place between the Educational Psychologist and pupil.
- Most sessions will last on average 45 – 60 minutes.
- CBT sessions will involve a range of different components such as psychoeducation, techniques to identify negative and distorted thoughts, behavioural goal setting, and problem solving.
- CBT sessions require children and young people to complete work in between sessions; this ensures that different skills and strategies are being practised and consolidated in real-world scenarios.

4. Referrals for CBT

Referrals for CBT intervention will be made in the usual way to the Educational Psychology team through the RFA (Request for Assistance) process. There are currently two members of the CBT intervention team. Prior to requesting CBT the following questions should be considered:

- Does the individual have a good understanding of the processes of CBT? CBT requires active participation from the child or young person so it is important that they know what is involved and choose to be part of the process. Informed consent must be given.
- Is the child or young person able to engage in the processes used in CBT? Consideration should be given to the individual's verbal and developmental skills (Grave and Bisslett, 2004).
- Is there a range of support currently available to the young person and their family and is this evidenced through their staged intervention plan?

5. Supervision

Peer supervision will be utilised within the Educational Psychology Service. Regular supervision will promote:

- The sharing and development of practice skills.
- The monitoring and evaluation of skills and practice.
- Frequent quality control exercises.

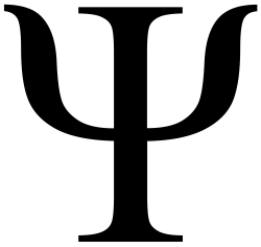
South Ayrshire Psychological Service

EMDR Team

1. Background and Approach to EMDR

The Psychological Service, through ongoing consultation and review, identified a need for local provision of a therapeutic service to children and families in South Ayrshire that could complement existing services, such as school based counselling and the Child and Adolescent Mental Health Service (CAMHS).

Educational Psychologists possess a range of skills which allow them to provide direct support to children and young people with emotional needs, such as:



- Establishing a therapeutic relationship
- Assessing children and young people's needs
- Understanding child development
- Encouraging development through an empathetic and strengths based approach
- Understanding and engaging with the wider ecological context
- Individualising support and providing focused intervention based on analysis of needs.
- Evaluating practice

Service discussion about the development of a therapeutic strands of intervention has agreed that most Cognitive Behavioural Therapy (CBT) approaches can be successfully delivered in school within the school allocation model. The service also works on developing capacity within schools and encouraging the further development of mental health prevention programmes within education. Cognitive Behavioural principles can be universally communicated in schools through programmes such as FRIENDS for Life (Stallard et al., 2007, Stallard et al., 2008), Living Life to the Full (Williams, 2009) and Bounce Back (McGrath and Noble, 2003). Educational Psychologists are well placed to encourage a wider roll out of such programmes. It was agreed that the protected time available for the therapeutic team would be most appropriately used for the delivery of EMDR, as well as CBT and VIG.

EMDR

Evidence base of EMDR

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapeutic approach developed in the late 1980s by Francine Shapiro (Shapiro, 1989b) that aims to treat traumatic memories and their associated stress symptoms.

EMDR is an evidence-based psychotherapy which has been recognized by the World Health Organization (WHO) as a first line treatment for Posttraumatic Stress Disorder (PTSD; WHO, 2013). Further to this, the guidelines of the International Society for Traumatic Stress Studies (ISTSS; Berliner et al., 2019) have also strongly recommended the use of EMDR in the treatment of PTSD in children, adolescents and adults. These recommendations were based on high quality systematic reviews developed through the Cochrane database, the National Institute for Health and Care Excellence (NICE) guidelines, and the WHO recommendation, as well as on the results of randomized controlled trials (Castelnuovo et al., 2019).

More recent NICE (National Institute for Health and Care Excellence) guidance in 2018 has further qualified that the use of EMDR for PTSD in children and young people should be undertaken if required, after initial trauma focused CBT intervention.

Like trauma focused CBT, EMDR therapy aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike trauma focused CBT, EMDR therapy does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework (World Health Organisation, 2013).

What can EMDR be used for?

EMDR (Eye Movement Desensitisation and Reprocessing) is best known for treating post-traumatic stress disorder (PTSD). According to the EMDR Association UK and

Ireland (n.d.), PTSD is caused by an inability to process a traumatic event naturally. This often occurs when the traumatic event feels especially overwhelming, shocking or distressing. Signs that a child or young person may be struggling with symptoms of trauma following a traumatic event can include:

- Intrusions (episodes of 'remembering' the original event)
- Flashbacks (where the child or young person may behave as if they are re-experiencing the original event)
- Avoidances of reminders of the event
- Behavioural or emotional changes.

For some children and young people, therapy may be beneficial. The EMDR International Association (EMDRIA, n.d.) has noted that in addition to PTSD, EMDR can be used to treat a variety of conditions and stress associated with challenges, such as :

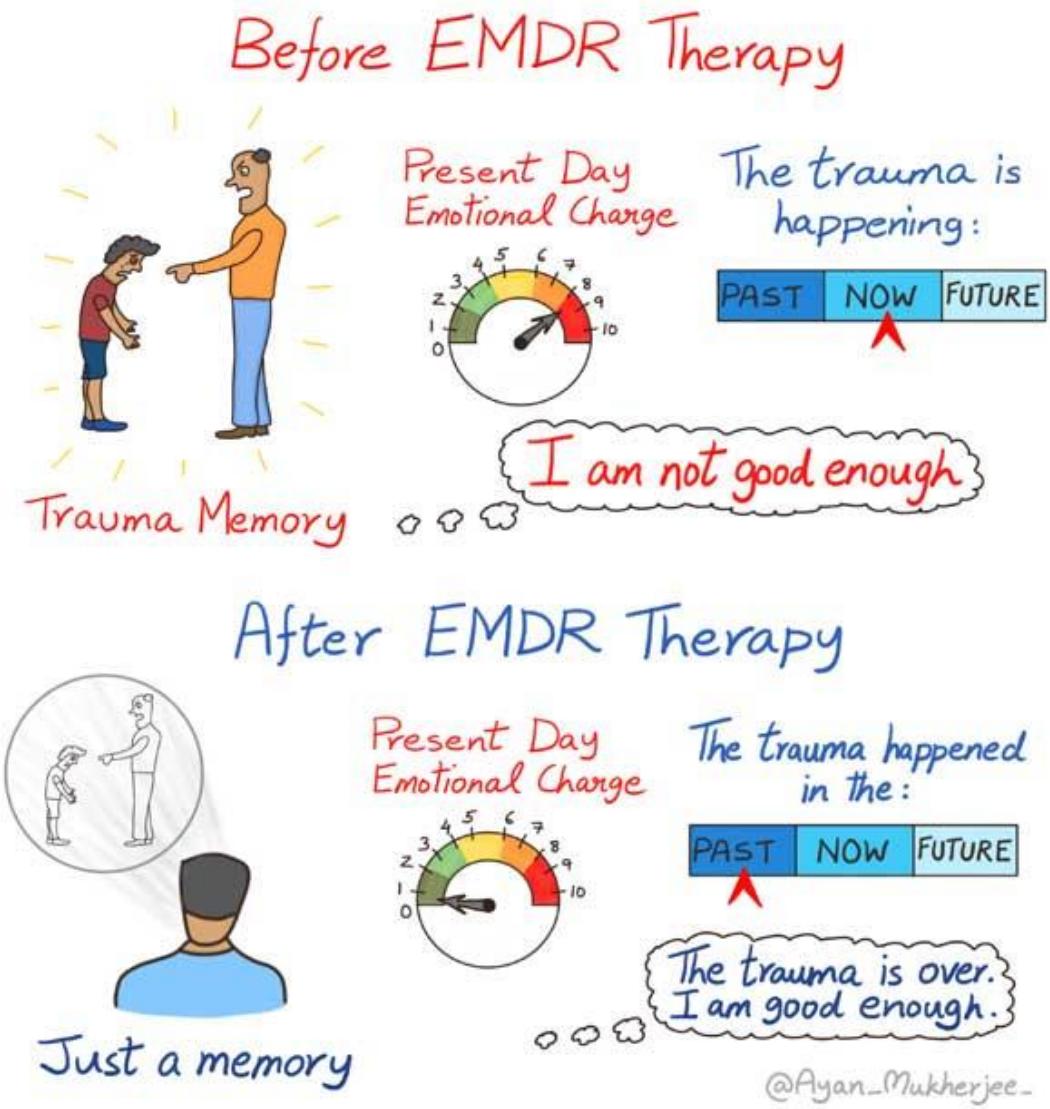
- Anxiety, panic attacks, and phobias
- Chronic Illness and medical issues
- Depression and bipolar disorders
- Dissociative disorders
- Eating disorders
- Grief and loss
- Pain
- Performance anxiety
- Personality disorders
- Sexual assault
- Sleep disturbance
- Substance abuse and addiction
- Violence and abuse

There are many studies which outline that EMDR can alleviate distress associated with traumatic memories (Bisson et al., 2013, Carlson et al., 1998; Ironson et al., 2002; Marcus et al., 1997; Power et al., 2002; Scheck et al., 1998; Shapiro, 1989a; Rothbaum, 1997; Van Etten and Taylor, 1998). There is now a growing evidence base for the effectiveness of EMDR for other presenting issues, for example there are randomised controlled trials reporting the efficacy of EMDR with sexual abuse survivors

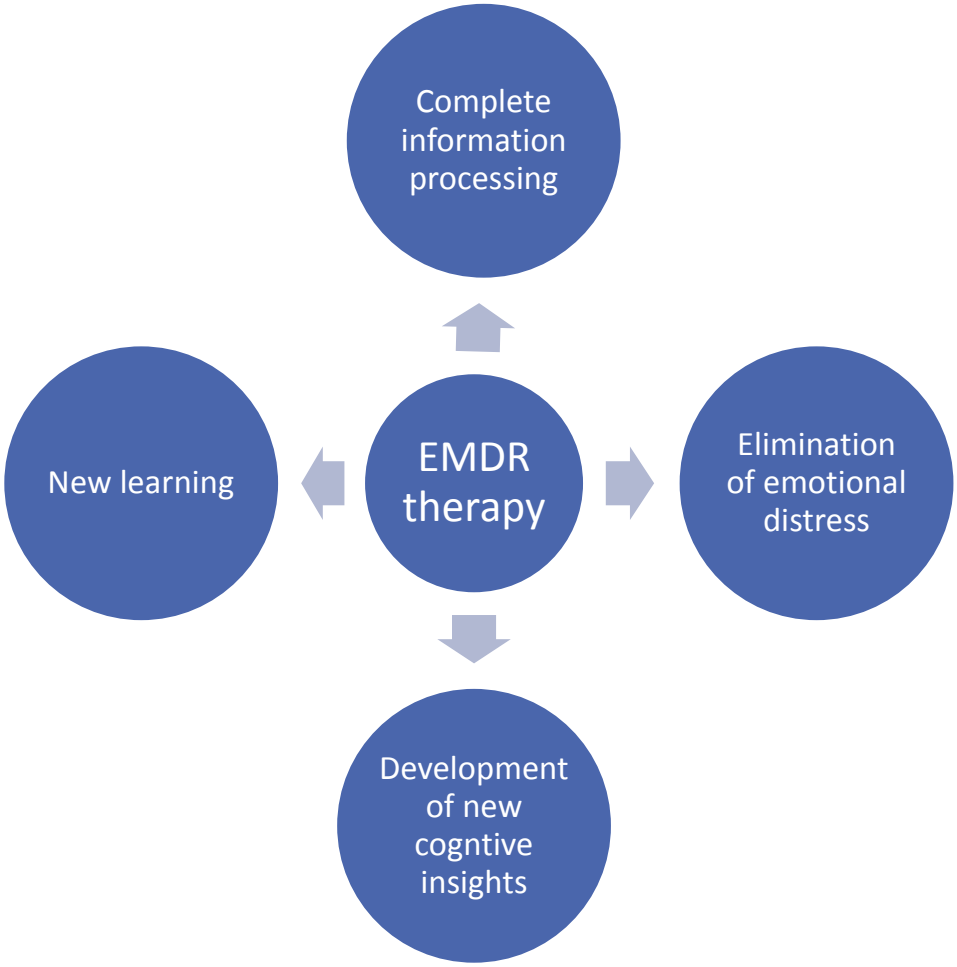
(Jaberghaderi et al., 2004), better post operative pain management in adolescents (Maroufi et al., 2016) and improved behaviour in boys with conduct problems (Soberman et al., 2002). Other studies have reported positive impacts of EMDR on phobias (De Jongh et al., 1999, 2010; Doering et al., 2013), body dysmorphic disorder (Brown et al., 1997), generalised anxiety disorder (Gavreau and Bouchard, 2008), bulimia nervosa (Kowal, 2005), borderline personality disorder (Brown and Shapiro, 2006) and depression (Hoffman et al., 2014).

How does EMDR work?

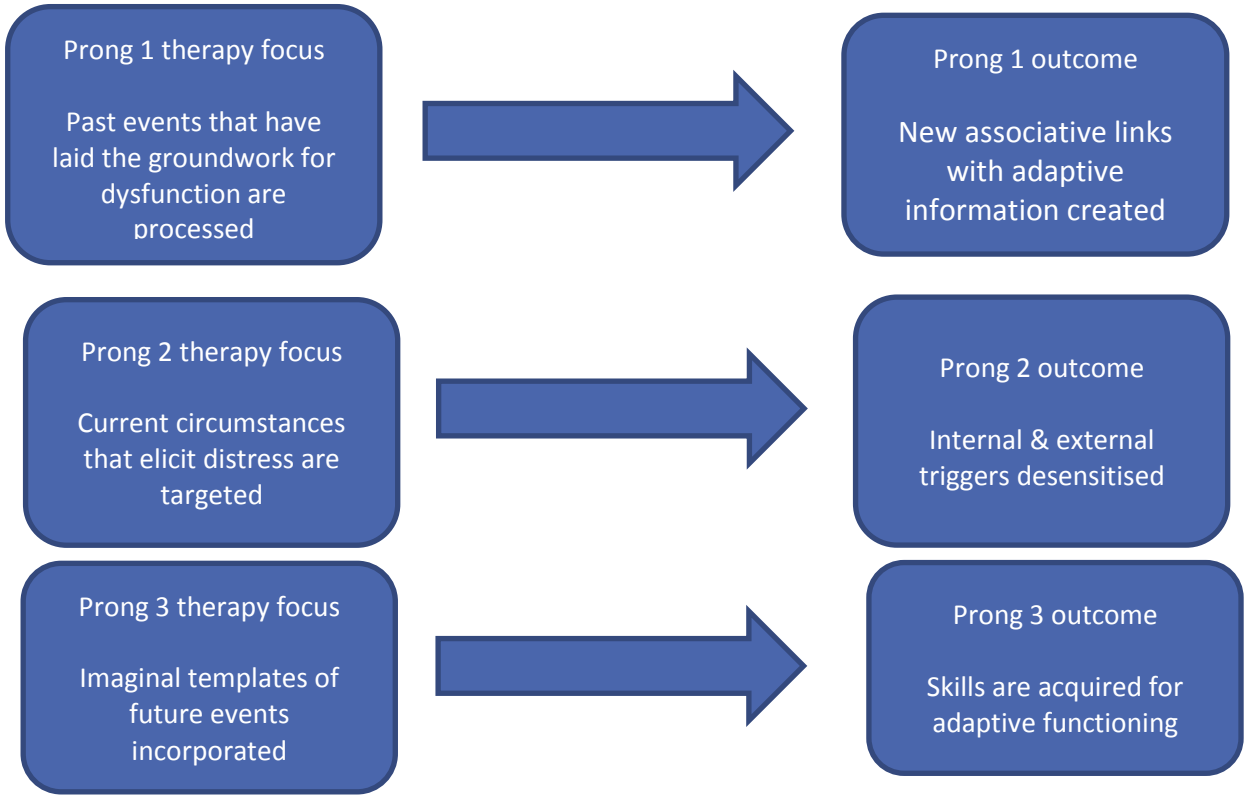
Shapiro's (2001) Adaptive Information Processing model outlines how EMDR therapy facilitates the accessing and processing of traumatic memories and other adverse life experiences to bring these to an adaptive resolution. After successful treatment with EMDR therapy, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced.



During EMDR therapy the client attends to emotionally disturbing material while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio stimulation can be used (Shapiro, 1991). EMDR therapy facilitates the accessing of the traumatic memory network, so that information processing is enhanced, with new associations forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in:



EMDR therapy uses a three pronged protocol

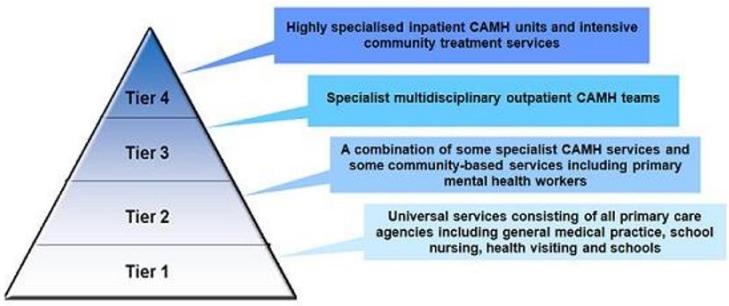


2. Service Procedures

2.1 Referral

Following consultation and agreement with the school educational psychologist, referrals to the EMDR team are made using a request for assistance form. Referrals will be considered by at screening group meetings which are normally held twice a month during term time. Referrals are restricted to children/young people of school age who meet the following criteria:

- In attendance at a South Ayrshire school or, in some cases, a South Ayrshire-based pupil currently being educated elsewhere (e.g. children who're looked after outwith, those attending external additional support provisions).
- A consensus has been reached between the school educational psychologist and the named person that this is an appropriate referral and that the family and child/YP, where applicable and appropriate, have given informed consent
- Priority is given to children who are looked after by South Ayrshire Council
- Priority will be given to those who present with emotional needs that are significantly impacting on functioning at school
- Symptoms persisting beyond 4 weeks following a trauma
- The EMDR team would usually not become involved for Tier 3 or 4 cases, those who are actively suicidal (where a referral to CAMHS is in place or CAMHS are actively involved)
- The child or young person should already have engaged with trauma focused-CBT if PTSD is identified, as this is the recommended first line evidence-based treatment for trauma in younger populations and must have been tried before a referral for EMDR can be considered.



2.1.1 Questions to consider prior to a referral to the EMDR team:

- Is the child/young person ready to engage and able to form a therapeutic relationship?
- Does the child/person have any ability to self sooth? Are they stable enough at this stage to begin EMDR therapy?
- Does the child/young person have any health needs (in particular any eye difficulties or history of seizures)
- Is the young person using alcohol, substances or prescribed medication?
- Is the child involved in any other therapeutic approaches which need to be completed before considering EMDR?
- Does the child/young person have any secure relationships and social support?

2.1.2 Assessment prior to referral/intervention

The Child Report of Post Traumatic Symptoms (CROPS), Parent Report of Post Traumatic Symptoms (PROPS) and Problem Rating Scale (PRS) (Greenwald, 2005c) may be used as part of assessment prior to referral to the EMDR team. The EMDR team should be viewed as offering a planned intervention as part of the overall process of assessment and intervention with the school psychologist continuing to have an ongoing role, if this is someone outwith the EMDR team. Following consultation with all involved, and discussion with the child or young person, the case psychologist will submit referral form EMDR (1).

2.2 Collaborative Process and Consent

The referring psychologists should endeavour to work with families, children and young people to ensure that they are active and willing participants prior to making a referral and gaining preliminary information on client goals. Children's consent

should be at the heart of this process with due consideration given to their age, any additional support needs and their capacity to understand the support being offered. A leaflet on EMDR is available for parents and young people

2.3 EMDR Requests

Prior consultation and discussion with the school psychologist to agree a referral is required. Referrals for EMDR intervention will be made in the usual way to the Psychological Service by submitting an RFA (Request for Assistance) form. Referrals will be discussed at a screening group. If it is felt by the panel that the EMDR team can provide support that meets case allocation criteria, a member of the team will be identified to offer this intervention. There are currently three members of the team trained to offer EMDR as an intervention.

2.4 EMDR Initial TAC Meeting

Following an agreed referral to the screening group, an initial TAC meeting should be organised by the named person. During the TAC meeting, the family, child/young person, other agencies and school will be present, as appropriate. The aim of this meeting is to discuss the reason for referral to the EMDR team, to gain background information and an insight into the child/young person's strengths and needs. Further information can be provided on the EMDR approach.

2.5 Sessions

The sessions will normally last around 60 – 90 minutes and will usually take place in school.

2.6 Evaluation

The following outcome measures should be completed prior to and following the EMDR intervention:

- Child Report of Post-Traumatic Symptoms (CROPS)
- Parent Report of Post-Traumatic Symptoms (PROPS)
- Subjective Unit of Distress (SUD) score for each target memory.

Additional measures will be used as required, e.g.

- Screen for Child Anxiety Related Disorders (SCARED) (Birhamer, 1995).

- The Child Dissociative Experience Scale and Post Traumatic Stress Inventory (Stolbach, 1997 – adapted from Bernstein & Putnam, 1986).
- The Adolescent Dissociative Experiences Scale II (Armstrong et al., 1997).
- The Young Persons CORE Scale (Twigg et al., 2010).

Accountability and evidence of outcomes should be achieved through analysis of pre- and post-intervention questionnaires, feedback from children and families as well as ongoing consultation with schools and other agencies.

2.7 Feedback/Review TAC Meeting

Once the agreed number of sessions has been completed, a meeting involving all those involved will take place to review the progress made and agree any further intervention that may be required.

3. Professional Development and Supervision

All psychologists within the EMDR Team have completed formal training in the EMDR approach and are eligible for accreditation with the EMDR UK and Ireland Association and EMDR Europe. Supervision is an important requirement for those who are offering an EMDR service. Formal supervision sessions take place every 4/6 weeks with a qualified EMDR supervisor.

South Ayrshire Psychological Service
Video Interaction Guidance

1. Introduction

The Educational Psychology Service in South Ayrshire deliver targeted therapeutic intervention for children and young people who have additional support needs (ASN) which present significant barriers to them accessing school

and the curriculum. Children and young people are identified through our collaborative working with schools and therapeutic intervention is discussed with the named person and/or the Team Around the Child before it is considered.

Video Interaction Guidance (VIG) is a therapeutic intervention that is typically used by the service to guide interactions between children or young people of any age and adults, either parents, or professionals. The aim of using VIG is to employ a relationships based approach to support communication between the child or young person and adult.

2. Priority Criteria and Considerations

Priority will be given to:

- South Ayrshire's most vulnerable children and young people whose families or key staff at school require relationships based support in order to meet their needs
- Children and young people on the Child Protection Register
- Care experienced pupils
- Pupils at risk of exclusion/who have been excluded
- Pupils whose placement is at risk of break down
- Concerns around non attendance
- Children and people who have experienced adverse childhood experiences/ trauma; social communication needs; social, emotional or behavioural needs.

2.1 VIG should be considered where:

- There is evidence that more intensive, direct intervention to support a particular relationship is needed. This can include a child/young person's relationship with family members or school staff
- A range of support is available to the young person and their family and this is evidenced through their staged intervention plan
- Parents and carers are able to access and engage with this type of direct support and the Team Around the Child feel that it would be beneficial

3. VIG

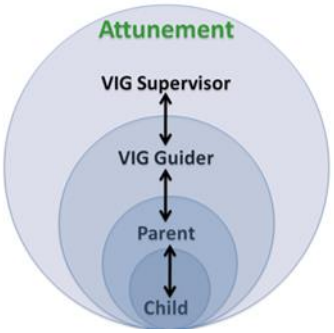
3.1 What is VIG?

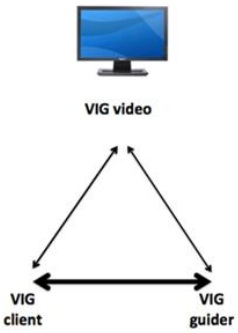
Video Interaction Guidance (VIG) is a relationships based therapeutic intervention that focuses on communication. It supports clients (usually parents/carers or school staff) to work towards goals for the future in relationships with children and young people. VIG has been described as the

"shared discovery of creative or constructive communication in relationships that are having trouble" (Trevarthen, 2013).

3.2 How is VIG delivered?

In a VIG session, the VIG guider (Educational Psychologist) supports the client who is usually a parent/carer or member of school staff. However, if a child or young person would like direct support with peer relationships it is also possible for them to be the client. Clients are supported to reflect on video clips of their own successful interactions with a child or young person. The process is illustrated below:

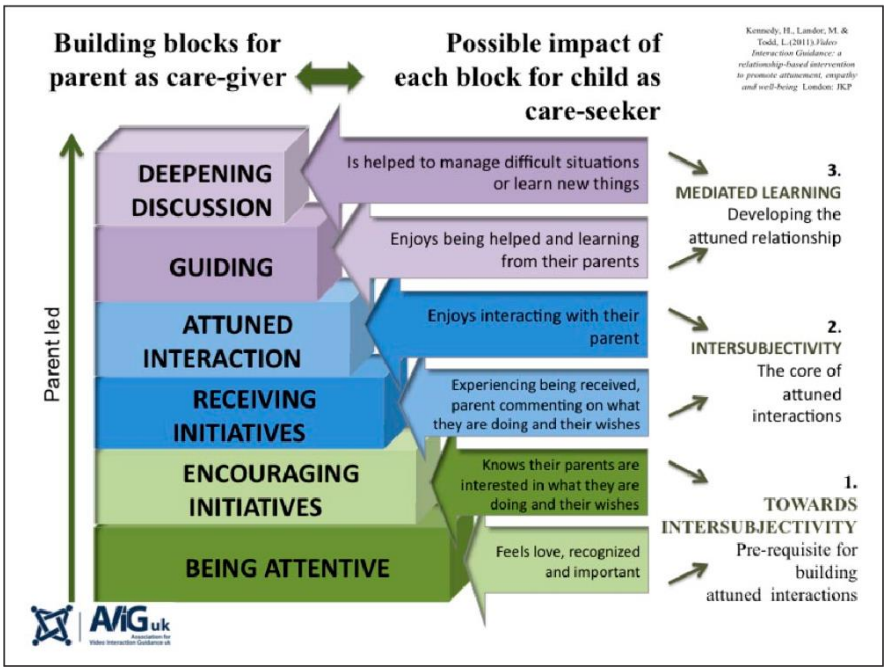




(adapted from AVIG UK, 2015)

VIG should be an empowering, collaborative process and this is evident in:

- attunement principles (see below) that guide interactions between both the client and the child, as well as the client and the VIG guider (see figure below)
- the methodology around editing videos
- the way in which clips are shared with the client
- interactions between the VIG supervisor and the VIG Guider



The process begins by helping the family or professional to set their own goals. Client-child interactions are filmed during a session and then edited by the VIG guider, to produce short clips and images that highlight positive communication. A shared review of the images and video clips then takes place. This involves viewing the clips and images in this therapeutic forum supports attachment relationships by giving the client time and space to reflect on sensitivity and attunement in their communication.

VIG usually takes the format of 3-4 ‘cycles’ with each client. A cycle consists of a film session of the client interacting with the child or young person followed by a shared review. The VIG Guider (Educational Psychologist) will arrange these sessions. Time will be included to:

- discuss goals prior to introducing VIG
- evaluate progress in sessions
- discuss ideas for next steps when the intervention is complete

3.3 Ethical considerations

Informed consent is sought from clients and is recorded on the consent form (see appendix 1). The details of this consent should be discussed during the first meeting with the client in order to ensure understanding of this. An evaluation form is used to track clients’ feelings about the intervention and evaluate progress when the intervention finishes. During the intervention period, all film and images are stored securely, in line with South Ayrshire’s Data Protection Policy and are destroyed when they are no longer in use. Case notes from each VIG session as well as the goal setting and evaluation paperwork will be added to the child or young person’s case file and chronology.

3.4 Practical Considerations

Having time and a suitable space is essential for VIG to take place and this can often be at a client's home or in a quiet room in the child/young person's school. This is to facilitate an environment where the client feels able to be open about their feelings towards their relationship and what they would like support with as well respecting their right to privacy in their experiences of looking at images and clips of their interactions.

4. VIG Supervision

After completing training in delivering VIG, the VIG Guider undergoes a period of supervision. This involves the use of films of the client and child/young person as well as of themselves with the client in shared review sessions. Consent should be obtained for this sharing of film when VIG is initially discussed.

Appendix 1

Video Interaction Guidance Consent Form

Video Interaction Guidance (VIG) is a relationships based therapeutic intervention that focuses on communication. The aim of VIG is to help clients to work towards goals for the future in relationships with others who are important to them.

In a VIG session, you will be supported by the VIG Guider to reflect on video clips of your own positive interactions with a child or a young person. We will begin by setting goals and review these throughout the block of sessions. We will spend all sessions after today watching video clips and pictures of positive communication and then filming further interactions between you and the child or young person. During the last session in the block, we will review video clips and pictures and then spend time discussing how you have found VIG and anything that you might take forward from it.

Video recording will be used in order for the VIG Guider to watch and edit clips of positive interaction between you and the child or young person and so that we can discuss the clips together. The clips will only be watched by the VIG Guider and you and they may be watched by a VIG supervisor in order to support the VIG Guider's professional development. Recording will be stopped at any time during the session if requested to do so by you or the child or young person.

The recordings will be stored securely at all times and will be erased within two months of the block of sessions ending or sooner if you should request this.

To find out more about VIG, click on the video below or use the following link to watch it:
https://www.youtube.com/watch?v=YRVaL_ZlxHs

This is to certify that I/we: -

□ Understand the purpose for which my/our consent is being sought to video record VIG sessions throughout this block.

□ I understand that all video recordings will be carried out in line with South Ayrshire Council's Data Protection Policy.

□Agree to my/our meetings being videoed for the purpose of Video Interaction Guidance.

□ Agree that the video recording may be watched by the VIG supervisor.

□ Understand that the video recordings will be erased within 2 months of the end of my/our involvement with Video Interaction Guidance.

□ Am/ are aware that I/we may withdraw consent at any time.

Client Name(s) and Signature(s):
Date and Sign

Appendix 2

Evaluation Before and After (shaded green) Form

Name of client(s): or initials	
Date of starting VIG	
Date of ending VIG	
Number of VIG cycles	
Level of Child Protection at start	None/CAF/CIN/CP
Level of Child Protection at end	None/CAF/CIN/CP
Name of VIG Guider	
Stage in AVIGuk Training	

Before VIG	After VIG
3 words to describe you as a parent	3 words to describe you as a parent
3 words to describe your child(ren)	3 words to describe your child(ren)
3 words to describe your relationship with your Child(ren)	3 words to describe your relationship with your Child(ren)
Take a 3 minute pre VIDEO of parent and child together Being as natural as possible (not better than usual)	Take a 3 minute post VIDEO of parent and child together Being as natural as possible (not better than usual)

Ask the parent to put a mark on the line

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

International Center for Clinical Excellence

Ask the parent to put a mark on the line

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

International Center for Clinical Excellence

Initial goals of client	A

(what they come to get help with).	
Client's rating of where they are now in relation to initial goals (N) and where they would hope to be in -____ weeks (H)	A Not there 1 2 3 4 5 6 7 8 9 10 Brilliant
Client's ratings of where they are at the end of the intervention	A Not there 1 2 3 4 5 6 7 8 9 10 Brilliant

Initial goals of client (what they come to get help with).	B
Client's rating of where they are now in relation to initial goals (N) and where they would hope to be in -____ weeks (H)	B Not there 1 2 3 4 5 6 7 8 9 10 Brilliant
Client's ratings of where they are at the end of the intervention	A Not there 1 2 3 4 5 6 7 8 9 10 Brilliant

Initial goals of client (what they come to get help with).	C
Client's rating of where they are now in relation to initial goals (N) and where they would hope to be in -____ weeks (H)	C Not there 1 2 3 4 5 6 7 8 9 10 Brilliant
Client's ratings of where they are at the end of the intervention	C Not there 1 2 3 4 5 6 7 8 9 10 Brilliant

TrajectPlan for use with family to summarize progress made at end of intervention and to make future plans

Traject Plan areas	What has changed since you started VIG work?	Next plans

My Communication with my child		
My Daily Life		
The development of my child		
My development as a parent		
My relationship with the neighborhood/ extended family/community		

Standardised pre and post measures
Note: If you are already using different standardised pre and post measures record these instead.
Choose a scale that will help you understand the parent and feels comfortable to you

Child
parents view of child

initiatives made in video
ASQ –SE (not at present)

Parent
Parent Stress Scale (PSS) or Edinburgh Post natal Depression Scale (EPDS) (or Hospital Anxiety and Depression Scale (HADS))
AND
Karitane Parenting Confidence scale (0-12 months) or Parental sense of Competence (12 months plus)

Parent-child relationship
Video analysis (Pre video and post video – 3 minutes interacting with child as usual) If Not VIG Video 1 and VIG Video at end (whole video not clips)

Parent – professional relationship
Micro-analysis of first and last shared reviews
Parent's feedback on VIG process

Professional change
Professional Traject plan
Reflective piece

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