

REPORT

SCHOOL-BASED COUNSELLING IN UK SECONDARY SCHOOLS: A REVIEW AND CRITICAL EVALUATION

Mick Cooper

Professor of Counselling, University of Strathclyde

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SUMMARY

School-based counselling is one of the most prevalent forms of psychological therapy for young people in the UK, with approximately 70,000-90,000 cases per year. School-based counselling services in the UK generally offer one-to-one supportive therapy, with clients typically referred through their pastoral care teachers, and attending for 3-6 sessions. Around two-thirds of young people attending school-based counselling services are experiencing psychological difficulties at 'abnormal' or 'borderline' levels; with problems that have often been present for a year or more. Clients are typically in the 13-15 year old age range, white, most commonly female; and presenting with family problems or, if boys, anger. With respect to effectiveness, non-directive supportive therapy is a NICE-recommended intervention for mild depression; and there is emerging evidence to suggest that school-based humanistic counselling – a distillation of common school-based counselling practices in the UK – is effective at reducing psychological distress and helping young people achieve their personal goals. School-based counselling is evaluated positively by service users and school staff; and is perceived by them as an effective means of bringing about improvements in students' mental health and emotional wellbeing. School staff and service users also perceive school-based counselling as enhancing young people's capacity to engage with studying and learning. From the standpoint of a contemporary mental health agenda, the key strengths of school-based counselling are that it is perceived as a highly accessible service; and that it increases the extent to which *all* young people have an independent, supportive professional to talk to about difficulties in their lives. However, there are also several areas for development: increasing the extent to which practice is evidence-informed, greater use of outcome monitoring, ensuring equity of access to young people from black and minority ethnic backgrounds, increasing service user involvement, and enhancing levels of integration with other mental health provisions. It is hoped that current initiatives in the development of competences, e-learning resources and accreditation for counsellors working with young people will help to achieve this. The conclusions of the review are that commissioners should give consideration to the utility of school-based mental health provisions; and that school-based counsellors – working with colleagues in the field of child and adolescent mental health – have the potential to contribute to an increasingly comprehensive, integrated and 'young person-centred' system of mental health care.

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AIMS

The report is written for professionals in the child and adolescent mental health field: including those who deliver and manage school-based counselling services; those who may consider commissioning it; and those in allied professions, such as child and adolescent mental health psychotherapists. The specific aims of the report are to:

1. Provide a concise and comprehensive briefing of what is known about school-based counselling in UK secondary schools today, including service delivery, service users, effectiveness and stakeholders' perceptions.
2. Critically evaluate its strengths and areas for development, with particular respect to England's contemporary mental health agenda as outlined in *No health without mental health* [1] and related policy and guidance documentation [2-7].
3. Discuss current initiatives that are attempting to address these areas for development.
4. Highlight key areas for future action.

This paper does not review school-based counselling for children in the primary sector, or counselling for young people and young adults in the community sector. These are significant areas for the delivery of counselling services, and it is hoped that future reports will review these provisions at similar levels of detail.

The report covers data on school-based counselling from across the UK, but there is a particular emphasis on discussing policy implications for England.

THE NATURE OF SCHOOL-BASED COUNSELLING IN THE UK

This section of the report presents a summary of what is currently known about the nature of school-based counselling service delivery. To provide some context for these data, equivalent figures from specialist CAMHS are presented, where relevant and available¹. It is important to emphasise, however, that data from both sources may be unreliable and unrepresentative, such that all comparisons should be considered as approximate only.

Scope and definition

In the UK, the terms 'school-based counselling', or 'school counselling'² have been used to refer to a range of school-based helping activities; delivered by a variety of professionals, paraprofessionals and peers. Increasingly, however, the term is being reserved for the activities of professionally trained counsellor [e.g., 8]. The British Association for Counselling and Psychotherapy defined school-based counselling as: 'a professional activity delivered by qualified practitioners in schools. Counsellors offer troubled and/or distressed children and young people an opportunity to talk about their difficulties, within a relationship of agreed confidentiality.'

¹ The term 'specialist CAMHS' is used throughout this report to refer to all child and adolescent mental health services as recorded in the Children's Service Mapping by the Durham University Mapping Unit. This includes: multidisciplinary generic CAMHS teams, single disciplinary generic CAMHS teams, targeted CAMHS team, dedicated CAMHS workers working in a non-CAMHS team, and Tier 4 CAMHS units/teams.

² In the UK, the term 'school-based counselling' tends to be preferred to 'school counselling', the former implying that the counselling service is located *in* the school, but that the focus of the counselling is not necessarily *on* school-related issues.

History

School-based counselling began in the UK in the 1960s and grew considerably in the 1970s [9]. In the 1980s, however, it appears that there was a reversal of this trend, such that by the early 1990s it was 'all but dead' [9]. The last two decades, however, have seen a 'significant revival' of school-based counselling activity [10].

Prevalence

In Northern Ireland, counselling services have been established in all post-primary schools since 2007 (and in all post-primary sections of special needs school since 2011); and in all secondary schools in Wales since 2008. In England and Scotland, accurate data on the prevalence of school-based counselling services is not available. However, a recent survey suggested that approximately 61-85% of secondary schools in England provide young people with access to counselling; with 64-80% of secondary schools in Scotland offering a similar provision [11]. This research also suggests that, in 90% of cases, the services are specifically located on the school premises [11] [though research from Wales suggests that many school-based counselling services do also provide off-site support, 12].

Based on these figures, it can be estimated that approximately 70,000-90,000 *episodes* of school-based counselling are delivered in the UK every year (defined as a complete series of sessions undertaken by a service user, equivalent to a 'case'), and approximately 50,000-70,000 in England alone (see calculations in Appendix 1). In around 90% of these episodes [12], the young person will be attending school-based counselling for the first time that year.

This figure of 50,000-70,000 episodes can be compared against the total numbers of cases (including consultation meetings) recorded for specialist CAMHS in England per year, 190,412 for 2009/10³. If only the number of cases in an approximately equivalent age range of 10-18 years is considered, however, the specialist CAMHS caseload falls to 76,966 (for 2008-9)⁴. This suggests that the numbers of young people in England that are attending school-based counselling may be approaching the number attending specialist CAMHS; though it must be re-emphasised that both sets of figures are approximate and may be unreliable.

In England and Scotland, there are considerable regional variations in the prevalence of school-based counselling services [11]. For instance, 46% of secondary schools in Rochdale provide young people with access to counselling, compared with 80% of schools in Southwark [11].

Internationally, 'counselling' is an integral part of educational provision in many countries, including the United States [13], Israel (Tatar, personal communication), Japan [14], and Australia [15]. However, as will be discussed below, there are significant differences in the nature and function of its delivery.

Orientation of practice

Data from a survey of Welsh counsellors [12], and from a UK-wide review of audit and evaluation studies [16], suggest that at least 80% of school-based counsellors in the UK identify with a person-centred/humanistic, or integrative, orientation [12]. Both of these approaches can be considered primarily *relational* forms of therapy, in which the focus is on providing the young person with a supportive, understanding and trustworthy relationship in which they can find ways, in collaboration with the counsellor, of addressing their difficulties and improving their mental health and emotional wellbeing. Counsellors at the person-centred end of this spectrum tend towards non-directive practices, in which the emphasis is on providing the young person with time and 'space' to find their own way forward. Counsellors towards the humanistic and integrative end of this spectrum tend to adopt a more active

³ www.childrensmapping.org.uk/tables/profile-43/table-1168/struc-sha2006/year-2009/

⁴ www.childrensmapping.org.uk/tables/profile-43/table-1175/struc-srvctyp/year-2008/

therapeutic stance – for instance, challenging the young person or asking them questions – and may also draw on a range of techniques and methods from such approaches as cognitive-behavioural therapy (CBT) (for instance, relaxation exercises) and solution-focused therapy. A small minority of school-based counsellors also specifically identify with other therapeutic approaches, such as CBT or psychodynamic therapy [12].

Format

Counselling in the UK is predominantly delivered in a one-to-one, rather than group, modality; and the young person is not normally seen with their family, which is more common in specialist CAMHS. Sessions tend to vary from 40 to 60 minutes: usually the length of one school period [16]. In around 80% of schools in England and Scotland – and the majority in Wales [12] – counselling is open-ended, with no maximum to the number of sessions offered to young people [11].

International context

The relational orientation of school-based counselling in the UK, and its focus on mental wellbeing, makes it somewhat distinct from school counselling as developed and delivered in many other regions in the world, particularly the US. In the latter, the work of school ‘counselors’ is more orientated towards educational and vocational guidance; with one-to-one, on-going therapy often only a small part of a counsellor’s workload (Lambie and Young, personal communication, 2012). Where therapeutic interventions are delivered in the US, these tend towards more group- or class-based interventions, and often drawn from CBT theory and practice [17].

Counsellors

Data from the Welsh counsellors’ survey suggests that school-based counsellors in the UK are predominantly female (85%), white (90%), have a master’s level qualification or above (70%) and are members of a professional training body (85%). Most, but not all, have had some training in therapeutic work with children and young people (80%) [12]. The average age of school-based counsellors is between 40 and 49 [12]. In just over 20% of cases, school-based counsellors in England and Scotland had additional roles, such as teacher, chaplain, or school nurse [11]. Most (80%) feel generally supported in their role [12].

The average number of counsellors employed by schools in England and Wales is approximately two; and they are typically available for one to two days per week, providing between five and nine sessions of counselling during this time [11].

Service delivery models

In England, school-based counselling seems to be most commonly funded through the school’s own budget (72%), with the counsellor employed on a sessional basis or through an external agency. In Scotland, research suggests that counselling is most likely to be funded by the local authority (40%), with the counsellor either employed by the local authority, another agency, or employed on teachers’ conditions [11]. In Wales, school-based counsellors are most commonly employed through an external agency or by the local authority, with around 10% employed directly through the school. School-based Counselling in Wales has been funded via a Welsh Government grant to local authorities since 2008-09 and, from 2013-14, the existing grant funding for school based counselling will be transferred to Local Authorities’ Revenue Support Grant for the continued support of this service (Reed, personal communication, 2012). In Northern Ireland, funding for school based counselling comes directly from the Department of Education with services being delivered via external organisations who have been awarded contracts through a public tendering process (Bell, personal communication, 2012).

Waiting times

The average time for young people to wait to see a counsellor in England and Scotland has been reported by schools as being one week or less (approximately 52%), with around 25% of young people reported as waiting up to a month, and the remaining 23% waiting one month or more [11]. In Wales, around a half of local authority leads also indicated that the average waiting time to see a school-based counsellor was less than one week, with a further third suggesting that the average wait is 1-2 weeks [12].

Parental consent and awareness

In approximately 55% of schools in England, and 60% in Scotland, young people can attend a school-based counsellor without parental or carer consent [11]. Data from counsellors suggest that approximately one-half to two-thirds of parents/carers are aware that their young person is attending school-based counselling [16].

Links to specialist CAMHS

There is limited research on the relationship between school-based counselling and specialist CAMHS, or on the development and monitoring of integrated pathways of care. Data from Wales, however, suggests that the relationship is generally perceived as a positive one. Almost all local authority leads (96%) believe that their counselling service has good relationships with specialist CAMHS; 92% of counsellors feel clear about when to refer a young person on to specialist CAMHS or other agencies; and 62% of counsellors have specifically made – or received – referrals from such services [12, 18]. Similarly, a small-scale study of professionals allied to school-based counselling – such as nurses and educational psychologists – indicated that most felt able to refer young people into school-based counselling, and were moderately confident that the counsellors would refer young people on as appropriate. Some school-based counsellors are also supervised by specialist CAMHS staff [12, 19].

The existence of a positive relationship between school-based counselling and specialist CAMHS is supported, to some extent, by more in-depth interview data from school-based counsellors; some of whom have described high levels of collaboration with specialist CAMHS, with regular meetings and the capacity for referrals in both directions [20]. On the other hand, some counsellors have described a lack of any collaborative engagement with specialist CAMHS, with no experience of making onward referrals [20].

Self-report data from counsellors and local authority leads suggest that around 3% of young people attending school-based counselling services are referred on to specialist CAMHS [12, 21], though one small scale study indicated a higher figure of 10% [19].

Evaluation

The extent to which school-based counselling services are evaluating the outcomes of their work is not clear. Recent indicative evidence suggests that only about 7% of schools in England are using a standardised outcome measure, with a further 18% using some other form of service questionnaire [11]. In Wales, for 2009-2011, where all school-based counselling services were asked to formally evaluate their outcomes, a mean response rate of 76.3% was achieved for those services that did implement routine outcome monitoring (33% across all services).

SERVICE USERS

In recent years, two large-scale reports on the users of school-based counselling services have been conducted: the first from 30 audit and evaluation studies from

across the UK [16], and the second from the implementation of the Welsh Government's Strategy for School-based Counselling in Wales [12]. Although the samples used in these studies may not be representative of *all* UK service users, each draws on data from over 10,000 young people. The findings from both studies are relatively consistent, thus providing a well-triangulated picture of the kinds of young people who attend school-based counselling services in the UK and the nature of their service use.

Severity of difficulties

School-based counsellors tend to work with clients at a range of levels of distress; and there are no set criteria for who is considered appropriate for school-based counselling. However, self-reported data from 611 young people attending school-based counselling services indicated that 32.7% were experiencing 'abnormal' levels of psychological difficulties [as defined by the Strengths and Difficulties Questionnaire (SDQ), 22]⁵, 26.4% were experiencing 'borderline' levels of difficulties, and 40.9% were experiencing difficulties in the 'normal' range [16]. This is a much higher levels of difficulties than in a normal community sample, where 10% would be expected to be in the 'abnormal' range, and 10% in the 'normal' range [23]. Comparative self-report data from 44,708 11-18 year olds attending specialist CAMHS from the CORC dataset indicates that 42.4% were experiencing 'abnormal' levels of difficulties, 23.1% were experiencing 'borderline' levels of difficulties, and 34.5% were experiencing difficulties in the 'normal' range [24].

Average levels of psychological difficulties for young people attending school-based counselling, as measured by SDQ Total Difficulties scores, were 16.87 ($n = 934$) for the UK [16] and 18.14 ($n = 476$) for Wales [12]. This compares with a mean of 18.10 for 44,708 11-18 year olds attending specialist CAMHS, as recorded in the CORC database. For specialist CAMHS service users who received a psychological intervention, and for whom 'Time 2' (i.e., six months after baseline) data were available, the SDQ Total Difficulties mean at baseline was 17.31 [24].

For approximately 40% of young people attending school-based counselling services, their problems had been present for a year or more; with less than 5% reporting that their problems were present for less than a month.

Data on formal mental health diagnoses for young people attending school-based counselling are not available. However, from counsellors' assessment records of over 20,000 cases, around 10% of young people are presenting with issues around depression, 10% with anxiety, 5% with self-harm issues, 4% with abuse issues, 2% with eating problems, 1.5% with substance misuse issues, and 1% with suicidal thoughts [12, 16]. By contrast, for 2008-9, 32.9% of children and young people were recorded as presenting at specialist CAMHS with emotional problems, 5.9% with deliberate self-harm, and 4.2% with eating problems⁶. Other common presentations at specialist CAMHS, for which there are no equivalent figures for school-based counselling, were conduct problems (14.7%), hyperkinetic problems (11.6%), autistic spectrum problems (7.7%), and developmental problems (6.6%); with 2.1% of children and young people presenting at specialist CAMHS with psychotic problems.

Session and episode data

On average, clients attend school-based counselling for approximately three to six sessions [12, 16, 19]; though a large proportion attend for just one or two session, with a small minority attending for ten or more [12, 16]. Mean attendance rates tend to be high: approximately 80-90% [12, 16]. In around 10% of episodes, clients will be attending for a second or more time that year [12].

⁵ 'Abnormal' = Total Difficulties score ≥ 20 ; 'borderline' = 16 - 19; 'normal' = ≤ 15 .

⁶ www.childrensmapping.org.uk/tables/profile-43/table-1177/struc-srvctyp/year-2008/

As a comparator, median length of treatment for specialist CAMHS is between 13 and 26 weeks⁷.

Source of referral

School staff, and particularly *pastoral care* teachers, are the most common source of referral in to school-based counselling, involved in around two-thirds of cases [11, 12, 16]. Self-referrals are less common – 25% of episodes at most [12, 16] – though approximately 75% of schools in England indicate that young people can access counselling through self-referrals, and over 40% report that they offer a ‘drop-in’ service [11]. Referrals by parents or carers occur in less than 10% of cases [12, 16]; though around 70% of schools report that young people can access the counselling service through parent or carer referral.

This profile contrasts sharply with sources of referral in to specialist CAMHS; where, for all clients for 2008-9, only 10.5% of cases came through education⁸. Instead, the most common source of referral was primary health care (43.4%); followed by child health (12.9%) and social services (10.5%), with 2.6% coming through youth justice. Self-referral rates for CAMHS were 2.3%.

Gender

Around 60% of clients who attend school-based counselling services are female and 40% are male [12, 16]. This can be compared against data from specialist CAMHS for 10-18 year olds (2008/9), where approximately 45% of clients are female and 55% are male⁹. This higher proportion of male clients in specialist CAMHS, however, is primarily due to a larger proportion of boys in the 10-14 year old age band. By contrast, in the 15-18 year old age range, the ratio of female to male clients in specialist CAMHS is 55-to-45, which is closer to school-based counselling.

Age and school year

Clients who attend school-based counselling services most typically come from the middle school years – 9 and 10 (aged 13 and 14) – with numbers tailing off towards the upper and lower years of the school [12, 16].

Ethnicity

Young people from BME backgrounds, and particularly those of Asian origin, have been found to be under-represented in those attending school-based counselling services [12, 16]. In the evaluation of school-based counselling in Wales, for instance, 0.4% of the young people attending counselling were from an Asian or Asian British background, compared against the 1.8% of all young people in Wales who were of this ethnic origin.

Presenting and developing issues

Data from both Wales [12] and UK-wide [16, 19] indicates that the most frequent issue that young people present with at school-based counselling, as recorded by their counsellor, is family issues (approximately one-third of all young people). Anger is the second most common presenting issue (approximately 16% of all young people), and is significantly more common for males, with about one-quarter of all males presenting with this difficulty. ‘Behaviour’ is another common presenting issue at school-based counselling (approximately 12% of all young people); as are bereavement, bullying, self-worth and relationships in general (each presented by approximately 10% of all young people).

⁷ www.childrensmapping.org.uk/tables/profile-43/table-1170/struc-srvctyp/year-2008/

⁸ www.childrensmapping.org.uk/tables/profile-43/table-1178/struc-srvctyp/year-2008/

⁹ www.childrensmapping.org.uk/tables/profile-43/table-1175/struc-srvctyp/year-2008/

The problems that are actually discussed by young people in counselling, as recorded by their counsellors, are relatively similar to those presented, with family issues again being the most prevalent issue by a factor of around two [12, 16]. However, from counsellors' records, there is a tendency for issues of anger and behaviour to become less prominent as the counselling proceeds, and issues of self-worth and relationships to become more focal [12, 16].

When young people, themselves, were asked about their goals for school-based counselling ($n = 73$), the most common concern was to 'increase self-confidence and self-acceptance' [approximately 40% of all young people, 25]. This was followed by: 'controlling or reducing anger', 'improving relationships with family', 'increasing happiness/reducing upset', and 'reducing anxiety/worry' [each approximately 20-25% of all young people, 25].

Looked after children

Data from Wales suggests that around 5% of young people attending school-based counselling services are looked after [12]. This compares with an approximate figure of 8.7% looked after children and young people for specialist CAMHS in 2008-9¹⁰.

EFFECTIVENESS

International research

Internationally, school-based counselling and psychotherapy interventions have been found to significantly reduce psychological distress in children and young people, with a moderate overall effect [mean effect size from 107 studies = 0.45, 17]. However, this evidence comes primarily from studies of cognitive or behavioural interventions in the US, and often of a group-based nature. Hence, it is not directly relevant to the effectiveness of school-based counselling as currently practiced in the UK.

NICE guidelines for depression

NICE (National Institute for Health and Clinical Excellence) guidelines recommend the use of *non-directive supportive therapy* for the treatment of mild depression in children and young people [26]. If mild depression is equated to moderate levels of psychological difficulties (for instance, a score of between 10 and 20 on the SDQ Total Difficulties scale), then the majority of clients in school-based counselling in the UK could be considered to fall within this range. In addition, although only a minority of counsellors in the UK would specifically define their practice as *non-directive* (see above); if it is primarily understood, as per NICE guidelines, as 'the planned delivery of direct individual contact time with an empathic, concerned and skilled non-specialist CAMHS professional' [26], then this might be considered representative of the way in which many British school-based counsellors work. However, auditing of the actual practice of school-based counsellors in the UK is rare – indeed, there are currently no clearly agreed guidelines or manuals for non-directive supportive therapy. Hence, evidence is not currently available on how many school-based counsellors do, indeed, deliver such an intervention.

School-based humanistic counselling for psychological distress

Three recent small scale RCTs [27-29] (Total sample = 90) have assessed the effects of a manualised *school-based humanistic counselling* intervention (SBHC), which is based on the humanistic competences for psychological therapeutic practice

¹⁰ www.childrensmapping.org.uk/tables/profile-43/table-1967/struc-srvctyp/year-2008/blanks-remove/

developed in collaboration with University College London [30]¹¹. This is relatively consistent with non-directive supportive therapy, as defined above, with an emphasis on the counsellor 'attuning' to the client in an accepting and genuine way, and reflecting back to them an accurate understanding of their lived-world, such that they can feel empowered to understand and address their difficulties [31].

A *meta-analysis* of this data indicates that, at both six weeks and 12 weeks following randomisation, young people participating in this counselling intervention showed significantly lower levels of distress on the *Young Person's Core* (YP-CORE) than those in a waiting list control group; and were also significantly closer to achieving their personal goals (see Appendix 2). In terms of total difficulties (SDQ), self-esteem (Self-Esteem Questionnaire), and levels of depression (Moods and Feelings Questionnaire), there were no significant differences between the counselling and waiting list groups, although the direction of effect was in favour of counselling. Combining outcomes across measures and across studies, school-based humanistic counselling brought about significant improvements at 12 weeks, with a mean effect size of 0.58; though change at six weeks was not significant, with a mean effect size of 0.41.

Practice-based evidence

Data from 'real world' settings, in which control conditions are not implemented, indicate that school-based counselling is consistently associated with significant reductions in psychological distress [12, 16]. The magnitude of this change is approaching that for adults participating in psychological therapies in the NHS: with mean *effect sizes* of 0.81 [16] and 1.09 [12] from over 5000 episodes of school-based counselling; compared against effect sizes of 1.10 for adults in the UK's Improving Access to Psychotherapy demonstration (IAPT) sites [32], and 1.39 for over 5000 adult clients who received either cognitive-behavioural therapy, person-centred therapy or psychodynamic therapy at one of 32 NHS primary-care services between 2002 and 2005 [33]. The magnitude of this effect remains large when school-based counselling services use weekly monitoring to ensure that data is available on *all* clients, and not just those who have completed to endpoint [34]. However, effect sizes for school-based counselling services do become inflated when response rates are poor [12, 16, 34]. In addition, outcomes measured by the YP-CORE have been found to be significantly larger than those measured by the SDQ [12, 16].

The magnitude of change associated with school-based counselling can also be compared against the magnitude of change found for 11-18 year olds receiving a psychological intervention in specialist CAMHS, as recorded in the CAMHS Outcome Research Consortium dataset [24] for SDQ total difficulties scores. In Wales, school-based counselling services recorded a reduction from beginning to end of therapy from 18.14 to 12.21 on the SDQ ($n = 476$); and UK-wide services recorded a reduction from 17.36 to 13.55 ($n = 611$), giving effect sizes of 0.68 and 0.56 respectively. The comparative reduction for specialist CAMHS interventions, from assessment (T1) to six months after assessment (T2), was from 17.31 to 13.79 ($n = 1698$), giving an effect size of 0.52. It is important to note, however, that not all young people in the specialist CAMHS dataset may have completed therapy.

Data from two studies suggest that the reductions in psychological distress associated with school-based counselling are maintained – and possibly enhanced – three months from the completion of counselling [29, 35]. Data on the longer-term effects of school-based counselling, however, are not available.

¹¹ In one study [29], a counsellor was rated as not being adherent to school-based humanistic counselling competences, and his/her data has been removed from this analysis.

Clinical change.

SDQ data from six service evaluations suggest that approximately 45% of clients in the 'abnormal' or 'borderline' ranges at the start of counselling move into the 'normal' range by its end (i.e., demonstrate clinical recovery), with around 10% moving from 'normal' levels of difficulties into the 'abnormal' or 'borderline' range by the end of counselling (i.e., demonstrate clinical deterioration).

Economic analysis

No analyses have been conducted of the cost-effectiveness, or cost-benefits, of school-based counselling in the UK¹².

Impact on education

In only one small-scale study have 'objective' indicators (e.g., attainment in exams) been used to assess the impact of school-based counselling on educational factors [36]. This found no statistically significant differences in attendance rates and numbers of exclusions from the beginning to end of counselling ($N = 54$ clients) although, in both instances, the direction of change was in favour of the intervention.

Predictors of outcomes

There is no evidence that the outcomes of school-based counselling vary across clients' gender, age, ethnicity, presenting problems, goals for therapy, total number of sessions, or levels of motivation [16, 21, 25, 34, 36, 37]. In addition, school-level factors – such as size of school, perceived quality of pastoral care provision, denominational status, and level of deprivation – have not been found to relate to outcomes [34]. The one exception to this is that young people who have better rates of attendance at school-based counselling (though not necessarily more sessions) have somewhat better outcomes than those with lower attendance rates [34, 36].

PERCEPTIONS AND EXPERIENCES OF SCHOOL-BASED COUNSELLING

In addition to quantitative outcome data, a range of surveys and questionnaire studies have examined how school-based counselling is perceived and experienced by key stakeholder groups.

Perceived helpfulness

Service users.

Evaluation studies have consistently found that a large majority of clients in school-based counselling rate the intervention as helpful [e.g., 12, 16, 19]. For instance, approximately 55% of 325 clients in a UK-wide review indicated that their problems were 'much better' since coming to school-based counselling, with a further 35% saying their problems were a 'bit better' [SDQ Impact Supplement, 16], and no clients indicating that their problems were worse. Similarly, around 80% of 1,426 clients in this review described school-based counselling as helping them 'quite a lot' or 'a lot' [16].

¹² Very approximate economic data from the evaluation of school-based counselling in Wales [12] suggests an average total service cost of £150.90 per session of counselling and £667.10 per episode of counselling. Based on average reductions in psychological distress, this suggests a cost of £81.95 per point reduction for each client on the YP-CORE, and £112.49 per point reduction for each client on the SDQ Total Difficulties Scale. However, these figures must be treated with extreme caution and may be very inflated, as they include a range of start-up costs from the initial phases of service implementation.

These quantitative ratings are matched by qualitative data, where clients are typically positive about the service that they have received: for instance, 'Personally, I think that if it hadn't have been there, then I wouldn't be here now' [16]. However, a small minority of clients do also indicate that they did not find school-based counselling helpful, for instance, 'It was all right: it wasn't that helpful and didn't change much' [16].

School staff.

As with service users, a majority of school staff – including headteachers, pastoral care teachers, and other teachers – also tend to perceive school-based counselling as helpful or very helpful for the young people who have used the services [11, 12, 16, 19, 38, 39]. Across 125 teachers in Scotland, for instance, a mean rating of 8.22 was given on a 1 (*Extremely unhelpful*) to 10 (*Extremely helpful*) scale [16]. Another survey found that over 90% of school staff in England and Scotland felt that their counselling service met the needs of their students well [11]. This is again matched by qualitative responses, for instance: 'This is an excellent service which has been of huge benefit to pupils on a short/long term basis' [16].

With respect to impact on teachers' workload, a majority of the 158 link teachers in Wales felt that it had had no effect, or had somewhat reduced it [12].

There is also evidence that a small minority of teachers hold strongly negative attitude towards an in-school counselling service [19, 39], seeing it as 'indulgent' or 'pointless' [39]. Across 71 teachers in Scotland, for instance, five (7%) gave it a rating of 0 or 1 out of 10 in terms of importance (0 = *not at all important*, 10 = *essential*) [39].

School students.

Surveys that have looked at the attitudes of school students, in general, towards school-based counselling services suggest that they are moderately positive towards it, but significantly less so than those who have specifically used the service [12, 21]. In Glasgow, for instance, school-based counselling services were given a mean rating of approximately 6 out of 10 in a survey of 457 students (0 = *not at all important*, 10 = *extremely important*); with males rating the service as significantly less important than females [21]. Lower ratings of importance were associated with less self-reported knowledge and understanding of what counselling is [12, 21].

Parents and carers.

There is little evidence on the perceptions of parents and carers – either of clients, or of students in general – towards school-based counselling. Data from a small number of parents in Wales [12], however, suggests that they are generally positive.

Satisfaction

Service users.

Clients generally report positive experiences of support and care in counselling [12, 16, 40]. One review, for instance, indicated that 95% of 692 clients who completed post-counselling questionnaires were 'satisfied' or 'very satisfied' with the service that they have received.

School staff.

Over 90% of school staff across four studies in England and Scotland indicated that they were 'satisfied' or 'extremely satisfied' with their current counselling provision [11]; with over 80% rating it as 'value for money', and the majority feeling that it was 'well-recognised and valued by school staff' [11].

Helpful aspects

Service users.

From both quantitative and qualitative research, clients indicate that the most helpful aspect of school-based counselling is the *opportunity to talk to someone who is listening* [12, 16, 19, 41]. *Getting things off one's chest* is also rated as one of the most helpful elements, as is the *confidentiality* of the counselling relationship [12, 16, 40, 41], the *counsellors' personal qualities* (such as being accepting, non-judgmental and supportive) [16, 19, 21, 41]; and the fact that they are *independent* from the family or peer context [41]. In addition, around half of clients have described more *directive therapeutic interventions* as a helpful part of their counselling; such as being given guidance, suggestions and advice from their counsellor; and being invited to participate in specific exercises, such as guided muscle relaxation or guided visualisations [16, 21].

School staff.

For school staff, the *accessibility* of school-based counselling is identified as one of its most helpful qualities: that young people can be referred in easily and without long delays [12, 16]. In addition, as with service users, school staff highlight the *independence* of the counsellor to the young person's life, and the fact that they provide a *confidential* service [16]. A fourth aspect of school-based counselling that school staff recognise as valuable is the fact that the counsellors have a *specialist training* in therapeutic skills, and are therefore able to offer a level of interpersonal support above and beyond what the school staff can offer themselves [38]. Closely related to this, they also value the *extended time periods* that counsellors can spend with young people; again, above and beyond their own capacities in a busy teaching schedule [16]. In these latter two respects, some school staff have said that a school-based counsellor 'takes the weight' off them, allowing 'the teachers to do their job' [12]. School staff have also indicated that school-based counselling may be a relatively *non-stigmatising* mental health intervention for young people [12, 16, 38]; that its location in the school means that *minimal time is lost* in going to classes [12]; and that it provides help for students with '*small*', as well as '*large*', *difficulties* [12]. Finally, some members of school staff have indicated that what they find helpful about school-based counselling is that it focuses on the young person's *wider mental health* and emotional wellbeing, and not just their behaviour [38].

Local authority leads.

As with school staff, local authority leads have particularly highlighted the *ease of access* to school-based counselling as a key strength: for instance, 'We are able to engage a young person with a professionally trained counsellor quickly when the need arises' [12].

Allied professionals.

A small scale study of professionals in Scotland who have responsibility for developing pathways of care for school students [36] – including educational psychologists and nurses – found that they also valued the *extended periods of time* that school-based counselling services could offer young people, their *independence*, and the fact that school-based counselling services are *confidential*.

School students.

Students from across the school context highlight the value of the *confidentiality* of the counselling service [12]. In addition, there is some evidence to suggest that young people see counselling as 'friendlier', *less stigmatising*, and less threatening than interventions prefixed by 'psycho-', such as 'psychotherapy' [40].

Helpful effects

There is limited evidence on the specific aspect(s) of young people's experiencing, mood or behaviour that school-based counselling has a positive effect on. RCT data [27-29], as above (see also Appendix 2), suggests that the strongest effects are on reducing immediate psychological distress; and on helping young people achieve their personally-defined goals, most notably increasing self-esteem and reducing anger (see above). Qualitative interviews studies with young people also seem to indicate a wide range of positive outcomes; with one study finding that the most common self-reported gains were in 'talking about feelings more easily', 'improvements in school,' 'more confidence,' and 'changed thinking' [41]; and another study finding that young people most commonly reported positive changes in behaviour, such as standing up to bullies or being more able to walk away from situations when they felt angry [21].

Perceived impact on education

Service users.

Around two-thirds of clients in post-counselling questionnaires ($n = 264$) said that school-based counselling had led to improvements in their capacity to study and learn [16]; as did 80-100% of clients in post-counselling interviews [36, 42]. Most frequently, clients indicated that the counselling had helped them to concentrate more in class, by giving them an opportunity to talk through – and 'get off their chest' – difficulties that were inhibiting their capacity to 'think straight' at school. In addition, clients reported that counselling had increased their motivation for school and schoolwork, and had led to improvements in their relationships with teachers.

School staff.

Across three studies, approximately 60-80% of headteachers and pastoral care teachers have indicated that they perceive school-based counselling as helping clients to study and learn [12, 16, 18, 38]. In one study, for instance, pastoral care teachers ($n = 51$) were asked to rate the effect of counselling on four educational variables – motivation to attend school, ability to concentrate in class, motivation to study and learn, and willingness to participate in class – on a 9-point scale (1 = *Much less*, 5 = *No difference*, 9 = *Much more*). Here, 75-90% of teachers said that the counselling had led to improvements, 5-20% said that it made no difference, and 2-3% said that it had made things worse [16]. As with the service users, the teachers particularly perceive this in terms of facilitating the young person's ability to concentrate in class, as well as increasing their attendance at school and helping them to improve their behaviour.

Limitations and areas for improvement

Service users.

Where clients have been asked what was unhelpful in their school-based counselling, or what could be improved, the most common response has been '*nothing*' [e.g., 19]. This is followed by requests that the counsellor should be *more available* or that there should be more counsellors [16, 30, 41]. However, fairly consistently, a small minority of clients [less than 2% in 21] do also indicate that they would like their counsellor to be *more active*: to give more advice and input and to do more than 'just listen' [16]. Similarly, a small minority of clients have indicated that they found it '*too painful to open up*'; were unhappy when *confidentiality was broken* for child protection reasons [12, 16]; or felt unhappy that they had to *miss classes* to attend counselling [19].

School staff.

When asked how their counselling service could be improved, the most frequent response from school staff is also an *increase in availability* and resourcing of the

provision, as well as the counselling service being *promoted more extensively* in the school [11, 12, 16, 38, 39]. However, fairly consistently, a minority of teachers also indicate that they would like to see *counsellors communicating more openly* and effectively with members of the school staff [12, 16, 39], particularly in terms of how students are doing in counselling, and whether there are any risk issues that they should be aware of. Some school staff also want to be given *more information* about the nature and functioning of the counselling service [12, 39]. Third, a small number of school staff have indicated that they would like to see school-based counsellors deliver a *wider range of interventions* than just one-to-one counselling for pupils: for instance, anger management groups, or counselling for parents or for school staff themselves [12, 16]. Consistent with this, research suggests that school staff do appreciate it when school-based counsellors offer a broader set of interventions [12, 19]. Finally, some school staff worry that young people will use attendance at the counselling service as an *excuse to miss classes* [39].

Parents.

As with school staff, there is evidence to suggest that some parents and careers would like to have *'more knowledge* of what is happening in counselling'. For instance, 'If something that much is going on in my daughter's life I'd want to hear about it... maybe things could be passed on or maybe we could pass things on to the counsellor – not everything but sometimes, it may be relevant' [12].

Allied professionals.

In a small scale-study, some allied professionals, such as social workers, also indicated a desire to receive *greater feedback* from school-based counsellors on how their work with specific young people was progressing. In addition, some wanted *more information* about the counselling services, and to see counselling *more integrated* with other services for children and young people [36].

School students.

Young people have emphasised the *need for self-referral* routes in to school-based counselling: for instance, 'I think people should be able to refer themselves, not like the teachers referring them' [12].

Preferences

Across a sample of school students, over two-thirds would rather see a counsellor at their school as opposed to outside of their school environment [43, 44]; and over 80% would rather see a counsellor on a one-to-one basis as opposed to in a group [43, 44]. Students, particularly females, also express a strong preference for a female, as opposed to male, counsellor [43, 44].

Demand for school-based counselling

Approximately one-third of a sample of students had an emotional difficulty that they might like to talk to someone about, and a similar percentage indicated that they might – or would – be willing to discuss this concern with a counsellor [45]. This is close to the 23% of 457 secondary school students in a separate survey who indicated that they 'probably', or 'definitely', would be willing to talk to a counsellor [21]. However, in a third survey, just 8% of young people indicated that they would talk to a school or college counsellor for help or advice about anything that was worrying them [40]; with substantially greater percentages indicating that they would consult parents (83%), friends (82%), online resources (46%), teachers (28%) and/or books (10%).

Understanding of counselling

When asked how much they knew about counselling, approximately three-quarters of students in a 2004 Glasgow sample indicated 'Nothing at all' or 'A little' [21]. A more recent qualitative study, however, suggested that young people 'had a fairly good understanding of what counselling was' [40], associating it with talking about personal problems and issues in their lives. This study also found, however, that there were many misconceptions about the nature of counselling, for instance that it is a 'place to be sent for bad behaviour and corrective measures' or 'that it involves lying on a couch' [40].

Reasons for not utilising counselling

Research suggests that there are seven main reasons why a young person might not want to talk to a counsellor about problems that they were experiencing [21, 40, 46]. First, as indicated above, many school students, particularly females, feel that there are *other people they can talk* to about their difficulties, in particular parents, family and friends [21, 40, 46]. Second, and closely related to this, young people may not want to talk to a *stranger* [21, 46]. A third major inhibiting factor is that young people may be concerned that *others will find out* what they are saying to the counsellor or that they are going to counselling per se – particularly other students, as well as parents/carers and teachers [21, 46]. Four further common inhibiting factors are *embarrassment* about discussing their problems; a belief that they can, or should be able to, *sort out their problems on their own*; *limited knowledge of counselling*; and a fear that their *problems may not be 'big enough'* [12, 21, 40, 46].

STRENGTHS

Drawing the evidence together, the following two sections of this report critically evaluate the strengths and areas for development of school-based counselling as it is currently delivered in the UK. This is specifically from the standpoint of England's contemporary mental health agenda, as detailed in *No health without mental health* [1, 7] and *Equity and excellence: Liberating the NHS* [2]; and as adopted and developed by the Children and Young Person's Improving Access to Psychological Therapies (CYP IAPT) programme [47, 48]. This can be described as a focus on placing the young people at the heart of service delivery, emphasising shared decision-making, personalisation of care, and the empowerment of young people through enhancing their capacity for choice of treatments and control. This agenda also emphasises evidence-based care, systematic monitoring of outcomes, and a focus on early intervention; with a commitment to ensuring equality of access to treatments and outcomes, and the de-stigmatisation of children and young mental with health difficulties [1-7].

Valued by stakeholders

Research suggests that the young people who participate in school-based counselling – as well as the adults involved in their care – are generally very positive towards this service provision, with high levels of satisfaction and perceived helpfulness. In this respect, school-based counselling appears to meet an important need in young people; and is a service that they, personally, value highly.

Accessibility

With its short waiting times, convenient location, and broad intake criteria, school-based counselling is perceived by many stakeholder groups as a highly accessible intervention: able to offer a wide range of young people professional therapeutic support in a direct and immediate way. Consistent with this, around 80% of young

people feel that it is easy to contact a school-based counsellor [12]; and there is also wider evidence to suggest that young people may be as much as ten times more likely to access a school-based mental health service as compared with a non-school-based one [49, 50]. This means that school-based counselling may have the capacity to act as an effective early intervention: supporting young people to address their difficulties in a timely manner, with the possibility that this will then inhibit the development of more serious problems at a later date.

Low stigmatising

While participation in school-based counselling clearly carries some degree of stigma, there is also data – from both teachers and young people – that it may be less stigmatised than other mental health interventions, particularly those of a ‘psycho-’ nature. This may add to its accessibility – with young people more willing to attend this service than others – and hence, again, its capacity to act as an effective early intervention and a bridge to other CAMHS.

An inherently young person-centred approach

As with a wide range of CAMHS provisions, school-based counselling, with its emphasis on listening to young people, responsiveness, and respecting young people’s perceptions and needs, can be considered an inherently young person-centred approach. Indeed, many of the practices that are core to school-based counselling are exactly the capabilities that children and young people, themselves, emphasise when discussing the ideal standards of attitudes and behaviours for people who work with them [51]. Furthermore, school-based counselling, in line with the wider CAMHS agenda, can be considered an inherently strengths-based approach, which does not start from the assumption that young people who are experiencing psychological distress are dysfunctional, maladaptive, or ill in some way. Rather, its basic premise is that such young people are ‘doing their best’, and have the capacity and resources to find ways through their difficulties if they can be supported to do so.

A support for young people who have no-one else to talk to

In terms of equality of access to psychological support, one of the key strengths of a school-based counselling service may be that it maximises the likelihood that *all* young people will feel that they have someone to talk to if they are experiencing difficulties in their lives. Research, as discussed above, suggests that many young people have difficulties that they would like to talk to someone about. In most cases, as the evidence also suggests, these young people will feel that they can turn to parents, carers or friends; but this is not always the case – some young people do not feel that they have anyone to turn to. Such young people may also not be at the level of psychological distress that warrants a referral on to specialist CAMHS; or be experiencing the kinds of educational difficulties that would bring them into contact with an educational psychologist. These young people may turn to other professionals in their lives – such as a pastoral care teacher or a GP – but the evidence suggests that such adults, however concerned and well-meaning, often do not have the time to fully attend to a young person’s concerns. School-based counselling, therefore, can be seen as a provision which increases the likelihood that young people will feel that they have someone to turn to at times of difficulties: however ‘large’ or ‘small’ their problems might be, however available or unavailable others are in their lives.

AREAS FOR DEVELOPMENT

Increased use, and development of, the evidence base

School-based counselling seems to bring about positive benefits, but these might be significantly enhanced if counsellors were to draw more fully from the evidence-base on effective practices. For instance, there is an emerging body of research to suggest that the systematic gathering of feedback from clients on the outcomes and process of therapy leads to improved gains [52-56], and such methods could be usefully incorporated into school-based counsellors' work. It may also be that school-based counsellors could develop skills in specific NICE-recommended practices for specific disorders alongside non-directive supportive therapy, such as interpersonal therapy for young people with moderate to severe depression [26]. Here, however, it is important to note that there are often no evidence-based guidelines – or data – on how to work effectively with the kinds of presenting problems that young people often bring to school-based counselling, such as family difficulties. Hence, as well as drawing from the evidence, there is also a need for to develop a better evidence base for effective work with the problems that young people present with at school-based counselling.

There is also a need for more research on *how* school-based counselling might actually be helping young people, as well as whom it may be most suited to help. Through this, the strengths of the intervention could be built on and more effective practices could be developed; and school students and commissioners could also be given clearer information about who this service is for, and what kinds of outcomes to expect. In Appendix 3, a very preliminary 'process model' of how school-based counselling may help, based on the evidence presented in this report, is outlined; but there is a need for more models, and for their testing and development through a wide range of qualitative and quantitative, counselling and psychological, outcome and process-outcome research.

As part of this, it would be very useful to evaluate whether the effectiveness and/or cost-effectiveness of school-based counselling could be enhanced through specific adaptations: for instance, through the use of systematic outcome monitoring, as discussed above [as is currently being trialled in the US, 57], through drawing on CBT methods, or through supporting face-to-face counselling with online counselling delivery¹³.

More broadly, there is also an on-going need for research to evaluate the effectiveness of school-based counselling, per se, particularly with respect to its cost effectiveness, longer- term outcomes, and comparative effectiveness and cost-effectiveness against alternative interventions.

Increased use of outcome and process feedback

As well as having the potential to enhance gains, regular monitoring of the outcomes of school-based counselling work is essential if services are to demonstrate their effectiveness to commissioners and to the wider field. However, the evidence suggests that the overall use of such systems in school-based counselling remains low. Furthermore, even where services have collected outcome data, response rates are often poor, and nearly always less than the 90% data completeness proposed in the Adult IAPT Minimum Quality Standards [48]. To address this, it will be necessary for services to undertake session-by-session outcome monitoring, so that endpoint data can be gathered on *all* clients, including those who drop-out of therapy. Encouragingly, there are several examples where this has been successfully implemented in school-based counselling services [e.g., 12, 34], and the generally positive response that this systematic monitoring has received from both practitioners and service users suggests that its wider use would be acceptable in the field.

¹³ As is currently being tested by Relate.

Increased participation of young people

Although, as discussed above, the underlying philosophy of school-based counselling is very young person-centred, there is limited evidence that school-based counsellors – either at a local or national organisational level – are involving young people in the design, development or monitoring of school-based counselling provisions [3]. Young people’s participation, here, is crucial to ensure that school-based counselling services, at a local level, are appealing and meet their needs; and, more broadly, to ensure that wider developments in the field (like those discussed in this section) are consistent with young people’s own priorities and concerns. Again, however, there are examples of excellent practice that can serve as models to the field: for instance, the involvement of *Funky Dragon*, The Children and Young People’s Assembly for Wales¹⁴, in the development of the Welsh Strategy for School-based Counselling, which influenced plans to ensure that funding also covered young people who were educated at home (Jones, personal communication, 2012).

Increased self-referrals

Although most school-based counselling services allow for self-referrals, and students express a desire to see this available, the research suggests that this is often not a well-used entry route into this service provision. Why this is the case, or what can be done to enhance it, is not clear; however, it may be related to a lack of knowledge about school-based counselling: what it is, how it functions, and also how it can be accessed within a particular school context. This points towards the importance of counselling services effectively informing the wider school community about their work; and also the value of involving young people in the development and evaluation of services, so that they can help to advise on strategies to develop self-referral routes. At the same time, however, there may be issues of resource limitations: with counsellors (and/or their schools) concerned about publicising the counselling service too widely, out of fears that an already over-subscribed service would become ‘swamped’ by demand (Cromarty, personal communication, 2012).

Increasing equity of access for young people from BME backgrounds

From an equity of access perspective, it is a concern that young people from BME – and particularly Asian – backgrounds are under-represented in those attending school-based counselling. This is a particular concern given that membership of such ethnicities is a risk factor for developing mental health disorders [5]. It is not clear why this is the case, but is an issue that needs to be addressed, and one that would benefit from input from BME young people themselves. Interestingly, one study found that the under-representation of young BME people was reversed with online counselling [12]: a finding that requires replication, but which may point, again, to the need for counselling services to offer a range of modalities of interventions.

Increased choice of interventions

Although some school-based counsellors offer a range of interventions beyond one-to-one counselling, this is not always the case, and the therapeutic provision offered to students is likely to be very dependent on the counsellor’s initial training and/or current interests. This limits the possibility for client choice, and means that some young people are less likely to engage with – and gain from – the therapeutic process, as it will not suit their personal preferences and needs. For instance, there is evidence that some young people want a style of counselling that is more interactive and directive than their counsellor has provided. Indeed, research suggests that, across both young people and other stakeholder groups, there does tend to be an appreciation of – and preference for – school-based counselling

¹⁴ funkydragon.org

services that offer a wider array of interventions beyond the one-to-one counselling format. Moreover, there is evidence to suggest that mental health and wellbeing interventions are more helpful when a 'whole school' approach is adopted, which targets interventions at the wider school context and the groups within it, rather than just the individual young person's problems and needs [5, 7]. Clearly, the extent to which counsellors can expand their services will be highly dependent on the resources available – with just one or two days per week, they may feel it is difficult to offer more than just one-to-one interventions – but there may also be issues here of training, and of how the school-based counsellor role is conceptualised. This is an area, again, where participation of young people in the development of services would be very helpful, to help ensure that the services are providing the kinds of interventions that young people are specifically wanting.

Developing coordinated care strategies

With respect to specialist CAMHS, school-based counsellors, and to some extent professionals in the wider field, indicate that they are generally satisfied with levels of coordination and communication. However, this is not always the case; and there is limited evidence of local protocols for ensuring integrated, seamless, and appropriately stepped pathways of care between school-based counselling and other CAMHS. For instance, when should a young person be referred from school-based counselling to specialist CAMHS, and when might it be appropriate for a young person to be referred in the opposite direction? Similarly, when might it be appropriate for a school nurse refer a young person to a school-based counsellor, when to a specialist CAMHS, and when would it be most appropriate for them to work with the young person themselves? Without such referral pathways in place, there is a danger that young people requiring specialist services may not be referred onwards as needed; or that young people who may benefit from school-based counselling will not be referred in to this provision. In addition, developing more integrated relationship between specialist CAMHS and school-based counselling would help to ensure that protocols on such issues as confidentiality and child protection are mutually understood. Where frustrations do arise between school-based counsellors and allied professionals – including teachers and social workers – it seems primarily related to unclear procedures around disclosure of information, and what is appropriate to be shared by whom. Further communication across professions at a local level is likely to be helpful in ensuring a greater transparency and mutual understanding of roles.

In terms of integrated mental health provisions, it would also be useful to consider how school-based counsellors could become more involved with school-based mental health programmes, such as the school-wide (wave 1) and skills-focused small group intervention (wave 2) that were developed as part of the Targeted Mental Health in Schools (TaMHS) programme [58, 59].

CURRENT DEVELOPMENTS

At the present time, there are a number of significant developments in the school-based counselling field that may go some way to addressing the limitations identified above.

Competences for counselling young people

An evidence-based competency framework for counselling young people – both in schools and in the wider community – is currently being developed by the British Association for Counselling and Psychotherapy (BACP) in association with Professor Tony Roth of University College London. This follows the methodology used to

develop competency frameworks for CBT and other psychological therapies [e.g., 60], in which the required skills and understandings are extracted from therapies of demonstrable effectiveness, as well as from clinical expert knowledge. The development of this competency framework, which will then be able to act as the basis for an accredited curricula for counselling young people, should increase the extent to which school-based counsellors are delivering an evidence-based intervention. In addition, the competences for counselling young people, drawing on the CAMHS competences developed by Roth, Calder and Pilling [61], will include skills in a number of the areas highlighted above, including effective integration of outcome and process monitoring, service user involvement, supporting self-referrals, educating other professionals on appropriate referrals in to counselling, and ensuring equality of access into services. In this respect, the development of these competences should help to address a range of limitations that currently exist in the school-based counselling field.

CYP IAPT

The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme, included in the Department of Health's *Talking Therapies: A four year plan of action*, is a four year service transformation project which began in 2011 working with existing specialist CAMHS. The programme focuses on client-guided, outcome-orientated, evidence-based practice with a strong emphasis on participation of children and young people. In 2012, the project received extra funds which has allowed it to develop a workstream to support counselling children and young people, including the appointment of a National Advisor for Counselling for CYP IAPT. A particular significance of this development is that it has brought counselling, both school-based and non-school-based, into a unified initiative with specialist CAMHS, which has the potential to support the development of more coordinated care strategies. More directly, it also provides a support system for school-based counselling to develop its service delivery in a client-guided, outcome-orientated, evidence-based and participatory direction. An important element of this will be the development of e-learning resources for counsellors.

CYP-MindEd for Counselling

In February 2012, the Department of Health (DH), England, announced funding to develop 'evidence based e-Learning packages to train school and youth counsellors and supervisors working in primary, secondary, tertiary and community settings, as well as the independent sector'. This was as part of a wider initiative to develop an internet-based learning resource for all professionals in England and the UK working with children and young people: the CYP-MindEd e-portal. BACP have been commissioned to undertake the counselling strand of this work, with the National Advisor for Counselling for CYP IAPT acting as Clinical Lead. The programme is due for completion in 2014, and will produce a range of accessible and engaging e-learning modules that will support counsellors working with young people in achieving the evidence-based competencies necessary for this work (see above): including outcome monitoring and service user participation. In addition, a key element of this e-portal resource is likely to be focused on helping professionals to identify specific mental health presentations; which should support school-based counsellors in referring onwards to more specialist CAMHS. As much of the CYP-MindEd material is likely to be common across counsellors and other professionals, this also creates further opportunities to develop shared understandings of protocols, procedures and roles, and to develop more coordinated and integrated pathways of care across the various provisions. Finally, some elements of the e-learning resources will be 'outward facing': informing young people, their parents or carers, and other professionals about the various services that are on offer. This should help young people and their parents and carers to understand more about counselling;

and also school staff and other allied professionals to know when a referral in to school-based counselling service may be appropriate.

Accreditation

Currently, both BACP and CYP IAPT are considering accreditation structures for counsellors working with children and young people. This has the potential of incentivizing counsellors to achieve the necessary competences for this work and, in association with commissioner-focused programmes like BOND (Better Outcomes, New Delivery¹⁵), has the potential to ensure that schools are employing counsellors with the necessary levels of knowledge and skills.

CONCLUSION

School-based counselling is one of the most widely delivered forms of psychological therapy for young people in the UK, and there is a need for all professionals working with child and adolescent mental health issues to understand the current nature and status of this provision. Although, to a large extent, this resource has emerged independently of other mental health and emotional wellbeing services for young people, the research suggests that it is highly valued by young people and those involved in their care, and appears to be producing positive effects. From the standpoint of a contemporary mental health agenda, the strength of school-based counselling is that it can provide an easily accessible mental health intervention for any young person struggling with difficulties in their lives, and particularly those who may have no-one else to turn to. This suggests that commissioners, if they have not already done so, should give full consideration to the utility of a school-based mental health provision as part of an integrated package of support services for young people (see actions for consideration, below). As the evidence indicates, having access to emotional wellbeing expertise in a school context can play a very valuable role and has the potential, if implemented systematically, to improve the mental health and emotional wellbeing of young people in the UK.

At the same time, there is much that the field of school-based counselling can learn from recent developments in child and adolescent mental health policy and practice, in terms of developing a more evidence-based, outcome- and user-informed approach. Current developments in the field may be able to achieve this, but there is also a need for more work within the field itself – as well as amongst allied professionals – to maximise the potential of school-based counselling to contribute to a seamlessly integrated package of mental health care for young people in the UK.

¹⁵ youngminds.org.uk

ACTIONS FOR CONSIDERATION

Based on this review and analysis, the following action points are proposed for professionals working in the field of young people's mental health.

Statutory sector commissioners

- When reviewing CAMHS as a whole, consider how young people access support across a range of settings, including young people presenting with life difficulties in schools.

Commissioners working with, or for, schools

- Consider how school-based provision, including counselling, can assist the whole school to build resilience and improve behaviour, attainment and psychological wellbeing.

NHS services

- Consider how colleagues delivering counselling interventions in schools can integrate into local care pathways.

School-based counselling practitioners and service managers

- Consider the importance of demonstrating robust outcomes and putting them in place.
- Consider means of communicating more explicitly what it is that counselling can offer (and what it cannot offer), to whom, and how.
- Ensure that young people from BME backgrounds have equity of access.
- Consider broadening the range of interventions offered to young people.
- Consider greater involvement of young people in developing services.
- Consider means of developing routes of self-referral.
- Consider means of developing shared referral protocols with specialist, and other, CAMHS.
- From 2014, individual practitioners should consider undertaking the CYP-MindEd modules as continuing professional development.
- From 2014, individual practitioners should consider accreditation of their practice through BACP/CYP IAPT structures.

Course leaders/trainers for counselling young people

- Consider adopting, and incorporating, the BACP competences for counselling young people into your curriculum.
- Review the E-Learning for Counselling on-line modules and consider incorporating into your curriculum.

Academics in the counselling and psychotherapy field

- Consider undertaking research that can:
 - describe the processes by which school-based counselling may be helpful;
 - assess the long-term effectiveness and cost-effectiveness of school-based counselling;
 - evaluate the effectiveness of alternative and potentially enhanced school-based counselling interventions;
 - help to understand why young people from BME backgrounds are under-represented in those utilising school-based counselling, and what can be done to overcome this.

GLOSSARY, ABBREVIATIONS AND ACRONYMS

(Glossary entries are adapted from Cooper, M. (2008) *Essential Research Findings in Counselling and Psychotherapy: The facts are friendly*. London: Sage; and from Hill et al.'s [12] *Evaluation of the Welsh School-based Counselling Strategy*.)

BACP: British Association for Counselling and Psychotherapy.

BME: Black and Minority Ethnic background.

CAMHS: Child and Adolescent Mental Health Services. For the purpose of this paper, the term 'specialist CAMHS' is used to refer to NHS-based, statutory provision; while CAMHS, per se, refers to all child and adolescent mental health services, including school-based counselling and third sector provision.

CYP: Children and Young People.

CYP IAPT: Children and Young Person's Improving Access to Psychological Therapies programme.

Cognitive-behavioural therapy (CBT): A range of techniques and therapies that try to produce change by directly influencing thinking, behaviour or both.

Control group: A group of individuals with characteristics similar to those in the 'experimental group', but who do not participate in the procedure being tested.

Counselling: An umbrella term, like psychotherapy, that covers a range of talking therapies. It is delivered by a trained practitioner who works with people over a short or long term to help them bring about effective change or enhance their wellbeing.

CPD: Continuing professional development.

Effectiveness: The extent to which an intervention, when used under ordinary circumstances, brings about a desired effect.

Effect size: A standardised measure of the strength of relationship between two variables (for the purposes of this paper, used synonymously with Standardised Mean Difference). Within the social sciences, an effect size of 0.2 is normally defined as 'small,' 0.5 as 'medium' and 0.8 as 'large'.

Emotional wellbeing: 'A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment' [5].

Episode (of counselling): A complete series of sessions of counselling undertaken by a client, equivalent to a 'case'.

Humanistic: A family of psychological therapies that place particular emphasis on establishing a warm, understanding relationship with clients such that clients can come to uncover, and express, their true thoughts and feelings.

IAPT: Improving Access to Psychological Therapies Programme.

Integrative therapies: Forms of therapeutic practice that draw on a range of different orientations.

Meta-analysis: A statistical procedure which pools findings from different studies to estimate overall effects.

Mental health: A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' [5].

Link teachers: Members of the teaching staff in a school who hold responsibility for the implementation and delivery of the school-based counselling.

Looked after children: Children who are cared for by the state, either as part of a voluntary arrangement or as the result of a care order.

Moods and Feelings Questionnaire (MFQ): 32-item questionnaire based on DSM-III-R criteria for depression.

NICE: National Institute for Health and Clinical Excellence.

Non-directivity: A therapeutic stance in which the practitioner tries to refrain from directing his or her client in any particular way.

Non-directive supportive therapy (NDST): 'This therapy involves the planned delivery of direct individual contact time with an empathic, concerned and skilled non-specialist CAMHS professional to offer emotional support and nondirective problem solving as appropriate and to review the child or young person's state (for example, depressive symptoms, school attendance, suicidality, recent social activities) in order to assess whether specialist help is needed [62].

Participation: 'A process where someone influences decisions about their lives and this leads to change' [3].

Pastoral care teachers: Teachers with a specific responsibility for the personal, and social development of a cohort of students. Can also be referred to as 'guidance teachers' or 'pupil support teachers'.

Person-centred: A form of humanistic therapy that puts particular emphasis on allowing the client to take the lead ('non-directivity'), in a relationship that is accepting, empathic and genuine.

Process-outcome research: Research that looks at the relationship between particular processes in therapy, such as the quality of the therapeutic relationship, and its outcomes.

Psychodynamic: A family of psychological therapies which aim to help clients develop a greater awareness and understanding of the unconscious forces determining their thoughts, feelings and behaviours.

Psychological distress: 'The unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person' [63].

Randomisation: The process of assigning research participants to treatment or control conditions by chance, to minimise the likelihood of systematic differences between groups.

Relational therapies: Counselling and psychotherapeutic practices, including most humanistic, integrative and psychodynamic orientations, which consider the client-therapist relationship the primary vehicle for therapeutic change, as opposed to the specific techniques that the therapist deploys.

Randomised Controlled Trial (RCT): (Aka randomised clinical trial) An experimental study in which participants are randomly assigned to two or more groups, such that the efficacy of the different interventions can be identified.

Recovery model: An approach to mental health treatment which aims to support people to find meaning in their lives, hope, control, and have a quality of life despite serious mental illness.

School-based counselling: 'a professional activity delivered by qualified practitioners in schools. Counsellors offer troubled and/or distressed children and young people an opportunity to talk about their difficulties, within a relationship of agreed confidentiality.'

School-based humanistic counselling: A recently developed, manualised distillation of UK school-based counselling practices which is based on the competences required to deliver effective Humanistic Psychological Therapies developed by Roth, Hill and Piling [30], and audited using the Person-centred and experiential psychotherapy scale (PCEPS) [64].

Session (of counselling): A specific meeting with a counsellor, normally of around one hour's duration. Generally held on a weekly or fortnightly basis.

Significant differences: A meaningful and important difference between two or more groups that is unlikely to be due to chance variations.

Solution-focused Therapy: A contemporary therapeutic approach that uses a range of strategies to help clients focus on strengths and solutions rather than problems.

Strengths and Difficulties Questionnaire (SDQ): a measure of psychological distress in young people with self-, parent- and teacher-completed versions.

Targeted Mental Health in Schools (TaMHS): 'A government programme that aimed to help schools deliver timely interventions and approaches in response to local need that could help those with mental health problems and those at increased risk of developing them (including looked after children)' [58].

Young Person's CORE (YP-CORE). A widely used measure of psychological distress for 11 to 16 year olds.

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APPENDICES

Appendix 1. Calculation of prevalence of school-based counselling in the UK

Total secondary schools:

- England = 3,088 [11]
- Scotland = 425 [11]
- Northern Ireland = 217¹⁶
- Wales = 223¹⁷.

Percentage of secondary schools providing access to counselling:

- England = 61--85% [11]
- Scotland = 64--80% [11]
- Northern Ireland = 100%
- Wales = 100%.
-

Estimated number of secondary schools providing access to counselling (using minimum percentages):

- 1,884 (England)
 - 272 (Scotland)
 - 219 (NI)
 - 223 (Wales)
- = 2,596.

Estimated number of secondary schools providing access to counselling (using maximum percentages):

- 2,625 (England)
 - 340 (Scotland)
 - 219 (NI)
 - 223 (Wales)
- = 3,405.

In 90% of schools, services are specifically school-based [11] = 2,336 (minimum schools in UK), 3,065 (maximum schools in UK); 1,696 (minimum schools in England), 2,363 (maximum schools in England).

Based on previous research [21, 36], counselling service of 1-2 days/week provides approximately 10 episodes of counselling/term = 30 episodes/year.

Total episodes of school-based counselling/year in UK (minimum)

$$= 2,336 \times 30 = 70,080.$$

Total episodes of school-based counselling/year in UK (maximum)

$$= 3,065 \times 30 = 91,950.$$

Total episodes of school-based counselling/year in England (minimum)

$$= 1,696 \times 30 = 50,880.$$

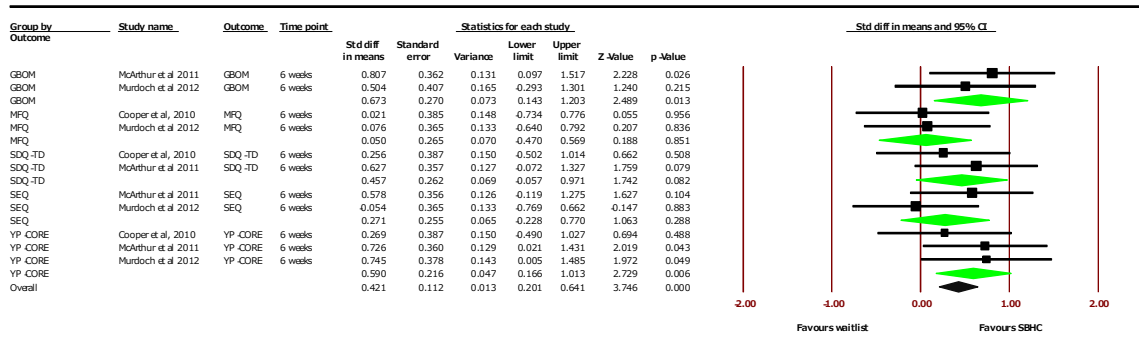
Total episodes of school-based counselling/year in England (maximum)

$$= 2,363 \times 30 = 70,890.$$

¹⁶ nisra.gov.uk/publications/default.asp6.htm

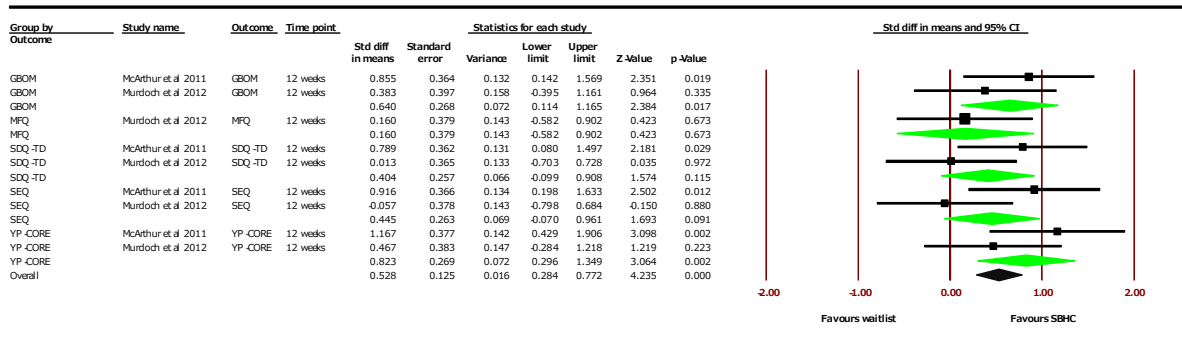
¹⁷ en.wikipedia.org/wiki/Education_in_Wales

Appendix 2: Meta-analysis of effects for school-based humanistic counselling at 6 weeks: data from Cooper et al. (2010), McArthur et al. (2012), and Murdoch et al. (2012) (adherent counsellors only)



Note. GBOM = Goal-based Outcome measure, MFQ = Moods and Feelings Questionnaire, SDQ-TD = Strengths and Difficulties Questionnaire – Total Difficulties, SEQ = Self-esteem Questionnaire, YP-CORE = Young Person's CORE. Std diff in means = effect size (ES, Cohen's *d*) = difference in means at 6 weeks for SBHC group vs. waiting list group / pooled standard deviation. Overall ES presented in figure assumes independence of means, and is less accurate than combined ES presented in report of 0.41

Meta-analysis of effects for school-based humanistic counselling at 12 weeks: data from Cooper et al. (2010), McArthur et al. (2012), and Murdoch et al. (2012) (adherent counsellors only)

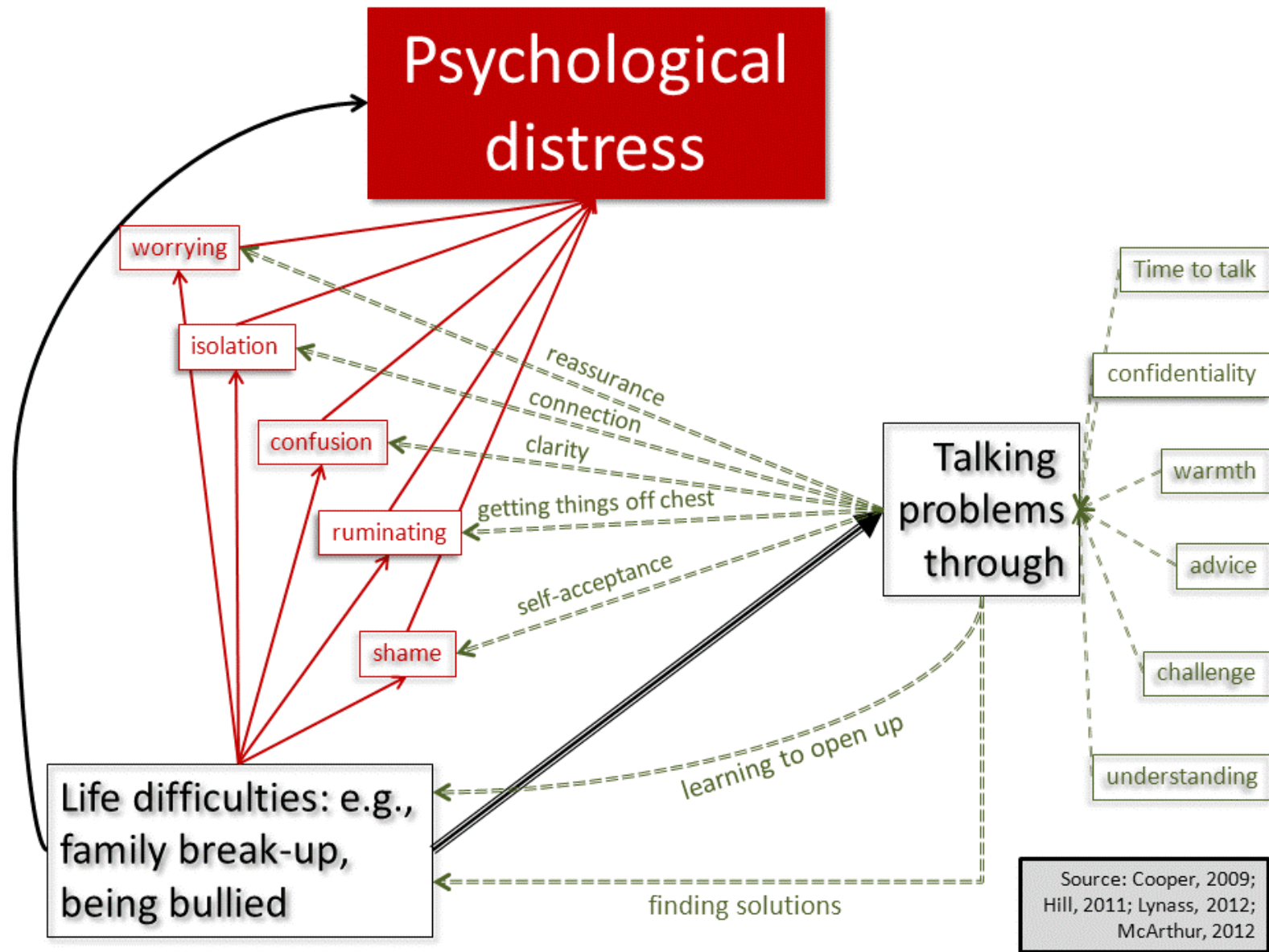


Note. GBOM = Goal-based Outcome measure, MFQ = Moods and Feelings Questionnaire, SDQ-TD = Strengths and Difficulties Questionnaire – Total Difficulties, SEQ = Self-esteem Questionnaire, YP-CORE = Young Person's CORE. Std diff in means = effect size (ES, Cohen's *d*) = difference in means at 12 weeks for SBHC group vs. waiting list group / pooled standard deviation. Overall ES presented in figure assumes independence of means, and is less accurate than combined ES presented in report of 0.58.

Appendix 3: A model of helpful processes in school-based counselling

As indicated in the report, there are no clear models for how school-based counselling actually helps young people and reduces psychological distress. Based on the evidence reviewed in this paper, the following model is proposed, and diagrammatised in the subsequent page:

1. When young people experience difficulties in their life, such as a family break-up or a bereavement, they may experience a range of 'primary' feelings that reduce their emotional wellbeing: e.g., loss, unhappiness and worry.
2. In addition, the existence of these difficulties, and this distress, can generate a range of 'secondary' feelings, which may be highly distressing in themselves. For instance:
 - a. Worrying that it will not be possible to resolve things
 - b. Overwhelmed
 - c. Ruminating
 - d. Feeling abnormal
 - e. Feeling isolated and alone
 - f. Confusion
 - g. Feeling burdened/weighed down
 - h. Feeling shame, guilt and bad about themselves.
3. Through talking openly and honestly about their problems -- and particularly by articulating their real feelings, wants and experiences -- a young person may come to find positive ways of addressing their life-difficulties. This should then reduce the primary distress that they are experiencing.
4. Even though it may be difficult for a young person to resolve their primary difficulties, the opportunity to talk about them openly and honestly may still reduce the secondary feelings of distress. For instance:
 - a. They may feel less isolated and alone with their difficulties
 - b. It may help them get perspective on their problems and feel less overwhelmed by them
 - c. They may get greater clarity on them, and feel less confused
 - d. It may help them to get them 'out' and 'off their chest'
 - e. They may come to feel more accepting of themselves
5. The process of talking openly and honestly to another person is most likely to be facilitated if the 'listener':
 - a. Provides the young person with enough time to talk
 - b. Has the skills to help the young person bring out their difficulties and talk honestly about their experiences
 - c. Reassures the young person that what they say will not be shared with others (confidentiality), unless it absolutely has to be
 - d. Is warm, friendly and non-judgmental
 - e. Offers suggestions advice, where helpful and appropriate
 - f. Offers supportive challenges to the young person
 - g. Conveys an empathic understanding of how the young person experiences their world
 - h. Supports the young person to stay focused in talking about their problem.



Source: Cooper, 2009; Hill, 2011; Lynass, 2012; McArthur, 2012