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Evaluating the effectiveness of a school-based counselling service in the UK

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## Abstract

Despite the growth of school counselling in the UK, very few studies have examined its effectiveness. As part of a wider evaluation of the work of the NSPCC Schools Counselling Project, 219 pupils aged 11-17 years completed the TEENCORE questionnaire before receiving counselling; 104 of these pupils also completed a questionnaire after counselling and a further 29 also completed a questionnaire three months after the end of counselling. The study found that the mean TEENCORE score after counselling was significantly lower compared to the mean score before counselling, indicating fewer problems / less distress. Analysis of the data collected after three months ( $n = 29$ ) suggests that this treatment gain was maintained at follow-up. This is evidence to suggest that school counselling is effective, but this paper argues that further research is needed to identify when and for whom it is most effective.

Over the last ten years there appears to have been a re-growth in school-based counselling services in the UK, although provision is still patchy (see Polat, 2005). As noted by Baginsky (2003), counselling in schools in the UK developed momentum in the 1960s in response to the Newsom Report ([Central Advisory Council for England, 1963](#)), which recommended the appointment of school counsellors, with growth continuing through the 1960s and into the 1970s. Specialist courses for practitioners, such as those at the Universities of Keele and Reading supported this growth in provision. However, there was a decline in the 1980s and 1990s, which has since been attributed to a lack of co-ordination (Lang, 1999), a failure to embed counselling into the culture of schools and a lack of monitoring (Robinson, 1996) (see Baginsky, 2003 for a brief historical overview). The growth that has been observed in the last 10 years seems likely to continue in the context of the current drive towards the improved integration of services of children and young people. The prominence of schools in the delivery of services can be seen in the Extended Schools Initiative (Children Act, DfES, 2004) as part of the move towards establishing Children's Trusts by 2008. A recent survey found that 71% of schools now claim to offer 'therapeutic individual counselling', although provision at present is rather patchy, ad-hoc and demand-led (see Jenkins & Polat, 2006).

The provision of school-based counselling remains contested, however. For example, there are undoubtedly some who still believe that it conflicts with the primary educational mission of the school (see Jenkins & Polat, 2006, for results of a recent school survey). School based counselling services also have many advocates (see Barwick, 2000; Baruch, 2001). Barwick notes how a whole range of issues affect and invade the lives of young people (e.g. bullying, bereavement, family division) and these issues disrupt school life and hinder learning. Baruch points to research which suggests that although a large percentage of children and young people experience mental health problems, only a minority are referred to specialist mental health services. There are also many advantages to locating mental health

services in schools such as: 1) normalising service provision, 2) enabling generalisation of treatment effects to beyond the clinical setting, 3) ensuring that young people's problems are assessed more accurately, and 4) making it easier to carry out preventative work, to ensure that problems are tackled before they become pathological (Baruch, 2001).

In a previous paper we reported on a survey of young people's views of school counselling within the UK, conducted as part of a National Evaluation of the NSPCC Schools Counselling Teams (Fox & Butler, 2007). Analysis of the survey responses and focus group data revealed that young people do seem to value having someone else to turn to. However, problems were identified with the scheme including a lack of awareness and issues of stigma (particularly for boys). In the present paper we present our analysis of data collected using the TEENCORE questionnaire, to evaluate the *effectiveness* (outcomes) of the school-based counselling provision.

Although many studies have evaluated the effectiveness of counselling and psychotherapy with children and young people (see Casey & Berman, 1985; Weisz et al, 1987; Weisz et al, 1995 for meta-analytic reviews), very few studies have focused on school-based counselling and only one study, to our knowledge, has been carried out in the UK. It is important to note that there are important differences between the nature and structure of school counselling in the UK and school based therapeutic services in the USA, where most research has been conducted. In the USA, most public schools have a part-time school psychologist, who, among other things, does provide mental health interventions. Most schools also have access to a 'school counsellor' who provides individual and group counselling interventions, as well as classroom guidance (Wiggins & Moody, 1987), but the amount of this service provision varies. In the 1990s, school-based mental health services were introduced in some areas, with teams of mental health professionals providing a range of services, including individual and group therapeutic work with the children themselves

(particularly those 'at risk') and work with their parents and families (see Catron et al, 1998, for an example of one such programme).

The situation in the UK is very different in that relatively few schools have a school counsellor and in those that do, there are differences in whether or not the counsellor is full-time or part-time, employed by the school or contracted in from an outside agency, and whether or not the counsellor is also a teacher at the school (see Polat, 2005). Anecdotal evidence suggests that, for the majority, their role is fairly independent, in that they are not part of a 'mental health team' or team of school counsellors (although they may work very closely with other school staff). One-to-one counselling with the children and young people is much more common than group-work and work with parents and families. Schools do, of course, have access to educational psychology services, but therapeutic one-to-one work is not typically provided as part of this.

Several meta-analytic reviews of the effectiveness of school counselling have been carried out over the years, which have mainly drawn on studies conducted in the USA. Prout and Prout (1998), for example, focused on 17 studies over a 10 year period (1985-1994). Studies were either conducted in a school setting or with a school-related problem and only studies that used a control group were included in the meta-analysis. Thus, pre-post comparison studies were not included. With an overall effect size of 0.96, their findings supported the use of school-based counselling and psychotherapy, particularly group interventions (which made up 20 of the 25 treatments that were used in the analysis). Effect size refers to the magnitude of the difference between two or more conditions with 0.20 considered small, 0.50 medium and 0.80 large (Cohen, 1988).

A small-scale study of a counselling intervention in primary schools in London had the somewhat ambitious aim of identifying changes on both emotional *and* educational parameters (Sherr & Sterne, 1999). 24 children who attended 50 minute weekly counselling

sessions during term-time were compared with a comparison group of children who were selected at random ( $n = 25$ ). Unfortunately, despite using a range of outcome measures, the only difference identified at post-test was that the intervention group children were significantly less worried at school (assessed using a single item), compared to pre-test and in comparison to the control group children.

This paper presents findings from an evaluation of school counselling provision in 13 NSPCC Schools Teams (spread across England, Wales and Northern Ireland) that were examined during the period January 2001-July 2003. At the time of the evaluation, each team typically included 5-6 counsellors or social workers, headed by a Manager, and each worked with approximately 10 local schools (both primary and secondary). In order to make judgements about the effectiveness of school counselling, the project employed the use of the TEEN CORE questionnaire, at point of entry and exit from the counselling service offered by the Schools Teams<sup>1</sup>. Using a pre-test, post-test comparison design, data were collected before counselling, after counselling and at three month follow-up. It was predicted that the young people would report fewer problems, would be less distressed and functioning better after receiving counselling ('post'), compared to before ('pre'). We further predicted that this treatment gain would be maintained at three month follow-up.

## Method

### *Participants*

A total of 219 pupils (90 males and 124 females, 5 unknown) aged 11 – 17 years, completed the TEENCORE questionnaire before ('pre') counselling (*mean age* = 13.24 years, *SD* =

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<sup>1</sup> The TEEN CORE is a 14-item questionnaire used to assess global distress in children and young people (aged 11-18 years). ~~It was subsequently replaced by the YP-CORE. Both questionnaires~~ ~~It was/were~~ adapted from the CORE system, developed by the Psychological Therapies Centre at the University of Leeds ~~(NB: the centre closed in March 2008). A new and improved version of the questionnaire (YP CORE) is now available, based on extensive research carried out during the development phase. For details, contact the Psychological Therapies Centre (University of Leeds).~~

1.44). 104 of these pupils also completed a questionnaire after ('post') counselling. Common reasons given by counsellors for missing 'post' data were as follows: pupil refused, pupil excluded, pupil stopped attending, pupil's long-term absence. A smaller number of these pupils ( $n = 29$ ) also completed a questionnaire three months after the end of the counselling ('follow-up'). See Table 1 for the breakdown of participants by sex and age. The mean number of sessions was 7.58 ( $SD = 4.73$ ).

In total, 24 practitioners forwarded this data to the research team (19 counsellors and 5 social workers working as counsellors). 18 of these practitioners forwarded both pre and post data (14 counsellors and 4 social workers). In terms of the number of cases (participants with pre and post data) generated by each counsellor, the range is 1-18 with a mean of 5.78 ( $SD = 4.82$ ). Two counsellors in particular, generated a large number of cases. Taken together, they were responsible for generating 33% of the data set ( $n = 16$  and  $n = 18$ ). As a consequence, we would acknowledge a particular response bias and the possibility that these data are not necessarily representative of the work of all of the Teams. Separate analyses not including the data from these two counsellors will be reported below. The period of data collection spanned 19 months (from January 2001 – July 2003). All of the counsellors worked primarily in a person-centred way, drawing on other therapeutic approaches as appropriate (e.g. cognitive-behaviour therapy). Similarly, the social workers used a wide range of *counselling skills*, as well as other more practical, problem-focused activities if appropriate for the young person. The counsellors were asked to consider using the TEENCORE with all clients aged 11-18 years<sup>2</sup>.

### *Materials*

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<sup>2</sup> The TEENCORE was also used with some children aged 9 and 10 years of age at the request of the Schools Teams. However, as the questionnaire was not developed for this age-group this data were not included. We have pre-post data for 12 children aged 9-10 years.



The TEEN CORE is a 14-item questionnaire used to assess global distress in children / young people (aged 11-18 years). The mean of the 14 items can be used as a global index of distress. Mean item scores for the domains of well-being, problems / symptoms and life functioning can also be used separately. The items are scored using a 5-point rating scale (0 – 4), with a high score indicating more problems / greater distress. The total mean score is calculated by dividing the total score by the number of completed items.

The TEEN CORE was adapted from the CORE System, developed by the Psychological Therapies Research Centre (University of Leeds). The CORE System is used widely within the NHS to assess the impact of counselling / psychotherapy with adults. The CORE System has been found to be both reliable and valid. In addition, it has been found to be acceptable to both clients and therapists and is sensitive to change (see Evans et al, 2000). At the time of the present study, the TEEN CORE was being piloted at a number of sites in the UK. The fact that it was being used in a number of other studies in the UK was seen as an advantage; a critical problem in the evaluation of counselling / psychotherapy is the large number of one-off measures used and this makes comparisons with other studies difficult. Other reasons for choosing the TEENCORE were that it is brief, user-friendly, and is acceptable to both clients and therapists (this is partly because it is brief, and also because of the mixture of positive, as well as negative questions). Based on the findings of the development phase of the CORE System, we were confident that the TEENCORE would be shown to be both reliable and valid (and sensitive to change). With our sample of children and young people, the questionnaire demonstrates acceptable internal reliability. The Cronbach's alpha using all 14 items is 0.78. Analysis of the factor structure of the questionnaire, using principal components analysis, did not support use of the three sub-scale scores.

### *Procedure*

The counsellors were asked to administer the TEEN CORE in the first session, or the second session if necessary (but not beyond the second session). The second administration (i.e. the 'post' measure) was in the final session (or if this was not possible, as soon as possible thereafter). The counsellors were required to complete certain details on the reverse of each questionnaire (e.g. sex, age, date, stage completed, and some ID numbers). They were also asked to complete two covering forms in order to collect data on source of referral, reason for referral, and number of sessions. Each young person was asked to complete the questionnaire on their own, place the completed questionnaire in an envelope and seal it before handing it back to the counsellor. Those children who provided pre and post data, and who gave their permission, were sent a third questionnaire three months after their final session, via the counsellor. In a covering letter the young people were asked to complete the questionnaire and send it back to the research team using the stamped addressed envelope provided.

*Ethical issues.* Counsellors were asked to use their discretion in whether or not to ask their client to complete the TEEN CORE questionnaire, for example, it would be inappropriate to ask a young person who was extremely distressed at Time 1 to take part. All of the young people were provided with an information sheet telling them about the study and how it fitted into the wider project. They were informed that they did not have to take part if they did not want to, that their name would not appear on the questionnaire, and that only the research team would have access to their questionnaires. Photographs of the research team were included on the information sheet. For young people for whom parental consent was deemed necessary for the counselling (by the counsellor), counsellors were asked to inform parents / guardians about the evaluation at the same time and gain their consent for the research.

## **Results**

### *Descriptive Statistics: Source of Referral and Presenting Problem*

Table 2 shows that the two main sources of referral were ‘self’ and ‘teacher’. From examination of the percentages, it can be seen that there were some differences between males and females. For females, there were more self-referrals, than teacher, parent and other referrals (self-referrals accounting for 65% of the referrals for females, 32% for males). In contrast, for males, there were more teacher referrals (49% compared to 27% for females).

Two age categories were devised using a median split; 11-13 year olds ( $n = 117$ ) and 14-17 year olds ( $n = 89$ ). In terms of age differences, it can be observed that there were more self-referrals for 14-17 year olds, compared to the younger age group (59%, compared to 44%).

The main presenting problem (this was assessed using the Schools Teams’ categorisation framework – see Table 3 for details) was family relationships. Table 3 also shows some differences between males and females. It seems that for males, school issues were more common reasons for referral, compared to females (36% / 13%). For females, family relationships (in particular), and health issues were more common (than males). Some age differences can also be observed. For the 11-13 year olds, school issues were more common, compared to the older children (31% / 9%). For the 14-17 year olds, other relationships were more common, compared to those aged 11-13 years (24% / 14%).

### *TEEN CORE scores*

*Sex and Age Differences.* An unrelated  $2 \times 2$  ANOVA was conducted to examine sex and age differences in the degree of distress and magnitude of personal problems as indicated by the TEENCORE scores (see Table 4 for the means and standard deviations). There were no main effects for sex or age ( $F(1,201) = 3.09, p < .08$ ;  $F(1,201) = 3.18, p < .08$ ), although these were approaching significance. From examination of the means it can be seen that the mean

score for the females was slightly higher than the mean score for males. Table 4 shows that the mean score of the 14-17 year olds was slightly higher than the mean score for the 11-13 year olds.

*Pre and Post Counselling.* The ‘pre’ TEEN CORE scores of those pupils who completed the questionnaire before and after counselling ( $n = 104$ ) were compared with the scores of those pupils who provided ‘pre’ data only ( $n = 115$ ) (the means are 2.00 and 1.94 respectively). An unrelated t-test found no significant difference between the mean scores ( $t = 0.66$ ,  $df = 217$ ,  $p > .05$ ). This suggests that there were no significant differences between those who provided pre data only and those who provided pre and post data. In other words, those who provided both pre and post data, were not more or less distressed, compared to those pupils who completed a questionnaire before counselling only.

A related t-test was used to compare the TEEN CORE scores before and after counselling. The difference between the two means was found to be statistically significant ( $t = 8.81$ ,  $df = 103$ ,  $p < .001$ ). See Figure 1 for a graphical illustration of the difference between the two means. The figure shows that the mean score after counselling was significantly lower compared to the mean score before counselling. The effect size (which refers to the magnitude of the difference between groups) was .85, which, according to Cohen (1988) is ‘large’. An unrelated  $2 \times 2$  ANOVA using the mean difference scores found that there were no sex or age differences (mean difference = ‘post’ score subtracted from the ‘pre’ score). This means that the outcome did not vary depending on sex or age (see Table 5 for the means and standard deviations).

A separate t-test was conducted for the sample minus those young people who engaged in counselling with the counsellors who, together, provided 33% of the data set. Even with a reduced sample size ( $N = 70$ ), the difference from pre to post counselling was

significant ( $t = 7.00$ ,  $df = 69$ ,  $p < .001$ ), with the mean score after counselling being significantly lower than before ( $M = 1.14$ ,  $M = 1.95$ ).

*Pre and Post Counselling and Follow-up.* The mean TEEN CORE scores before, after counselling, and at three-month follow-up were analysed using a one-way related ANOVA. This test revealed a significant difference with  $F(2, 56) = 12.73$ ,  $p < .001$ . Follow-up t-tests confirmed that there were significant differences between the pre and post scores ( $t = 3.89$ ,  $df = 28$ ,  $p < .001$ ) and the pre and follow-up scores ( $t = 4.04$ ,  $df = 28$ ,  $p < .001$ ). There was no significant difference between the post and follow-up scores ( $t = .23$ ,  $df = 28$ ,  $p > .05$ ). The three means are displayed graphically in Figure 2. The figure shows the decrease in the scores from before to after counselling. There is only a slight difference between the means after counselling and at three-month follow-up. This suggests that the pre-post treatment gain was maintained at follow-up.

## **Discussion**

As noted by Kazdin (2000), '*The most fundamental question about therapy is whether it works*' (p. 55). Research into the effectiveness of counselling and other forms of child psychotherapy is certainly not new; over the past few decades a number of meta-analytic reviews have brought together the findings of studies with both children and adults, mainly in a clinical setting. However, as noted above, very few studies have examined the effectiveness of school-based counselling services, especially in the UK.

Given the likelihood that school counselling provision will continue to grow within the UK, it is important that rigorous evaluations are conducted to evaluate its effectiveness. To date, most studies have been conducted in the USA where therapeutic provision in schools is very different. UK based studies have been fewer in number and have been hampered by

problems of small sample size. Furthermore, we cannot simply generalise from those studies which have examined the effectiveness of school counselling and psychotherapy with children in a clinical setting to school-based counselling provision.

This paper provides evidence, specifically in a UK context, to suggest that school counselling is effective, based on the data collected before and after counselling. In addition, there is evidence from this relatively small sample of children that this progress is sustained in the medium term. The findings also show that despite initial sex and age differences, the pre-post outcome did not vary depending on sex and age.

Certain limitations of the study must be noted however. Firstly the validity of the TEEN CORE measure is now questionable, given that it was replaced by a new measure – the YP-CORE. a new measure, the YP-CORE has since been developed. We have our own concerns about the wording of some of the TEEN CORE items, which are slightly ambiguous. Nevertheless, the 14-item scale was found to have adequate internal reliability with the current sample, ( $\alpha = 0.78$ ). We are of course lacking supporting information regarding the validity of the measure and appropriate normative and clinical data. Our results must therefore be treated with caution.

In future, researchers should carefully consider which outcome measure to use (see Barkham & Barker, 1996 for useful criteria). The YP-CORE measure is nearing the end of its development phase and the initial findings look promising. One The advantage of this measure the YP-CORE is that it is a core general measure, usable across samples and treatment settings; this enables comparisons to be made between studies. An alternative questionnaire is the Strengths and Difficulties Questionnaire (Goodman, 1997) which assesses 25 psychological attributes. It is applicable to children aged 4-16 years, with parent and teacher forms and self-report forms for 11-16 year olds.

A second limitation of the study is the lack of an appropriate control group, which means that it is difficult to rule out alternative explanations for the improvements in well-being, general functioning and problems reported. It is of course possible that the young people would have improved anyway, with the simple passage of time. However, there are ethical issues involved in using a control group and a 'waiting list' control group in terms of withholding treatment from children who really need it.

It must also be acknowledged that 115 of the young people who completed a questionnaire at Time 1 did not complete a questionnaire at Time 2. However, the findings show that these young people were not more or less distressed at Time 1 than those who did provide data at both time points. Nevertheless, given the reasons that were reported for students not completing the second questionnaire (see Participants section) it is quite possible that the outcomes may not have been as positive for these young people. With such a problem of drop-out it does restrict the generalisability of the findings somewhat. While it is clear that school counselling is effective for many children, it is not going to be effective for all. However, this problem is inherent in any study which seeks to evaluate outcomes in counselling / psychotherapy.

These limitations must be understood in the context of the difficulties associated with conducting applied research. The research was designed around a system that was already in place and it required a great deal of commitment from the counsellors and social workers themselves, to administer the questionnaires and forward the data to the research team. For those workers who did agree to take part this meant additional paperwork and they also had to put their concerns about 'being evaluated' to one side. Certain constraints were imposed on the research to ensure that the evaluation met the needs of the Schools Teams. Despite the limitations outlined above, the present study is the first rigorous study of school counselling in the UK to identify improvements from pre to post counselling.

In future studies, researchers must consider more complex questions such as, ‘*What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?*’ (Paul, 1967, p. 111, cited in Kazdin, 2000). School counselling is certainly not a uniform intervention; different practitioners adopt different therapeutic approaches, often depending on their client and their presenting problems. With a large sample size it would be possible to address these more complex questions. We should not assume that the outcomes of school counselling will be the same, irrespective of the model of counselling employed or the specific populations for whom it is made available. Given that school counselling services are very likely to adapt as they grow, in line with the types of services promoted by *Every Child Matters* (e.g. multi-agency work, work with parents), then this issue becomes even more important.

Future evaluations should also try to address the issue of cost-effectiveness – are school counselling services *really* preventing problems from becoming pathological and therefore needing more expensive specialist services? Still, another option worth exploring is community-based youth counselling services, which can be accessed outside of school time. What are children’s views of community-based counselling and what is the evidence for *its* effectiveness?

Of course there are many different ways to evaluate the effectiveness of counselling and psychotherapy; some are quantitative, whereas others are qualitative and the two are rarely combined. Anecdotal evidence suggests that some counsellors and psychotherapy services utilise client satisfaction questionnaires to assess clients’ overall satisfaction with the process. However, as noted by McLeod (1994), these questionnaires merely provide an overall estimate of satisfaction and they do not allow the tracking of changes on specific variables. More ‘process’ oriented (qualitative) research, such as interviews with clients (and



therapists), can elucidate how a client has experienced the counselling and thus, can help to identify the therapeutic elements that are associated with change.

We do not think it appropriate or helpful to enter into a discussion of the merits of quantitative and qualitative research here. As part of the national evaluation, interviews with 16 young people who had accessed school counselling were also conducted and the findings are reported elsewhere (Fox & Butler, 2003). The findings, when used in conjunction with the findings from the present study, do provide support for school-based counselling provision. The young people were able to articulate that the counselling was helpful and in what way. They talked very positively about feeling better, a problem being solved or being able to cope with a problem in a better way. Many of them recognised that *they* had brought about the change. They valued having someone else to turn to (i.e. other than parents, teachers and friends) and the confidential nature of the service.

Despite the wealth of research into the effectiveness of counselling and psychotherapy, very few counsellors routinely evaluate what they do, probably for a whole range of reasons (e.g. high demands on staff, lack of appropriate knowledge and research skills). The British Association for Counselling and Psychotherapy (BACP) recognises evaluation of ‘outcome’ in counselling as an essential element of good practice. In the ethical guidelines for monitoring, evaluation and research (1996), BACP states: *‘Counsellors owe a duty to their clients, to other counsellors, and to society generally to measure and assess the effectiveness of what they do’*. Many writers in the counselling and psychotherapy field agree, e.g. Barkham & Barker (1996) concur with Barker, Pistrang and Elliott’s (1994) view that, *‘Evaluation should be a routine part of applied psychology: much clinical and counselling work is based on custom and practice rather than any formal knowledge base and evaluating it is a way of seeing whether or not it lives up to its claimed benefits’* (pp. 196-7). We would hope that this study serves to illustrate how an evaluation of *outcomes* in school counselling

can be carried out fairly easy *by those working in schools*. However, one final caveat is that we would argue for a mixed method approach, combining both quantitative (outcome) and qualitative (process) methods to track changes *and* to shed light on the elements of the therapeutic process that appear to contribute to change.

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TABLE 1: Details of Participants Who Completed the TEEN CORE (Sex and Age)

	11-13 years	14-17 years	Overall
<i>Time 1</i>			
<i>N</i> = 219	61	27	88
Male	55	62	117
Female	116	89	205
Overall			
<i>Time 1 – Time 2</i>			
<i>N</i> = 104	25	12	37
Male	32	33	65
Female	57	45	102
Overall			
<i>Time 1-Time 2-Time 3</i>			
<i>N</i> = 29	13	3	16
Male	7	6	13
Female	20	9	29
Overall			

The overall numbers for  $N = 219$  and  $N = 104$  are less than the original sample size due to missing data for sex and age.

TABLE 2: Source of Referrals at Time 1: Frequencies and Percentages (in brackets)

	Male	Female	11-13 yrs	14-17 yrs	Overall
Self	27 (32)	77 (65)	50 (44)	48 (59)	105 (51)
Teacher	43 (51)	32 (27)	47 (42)	26 (32)	78 (38)
Parent	6 (7)	2 (2)	6 (5)	2 (2)	9 (4)
Other	9 (11)	7 (6)	10 (9)	6 (7)	16 (8)
Overall	85	118	113	82	208

Missing data for 11 participants for source of referral. Within this sample, missing data for 5 participants for sex, and for 13 participants for age.

‘Other’, e.g. Education Social Worker, School Nurse, Learning Mentor, Psychologist.

TABLE 3: Reason for Referral at Time 1: Frequencies and Percentages (in brackets)

	Male	Female	11-13 yrs	14-17 yrs	Overall
Family relationships	18 (22)	44 (40)	33 (31)	27 (35)	63 (32)
School	29 (36)	14 (13)	34 (31)	7 (9)	44 (22)
Other relationships	9 (11)	24 (22)	15 (14)	19 (24)	34 (17)
Personal / self	21 (26)	16 (14)	16 (15)	18 (23)	38 (19)
Health	2 (3)	11 (10)	7 (7)	6 (8)	13 (7)
Abuse	2 (3)	2 (2)	3 (3)	1 (1)	4 (2)
Overall	81	111	108	78	196

Missing data for 23 participants for reason for referral. Within this sample, missing data for 4 participants for sex, and 10 participants for age.

TABLE 4: Means (and Standard Deviations) of the TEEN CORE Scores at Time 1 by Sex and Age

	Male	Female	Overall
11-13 years	1.77 (.70)	2.01 (.64)	1.88 (.68)
14-17 years	2.01 (.67)	2.11 (.63)	2.08 (.64)
Overall	1.84 (.70)	2.06 (.63)	1.97 (.67)



TABLE 5: Means (and Standard Deviations) of the TEEN CORE Difference Scores (Time 2-Time 1) by Sex and Age

	Male	Female	Overall
11-13 years	.53 (.98)	.67 (.84)	.61 (.90)
14-17 years	.71 (.66)	.99 (.88)	.92 (.83)
Overall	.58 (.88)	.83 (.87)	.74 (.88)

FIGURE 1: Mean TEENCORE Scores Before and After Counselling

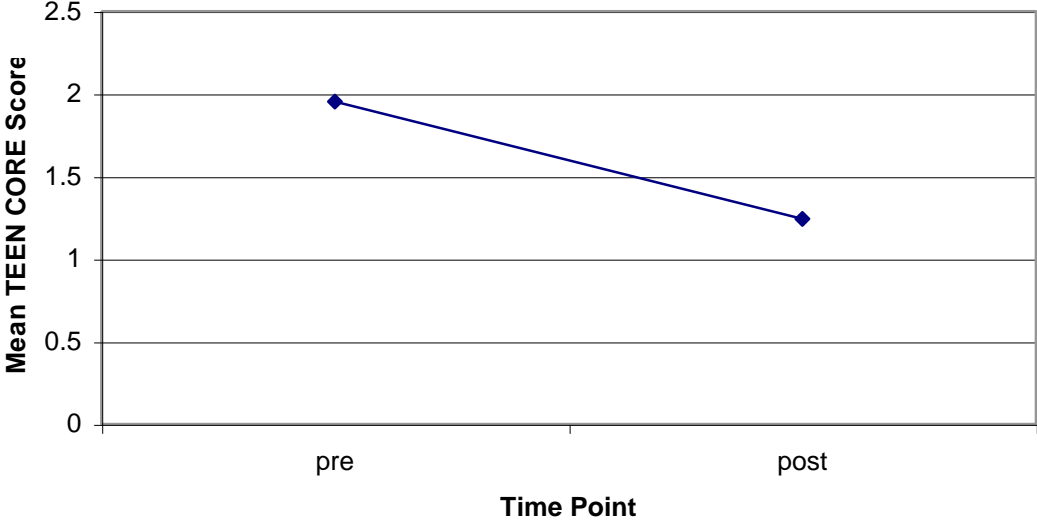


Figure 2: Mean TEEN CORE Scores Before and After Counselling and at Three-Month Follow-up

