

Breaking down barriers to learning: primary school-based counselling and support

No.14 Policy and
practice briefing

Believe in
children



Barnardo's
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'It is about reducing and removing barriers to learning, whatever those barriers may be...and there can be a myriad of reasons why children would have a barrier to learning.' (Teacher)

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Introduction

Education provides children with vital life skills and can help combat future unemployment and social disadvantage. Many children are not achieving in school¹, often coping with a chaotic family life, poverty, mental ill health and emotional problems. This presents a challenge for schools which cannot always provide the requisite support.

Barnardo's NI supports many children and young people experiencing barriers to participation in education. Our range of evidence-based education work includes family support, coordinating extended schools clusters, restorative practices, social and emotional skills development, and school-based counselling. We believe resources should be more focused in schools while children are young to help them achieve their full potential. At a time of significant cuts in public sector funding, greater priority should be given to targeted early intervention programmes to prevent more costly interventions being needed later.

About this briefing

Rates of childhood depression or anxiety have doubled in the UK between 1988 and 2006 (Collishaw et al, 2010). One in ten UK children aged 5-16 years have been shown to experience a clinically diagnosable mental disorder (Green et al, 2005) which is around three children in every class. Only a minority

of children experiencing mental health difficulties are referred to specialist mental health services (Ford et al, 2007; DHSSPS, 2006). Pressure on both children's social services and child and adolescent mental health services (CAMHS), together with growing recognition of the importance of early intervention (Allen, 2011a; 2011b), has led UK policy makers to explore how best to improve children's mental health and emotional well-being outside clinical settings.

This paper outlines the benefits of school-based counselling in improving emotional well-being and subsequent learning potential. It also presents the key findings of an independent analysis of Barnardo's NI 'Time 4 Me' primary school-based counselling service (Cooper et al, 2011, in preparation).

Child mental health and emotional well-being

Parental unemployment, lower family income, low parental educational attainment and family breakdown are associated with higher rates of mental disorders amongst children (Green et al, 2005). In Northern Ireland it is estimated that more than 20 per cent of young people are suffering 'significant mental health problems' by their 18th birthday (Chief Medical Officer, 1999) and that they have, on average, experienced twice the number of negative life events and report much higher stress scores than adolescents in other

countries (Royal College of Psychiatrists, 2006). High rates of mental health difficulties in Northern Ireland are attributed to higher levels of deprivation than other parts of the UK coupled with thirty years of civil conflict (DHSSPS, 2006).

A young person's mental health problems can impact on their family, educational and social life (Cooper et al, 2006; Fox and Butler, 2007) and greatly persist into adult life (Rutter et al, 2006). Long-term adverse outcomes include continuing mental health difficulties, poor educational performance, unemployment, low earnings, teenage parenthood, marital problems and criminal activity (Richards and Abbot, 2009). The cost to society of a young person with a diagnosed psychiatric condition (conduct disorder) is estimated to be around £52,000 by the age of twenty-five (Barclays Wealth/New Philanthropy Capital (NPC), 2011).²

Emotional well-being is an important foundation for learning and educational achievement. There is a fundamental inverse relationship between high emotional arousal and thinking-learning capacity (Goleman, 1996). Research in the field of emotional intelligence demonstrates that a person's ability to perceive, identify and manage emotion is the basis for being successful (Cherniss, 2000). This develops early in life and affects how productive children are in school (Goleman, 1996).

¹ For example, one in five children in Northern Ireland leaves primary school with literacy and numeracy problems (Education and Training Inspectorate (ETI) (2010) *Chief Inspector's Report 2008-2010*, ETI)

² Based on NPC calculations using figures from The Place2Be (2010) *Cost-effective positive outcomes for children and families: An economic analysis of The Place2Be's integrated school-based services*. London: Place2Be

Policy context

- The Bamford Review of Mental Health and Learning Disability in Northern Ireland (DHSSPS, 2006) recommended that mental health promotion and prevention should be developed across all schools, to include independent school counselling services.
- Both Northern Ireland and Welsh Governments are committed to the universal provision of independent counselling in secondary level education. Funded by the Department of Education in NI it is available to all post primary schools who choose to use it, *'Counselling can assist young people during difficult and vulnerable periods in their lives and so, by having this service available, we aim to address the barriers to learning therefore improving the educational outcomes of all our pupils.'*³
- School-based counselling services have been developed in some UK primary schools, including Northern Ireland. A recent evaluation of school-based counselling in primary schools across Wales found high levels of satisfaction amongst stakeholders (Hill et al, 2011). The report recommended that the Welsh government consider rolling out their school-based counselling strategy to the primary school sector (Hill et al, 2011). The Scottish Executive has committed to counselling provision for all pupils in Scotland by 2015 (Public Health Institute of Scotland, 2003). The Department of Education in NI has previously stated but not yet actioned its intention to roll out counselling to primary schools.⁴
- Where available, primary school-based counselling in NI is typically delivered as an integral part of extended/full-service schools programmes. In almost all cases where extended schools are serving disadvantaged communities effectively, significant improvements are evident in the educational outcomes and the personal and social well-being of pupils (ETI, 2010).
- The schools counselling model complements the DE Pupil and Emotional Health and Well Being Programme (PEHAW). This initiative provides the 'glue' to integrate policy and services such as counselling, pastoral care systems, suicide prevention, and anti-bullying.⁵

What works?

A growing body of evidence points to the efficacy of therapeutic approaches to address children's various mental health difficulties. Carr's (2000; 2009) systematic reviews support the effectiveness of family therapy and systemic

interventions for conduct disorders, emotional problems and eating disorders.

Evidence from randomised controlled trials across a range of clinical settings also indicates that counselling interventions can be effective with children experiencing mild to moderate depression (NICE, 2005).

Schools are increasingly viewed as integral to providing an accessible, non-stigmatising environment in which to promote emotional wellbeing and support children experiencing emotional, psychological and behavioural difficulties (NIMHE/CSIP, 2005; Welsh Assembly, 2006; DENI, 2009).

School-based counselling

Evaluations of counselling services in UK secondary schools indicate it is an effective intervention (Adamson et al, 2006; Fox and Butler, 2007/2009; McKenzie et al, 2011). A systematic review of UK studies has shown post-primary counselling services are associated with large improvements in mental health, with approximately fifty per cent of clinically distressed young people demonstrating clinical improvement (Cooper, 2009). There was also evidence that counselling indirectly benefited the students' capacities to study and learn. A recent study using randomised controlled trial methodology found that young people allocated to counselling showed significantly greater improvements in well-being than those on a waiting list control (McArthur et al, 2011).

Primary schools

Although rates of mental disorders are lower amongst children aged 5-10 years compared to 11-15 year olds, eight per cent are still affected, particularly boys (Green et al, 2005)⁶. Across the UK counselling services are available in some primary schools, but there is no universal provision. While larger scale research is needed, small studies

3 Former Education Minister Catriona Ruane NI Assembly Press Release, 29/7/2009

4 Response to NI Assembly Question AQO 1336/11, 24/3/11

5 For information on PEHAW see: http://www.deni.gov.uk/index/21-pupils-parents-pg/pupils_parents-newpage-2.htm

6 Among 5-10 year olds, ten per cent of boys and five per cent of girls have a mental disorder. In the older age group (11-16 year olds), the proportions are thirteen per cent for boys and ten per cent for girls

investigating the efficacy of primary school-based counselling services show a range of positive impacts on children's health, well-being, attitude to school and ability to enjoy learning (Lee et al, 2009; McLaughlin, 2010). The long term savings to society by providing specialist counselling in primary schools is estimated to be in the region of £3 for every £1 invested⁷ (Barclays Wealth/NPC, 2011).



Barnardo's NI 'Time 4 Me'

Winner of the 2011 British Association for Counselling and Psychotherapy (BACP) award for innovation in counselling and psychotherapy, Barnardo's

NI school-based counselling service 'Time 4 Me' uses a 'client-directed outcome-informed' (CDOI) approach. CDOI research indicates that the best counselling outcomes occur by focusing on the therapeutic relationship and client's rating their personal outcomes (Duncan, 2011). Central to this, CDOI children's practitioners use a weekly measure called 'child-outcome-rating-scale' (CORS) (Duncan et al, 2003).

'Time 4 Me' offers a range of psychological interventions including therapeutic play, strengths-based therapy, brief therapy, cognitive-behavioural therapy (CBT), narrative therapy and person-centred counselling. The service is currently provided in fifty-four primary schools in NI, including several special primary schools⁸. **The main aim of 'Time 4 Me' is to increase emotional well-being in order to improve learning potential.**

Since its inception in 2008, the service has supported over 900 children aged 4-11 in some of the most disadvantaged areas in Belfast, with the main reasons for pupil referral outlined at Table One. 'Time 4 Me' also provides support and guidance to families, engaging 303 parents/carers in 2010-11. Two-thirds of referrals in 2010-11 were for boys, an important factor given concern about

mental health and suicide risk among young males in NI⁹ and also boys' poor educational performance.¹⁰

A previous evaluation of 'Time 4 Me' indicated a significant reduction in behaviour problems and a significant increase in treatment progress after counselling (McLaughlin, 2010). Schools have found 'Time 4 Me' plays an important part in helping children deal with complex issues so they are happier and more able to listen and learn in the classroom.¹¹

'I just think that this counselling service ['Time 4 Me'] is absolutely invaluable. We really, really need it... I would hate to lose it.' (Teacher)

'There is a definite improvement in behaviours – [that] leads to improvement in attainment.' (Teacher)

'We were stuck in a bad place, and it was an outlet for us. As a family, we were in a state of despair, but now there's more communication – lots of tiny, small changes that have brought a big change. It's like having [my son] back again.' (Parent)

'Teachers have noticed a change in me. Teachers notice me when I am good. I like that.' (Pupil)

Table One: 'Time 4 Me' pupil referral, 2010-11

| Referral category | Specific referral reasons | Per cent |
|-------------------------|---|-------------|
| Family Problems | Separation/divorce, family communication difficulties, family member with serious illness | 25 per cent |
| Trauma and Abuse | Domestic violence/abuse, developmental trauma, attachment difficulties, abuse and neglect, community trauma | 22 per cent |
| Friendship and Bullying | Making and sustaining friendships, victim of bullying, bullying instigator | 22 per cent |
| Bereavement | Includes bereavement by suicide | 16 per cent |
| Anxiety | General anxiety, academic stress and anxiety | 13 per cent |

⁷ Based on NPC calculations using figures from The Place2Be (2010) *Cost-effective positive outcomes for children and families: An economic analysis of The Place2Be's integrated school-based services*. London: Place2Be

⁸ Barnardo's NI also provide counselling in nearly twenty post primary special schools

⁹ Suicide rates in NI increased by 64 per cent between 1999 and 2008, mostly attributable to young males aged 15 to 34 years living in disadvantaged areas, particularly North and West Belfast. Recent figures show a sharp increase in suicide rates of twenty per cent between 2009-2010, with rates for young males 20-24 years increasing by 52 per cent (NISRA)

¹⁰ *Educational Underachievement and the Protestant Working Class, A Summary of Research for Consultation* (2010), Dawn Purvis MLA; Northern Ireland Audit Office (2006) *Improving literacy and numeracy in schools*, Belfast: NIAO

¹¹ Small qualitative evaluation with five teachers and thirteen children (Regan and Craig, 2011, Barnardo's NI, available on request)

'Time 4 Me' outcomes evaluation: Client-directed outcome-informed school counselling for psychological distress in children: Outcomes and predictors of change (Cooper et al, 2011)

Using outcomes to inform practice is central to Barnardo's NI work and an in-depth outcomes evaluation of 'Time 4 Me' has been completed. The study evaluated the impact of a client-directed, outcome-informed (CDOI) school-based counselling model of intervention with 288 primary school children aged 7 to 11 years old across 28 schools in Northern Ireland. The schools were non-fee paying state schools, covering each of the five education sectors and all but one were in an urban area of high multiple disadvantage. Through the use of weekly outcome monitoring, data was available on all children who accessed the counselling service over the evaluation period.

Almost all the children (>99%) were of white ethnic origin and approximately two-thirds were male and a third female, with a mean age of 9.65 (SD – 1.24). Where details of disability status were recorded (2010-11 academic year), around one-third of children were identified as having a physical or psychological disability¹². The most prevalent types of presenting issues, where recorded, were 'family' and 'personal', with approximately seventy per cent of children presenting with difficulties in these areas. This compared with approximately one quarter of children with school-related issues, and ten per cent with peer-related issues.

An observational, cohort design was adopted, with levels of psychological wellbeing and distress compared from the beginning of therapy to the end. The primary outcome measure was the child-completed Child Outcome Rating Scale (CORS) (Duncan et al, 2003); with parent and teacher completed versions of this measure, and parent and teacher completed versions of the Strengths and Difficulties Questionnaire (SDQ), used as secondary outcome measures.

Key Findings:

Based on the children's own ratings, the CDOI intervention was associated with significant improvements in wellbeing from the beginning of counselling (M – 25.56, SD – 8.32) to its end (M – 37.92, SD – 4.26). In addition, parents' and teachers' ratings indicated significant improvements following counselling – on both the CORS and the SDQ.

On the child-CORS primary outcome measure, the amount of improvement in psychological wellbeing can be considered large (an effect size of 1.49), and is somewhat greater than in previous studies of school-based counselling. Furthermore, 88.7 per cent of the children who were in the clinical range at the start of the counselling showed clinical improvement (i.e. they moved into the non-clinical range by the end of counselling). The greatest improvements were for young people identified as having a disability, and where CBT-informed strategies were incorporated as part of the overall intervention.

The findings provide strong support for the hypothesis that school-based CDOI counselling is an effective intervention for psychological distress in children.

Recommendations

- The NI Executive should further expand mental health promotion and prevention in Northern Ireland by committing to the implementation of school-based counselling services in all primary schools as a cost effective early intervention.
- The Department of Education should integrate the primary school-based counselling model as a key component of the DE Pupil and Emotional Health and Well Being Programme (PEHAW).
- The Department of Education should expand the full-service and extended schools programme across Northern Ireland, particularly in communities where there is disproportionate disadvantage.
- The NI Executive should support the delivery of integrated, effective early intervention services in all school settings in order to achieve the outcomes set out in the 'Ten year strategy for children and young people in Northern Ireland'.
- To best support the delivery of integrated early interventions in school settings, the NI Executive should undertake a strategic review of what is effective and invest resources accordingly.

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¹² This can include Autistic Spectrum Disorder, behaviourally-based disabilities, communication impairment, hearing impairment, learning disability, physical impairment and sight impairment



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