

Evaluating the Effectiveness of Counselling in Schools

**Jointly funded by the New Zealand Association
of Counsellors and the Ministry of Education**



PRINCIPAL RESEARCHERS

Robert Manthei	Bryan Tuck	Alastair Crocket
Brent Gardiner	Margaret Agee	Nan Blanchard

February 13, 2020

A THANK YOU

The Research Team thanks all the schools and participating counsellors for your participation in the project. We are grateful for your willingness to add yet another set of tasks to very busy days and for the courage it takes to allow your professional work to be scrutinised in such detail. The entire profession owes you a vote of thanks for your commitment to the evaluation of practice.

*“Have really enjoyed being involved with the research –
such an important piece of work...!”*

*“I think this would be the start of something that would
benefit the profession as a whole.”*

*“I’ve gained a lot of great insights into my work and I just
think these projects are so vital for our profession...”*

EVALUATING THE EFFECTIVENESS OF COUNSELLING IN SCHOOLS

SUMMARY OF FINDINGS

In mid-2017, the New Zealand Association of Counsellors (NZAC) Executive initiated the idea for a research project to assess counselling outcomes in secondary schools. The purpose would be to generate findings that would facilitate discussion between NZAC and the Ministry of Education (MOE) about the staffing level of counsellors in secondary schools, a discussion that has been limited by a lack of counselling effectiveness evidence. Once NZAC had an acceptable proposal, they presented it to the MOE for its approval. After discussion and modifications, a final proposal was approved by both organisations and a co-funding arrangement confirmed. The project was launched in Term 1, 2019, and data collection continued throughout the year.

- ✚ This is the first study that systematically investigated the effectiveness of counselling in New Zealand secondary schools.
- ✚ Using the Outcome Rating Scale (ORS; Appendix 1), pre-, during, and post-counselling data were collected from 16 schools and 31 counsellors during the 2019 school year.
- ✚ Results from 490 counselled students showed that 70% of the students were females, 63% were Pākeha, 15% were Māori and 22% represented ‘other’ ethnicities.
- ✚ Counselling tended to be brief (an average of 4 sessions per student).
- ✚ Boys had significantly higher first session and last session ORS scores than girls, but the average gain score for each group was the same.
- ✚ All ethnic groups made significant gains in ORS scores after counselling. There is the suggestion that gains are associated with student ethnicity.
- ✚ On average, the ORS score of all students receiving counselling changed positively and significantly over time. The effect size of this change (.87) was “large” and similar to what has been found elsewhere.
- ✚ These positive results were achieved despite the fact that in every participating school the ratio of students to counsellors (1:668) far exceeds the American School Counselor Association’s recommended 250:1, and the NZAC’s recommended 400:1.

In summary, this study analysed school counselling outcomes in a number of ways, using both inferential statistics and clinical indicators of significance. No matter how it was analysed, counselling was shown to be effective.

LIST OF TABLE AND FIGURES

Table 1	Participating schools	9
Table 2	Schools targeted, approached and participating	9
Table 3	Participating counsellors	10
Table 4	Characteristics of counselled students: year in school, age, gender and ethnicity	11
Table 5	Characteristics of baseline/comparison students	13
Table 6	ORS means and standard deviations for counselled and baseline students	19
Table 7	Independent samples T-Tests of ORS for baseline and counselled students at first and final administrations	19
Table 8	Means and standard deviations for gender by change over time	20
Table 9	Repeated measures ANOVA for gender by change over time	20
Figure 1	Plot of ORS means over time by gender	21
Table 10	Means and standard deviations for ethnicity by change over time	21
Table 11	Repeated Measures ANOVA for ethnicity by changes over time	22
Figure 2	Plot of ORS means by ethnicity	22
Table 12	Means and standard deviations of ORS over time for counselled students	23
Table 13	Paired samples t-test of ORS over time for counselled students	23
Table 14	Means and standard deviations for ORS across counselling sessions	23
Table 15	Correlation matrix for ORS1 through ORS12	24
Table 16	Change related to different 1st session scores	25
Table 17	Average number of sessions in studies using either the ORS/CORS or other outcome measures	28
Table 18	Actual and recommended counsellor/student ratios and staff levels for an enrolment of 1473	29
Table 19	Non-clinical ORS scores for those not seeking counselling	29
Table 20	ORS pre- and post-counselling scores and resulting gain scores	30
Table 21	Effect sizes from various studies using various populations, outcome measures and age groups	31
Table 22	Percentages of clients achieving ‘clinical change’, ‘reliable change’, ‘no change’, or ‘deteriorating’ after counselling	32

Abbreviations used in the report:

ACA	American Counseling Association
ANOVA	Analysis of variance
ASCA	American School Counselor Association
CORS	Children's Outcome Rating Scale
ERO	Education Review Office
KORS	Kaupapa Outcome Rating Scale
LGBTQ	Lesbian, gay, bisexual, transgender, queer
MOE	Ministry of Education
NZAC	New Zealand Association of Counsellors
PCOMS	Partners for Change Outcome Management System
SRS	Session Rating Scale
TAU	Treatment as usual

STUDY AIM

The aim was to evaluate the outcomes of secondary school-based counselling in a sample of New Zealand secondary schools.

INTRODUCTION

1 Origin of the project

In mid-2017, the NZ Association of Counsellors (NZAC) Executive asked the newly-formed Research Working Party (consisting of Alastair Crocket, Colin Hughes and Bob Manthei) to draw up a research proposal to assess counselling outcomes in secondary schools. The purpose was to generate findings that could facilitate discussion between NZAC and the Ministry of Education (MOE) about the staffing level of counsellors in secondary schools, a discussion that has been limited by a lack of evidence about counselling effectiveness in schools.

The Working Party completed the research proposal in early 2018, which was then presented to the MOE for consideration. After discussion and modifications, NZAC and the MOE agreed to co-fund the project. Two members of the Working Party (Alastair Crocket and Bob Manthei) agreed to oversee the project; the third member (Colin Hughes) declined because of involvement in another research project.

One of the limitations in advocating for additional counsellors in New Zealand schools has been the absence of any systematic research in the area. Surprisingly, in spite of school counsellors' importance to schools and their communities, there have been virtually no studies evaluating counselling effectiveness. Earlier reviews in New Zealand have suggested that political, economic and social influences (rather than published research results) have had greater influence on the practice of counselling, including in schools (Manthei & Miller, 1991, 2001; Small, 1980). This situation has persisted to the present time (Manthei, 2015). In effect, school counsellors have been a respected part of New Zealand secondary schools since their formal introduction in the 1960s, but their effectiveness has largely been taken for granted.

Significantly, their roles have expanded over the years to providing mental health services to students challenged by household poverty, family dysfunction, bullying, drug use and suicidal behaviour (Education Review Office, 2013; UNICEF New Zealand, 2017). Schools here and abroad continue to be touted as 'health promoting', that is, an ideal setting in which to link mental health and learning outcomes (Cushman, Clelland, & Hornby, 2011). In response, the present study was designed to address this lack of evidence by systematically assessing counselling outcomes in schools.

2 Possible benefits of the project

For schools and counsellors: Both would gain evidence regarding the effectiveness of the school's counselling service. Results could provide information about how to develop, alter and/or expand the service to enhance its impact.

For students: Discussion of their self-ratings about progress during counselling would enrich the process and has been shown to enhance the effects of counselling.

For NZAC: Data demonstrating counselling effectiveness would better inform NZAC and MOE about the current state of counselling in schools and what additional resources might enhance the service.

For counsellor educators and the wider profession: The data should guide and inform training courses and future research in the area.

REVIEW OF LITERATURE

1 Counselling has been shown to be effective

Counselling in general has been repeatedly demonstrated to be effective, that such success can be achieved in relatively few sessions (5-10), and that its effects can persist for 6-12 months after termination (Lambert and Cattani-Thompson, 1996). An early meta-analysis of outcome studies found that up to 80% of clients are better off at the end of their counselling (Smith, Glass, & Miller, 1980). Subsequent meta-analyses have reported similar positive outcomes (see, for example, Anderson & Lambert, 1995; Hartman, Herzog, & Drinkman, 1992).

2 Counselling in overseas schools has been shown to be effective

Similarly, counselling in school settings has also been found to be effective in the USA (see, for example, ACA, 2007; ASCA, 2019; Carey & Dimmitt, 2012; Carey & Harrington, 2010a and 2010b; Lapan, Gysbers, & Sun, 1997; Whiston & Sexton, 1998). Baskin, Slaten, Crosby, Pufahl, Schneller, and Ladell's (2010) meta-analysis of 107 studies reported an overall effect size of .45 for students who received counselling. In addition, American research has shown that school counselling can produce positive outcomes across a range of areas: enhancing academic achievement; reducing test anxiety, school dropouts and classroom disturbances; boosting students' future expectations; helping with family problems; preventing suicides; reducing violence in schools and assisting with student career development (see summaries produced by the ACA, 2007 and ASCA, 2019).

Research on counselling conducted in secondary schools in the UK has also shown counselling to be effective. For example, Cooper (2009) reviewed 30 studies that investigated counselling being delivered in secondary schools and found that based on an average of 198 students per study, counselling resulted in large levels of improvement with an overall effect size of .87. Just over 80% of the students rated their counselling as moderately or very helpful. In addition, a large-scale study in Wales involving 3613 episodes of school-based counselling (Cooper, Pybis, Hill, Jones, & Cromarty, 2013) showed again that counselling was effective and resulted in significant reductions in psychological distress. They summarised by saying that "given the numbers involved in this and previous studies, it may be safe to now state that the significance and magnitude of this association is now beyond doubt" (p.93).

In 2015, Cooper, Fugard, Pybis, McArthur and Reese found that a sample of 256 school students who received counselling exhibited "large and significantly greater change than would be expected without the intervention [counselling]" (p262), even after any improvement estimated to be due to 'natural change' was removed from their improved post-counselling scores. A smaller, more recent study found essentially the same results: students who received school-based counselling had lower psychological distress and emotional symptoms and greater self-esteem than students who did not receive counselling (Pearce, Sewell, Cooper, Osmond, Fugard, & Pybis, 2017). However, at 6 and 9-month follow-up, the groups differed only on emotional symptoms. These findings provided additional support for the conclusion "that school-based counselling is associated with reductions in psychological distress for young people" (Cooper et al., 2015, p263).

3 Equivalent evidence in New Zealand schools is absent

By comparison, in New Zealand there is virtually no outcome data from the school counselling setting. Nevertheless, guidance services and counsellors have been surveyed and their work described regularly over the years (see, for example, Crowe, 2006; Hermansson, 1980; Manthei 1991 and 2001; Manthei and Miller, 1991 and 2001; Miller and Manthei, 1992). More recent descriptions of the

school counsellor's work have been published by Barclay, Crocket, Kotzé and Peter (2013), Crocket, Kotzé and Peter (2015), Hughes, Burke, Graham, Crocket and Kotzé (2013), Hughes, Barr and Graham (2019) and Manthei (1999), but no published research has systematically evaluated the effectiveness of their practice across a wide sample of secondary schools.

There are three limited studies: the evaluation of a guidance resource teachers pilot project in intermediate schools (Tuck, Adair, & Manthei, 1990); the evaluation of the guidance programme at Burnside High School (Manthei, 2009); the work of the counsellor at Hillmorton High School (Manthei, 2012) and the two reviews by ERO (2013 and 2015) of secondary school counsellors and their practice. However, as useful, positive and informative as these reports have been, not one of them assessed the counselling being provided in a detailed, systematic way.

Thus, although both counselling in general and school counselling specifically, have been demonstrated to be successful overseas, there is still a lack of convincing data confirming the effectiveness of counselling in New Zealand schools.

METHOD

1 Design and ethical approval

Given the limited scale of the study (up to 20 schools spread across the country), urban schools were targeted in preference to rural schools or a mixture of both. The study used a non-randomised, pre and post-test design to assess the self-reported changes in the emotional distress of secondary students who sought counselling from trained school counsellors. Self-reported changes in students who attended counselling from the beginning of the relationship (baseline, or pre-counselling score) to its completion (endpoint, or post-counselling score) were measured by the Outcome Rating Scale (ORS) (from the Partners for Change Outcome Management System, PCOMS; Duncan and Miller, 2000). A complete relationship was called a *counselling episode*, or a *counselling case*, and all episodes that included both baseline and endpoint ORS scores were included in the data set.

The design lacked control groups in each school. This was partly offset by data gathered from a sample of several school's general student population. This provided a comparison group of *non-clinical* students.

Formal ethical approval for this study was gained from NZAC and Waikato Institute of Technology's Human Research Ethics Committee. Informed consent was obtained from all participating school principals, counsellors and all students who provided ORS data, whether for their school's baseline score or as part of their counselling. The risks for participating students were determined to be no greater than what would exist for anyone who sought help from the school's counsellor via the normal process. In addition, it was determined that the use of the ORS measure as part of the counselling interaction would not impose any major time or procedural restrictions on the counselling process as it already existed.

Although the schools that agreed to participate are listed in Table 1, all schools and their participating counsellors were assured that no counselling-related information about any specific school, individual counsellor or client, would be shared with anyone outside of the research team. All information gathered for the project was coded to mask identities. In addition, the data and analyses would be reported only in aggregated, anonymous form. If requested, schools would be given a summary of their own results which they could then compare with the combined, anonymous results of all other schools. This information would be released only to the counsellors in the school.

Schools and counsellors were not provided with any direct incentive to take part in the research. However, they were told that depending on the project budget, there would be a small gratis

payment—koha—made to each participating school’s guidance department at the end of the project to acknowledge their participation.

Table 1 Participating schools*

School (N = 16)	Location	Co-ed / single sex	Decile	Roll	Participating counsellors: full or part-time	Counsellor staffing	Counsellor : student ratio
Logan Park High School	Dunedin	Co-ed	7	644	1 FT	1.0	1:640
Hagley Community College	Chch	Co-ed	6	2041	1 FT	2.7	1:756
Hillmorton High School	Chch	Co-ed	4	908	2 (.8 , .4)	1.2	1:757
Villa Maria College	Chch	Girls	9	847	2 (.8 , .8)	1.6	1:529
Avonside Girls HS	Chch	Girls	6	984	1 FT	1.5	1:656
Napier Boys High School**	Napier	Boys	6	1146	1 FT	1.4	1:849
Palmerston North Boys HS	Palm Nth	Boys	9	1685	1 FT	2	1:843
Hutt Valley High School	Wellington	Co-ed	8	1673	1 FT	3.1	1:540
Cambridge High School	Hamilton	Co-ed	9	1553	3 (1FT, .25, .25)	1.5	1:1035
Fraser High School	Hamilton	Co-ed	4	1365	3 (2FT, .8)	2.8	1:487
Hillcrest High School	Hamilton	Co-ed	7	1750	2 (1.0, .8)	2.3	1:761
Birkenhead College	Auckland	Co-ed	6	584	1 FT	1	1:584
Mt Roskill Grammar	Auckland	Co-ed	4	1939	4 (2FT, .8, .6)	5.0	1:537
Takapuna Grammar	Auckland	Co-ed	10	1687	3 (2FT, .6)	2.6	1:649
McLean’s College	Auckland	Co-ed	9	2550	3 FT	5.0	1:510
Rosehill College	Auckland	Co-ed	5	1641	3 FT	3	1:547
			M=6.8	22997 M=1437	32 counsellors	37.7 M=2.4	M=1:668

*Decile and roll numbers were taken from www.educationcounts.govt.nz/statistics/schooling/student-numbers/6028 The figures were from a time series spreadsheet dated July 1, 2019.

**Provided baseline data only

2 Participants

Schools: The study targeted schools with a recognised, well-functioning counselling service. Such schools were identified by several indirect means: by generating a list of possible schools based on Education Review Office (ERO) reports (see ERO 2013, 2015); using recommendations from the NZAC’s Executive Member in charge of the Secondary School Counselling Portfolio and by seeking advice from university counsellor educators whose contacts with schools included visiting them each year when their students were fulfilling practicum requirements.

The participating schools were to be a nation-wide sample of up to 20 public or fully integrated schools, located in largely urban areas of both the North and South Islands. Rural and district schools were not included. The sample was to include at least four single sex schools. As shown in Table 2, the final list of schools was not far off the targeted numbers.

Table 2 Schools targeted, approached and participating

Area	Targeted	Approached	Actual*
South Island	5	9	5
Wellington and lower Nth Island	4	12	3**
Central Nth Is, including Hamilton	4	4	3
Auckland	7	12	5
TOTAL	20	37	16
Of the above, two boys’ and two girls’ schools were targeted	4	Not known	4**

*Several schools agreed to participate initially but later withdrew citing pressures of time and work as the reasons. None of them submitted data.

**One of the boys’ schools provided baseline data only.

The spread of schools was not substantially different to the targeted numbers in each area. Of the 37 schools that were approached to participate, 16 (43%) participated by furnishing data. Reasons given

for not participating almost always had to do with the counsellor(s) being too busy or too pressured by work demands to take on additional responsibilities. Their reasons were consistent with the results of a 2018 NZAC survey of secondary school counsellors which found that of the 169 respondents “81% reported an increase in the number of students seeking counselling, 96% had noticed a change in the severity of issues students were presented with, 91% said they had a wait list and 90% said more resources were needed to meet the needs of students” (The Press, December 3, 2018).

In addition, in a series of articles on Stuff.co.nz (see Sarnae Hope, Nov 12, 2019 and a related article by Mark Taylor), Morrinsville College Principal John Inger and counsellor Vick Tahau-Sweet stressed the need for more trained school counsellors to deal with what they call a ‘crisis’ for the schools. Many of the 16 schools surveyed by Mr Inger indicated their counsellors could not see students requesting help for up to eight weeks, and many reported they were unable to provide an adequate counselling service due to ‘unsustainable workloads’.

In Christchurch, most of the refusals to participate could be attributed wholly or partly to the extra work and stress generated by the terrorist attack on March 15, 2019. One counsellor declined participation by saying “*Apologies, I have barely come up for air this week after the horrendous events of Friday and the aftermath. My counselling colleagues and I have already seen 105 students in the first three days of this week...Frustrating, as I am keen for us to contribute..., however, I need to look after my team and prioritise being available and responsive to our student community.*”

‘Terrorist attack’ stress was compounded in another school by the disruption associated with the school shifting to a new location in term two, thus delaying its participation until the term three. Two other schools ceased participating shortly after commencing. Both cited pressures of huge workloads and outside events. One school refused the invitation to participate for ‘philosophical reasons’, reasons which seemed to misconstrue the intent of the study and the procedures involved. Nevertheless, all of the schools that were approached expressed their support for the study and deemed it to be a valuable initiative that supported the profession. Table 1 summarises key information about the 16 participating schools.

Counsellors: A total of 31 counsellors (12 part-time) from 15 schools generated counselling data for the project (the sixteenth school provided baseline data only). The aim was to recruit counsellors who were experienced, fully trained members of NZAC and working in ‘well-functioning counselling services’ (see previous page). The data in Table 3 confirm that the participating counsellors met the agreed selection criteria: they were experienced members of NZAC, were trained professionals receiving clinical supervision and used a variety of currently accepted therapeutic approaches.

There were far more females than males (71% vs 29%, respectively), consistent with school guidance departments and the counselling profession in general. The three ‘most-used modalities’ as cited by counsellors were person-centred, narrative and eclectic or integrative. These often were paired with other approaches such as solution focused, cognitive behavioural, mindfulness or any of the other 12 approaches mentioned. The diversity of modalities is not surprising, given the variety of approaches taught in New Zealand.

Table 3 Participating counsellors*

COUNSELLORS N = 31	CO-ED SCHOOLS N = 12		SINGLE SEX SCHOOLS N = 3		TOTAL SCHOOLS N = 15	
Gender	F = 19	M = 8	F = 3	M = 1	F = 22 (71%)	M = 9 (29%)
NZAC membership	Yes = 25	No = 3**	Yes = 3	No = 0	Yes = 28	No = 3
Supervision	Yes = 27	No = 0	Yes = 4	No = 0	Yes = 31	No = 0
Professional qualification	Yes = 27	No = 0	Yes = 4	No = 0	Yes = 31	No = 0
Employment status	F/T = 17	P/T = 10	F/T = 2	P/T = 2	F/T = 19	P/T = 12
Years of experience	Ave = 13.5 years		Ave = 12.5 years		Overall Ave = 13.4 years	

*The information in this table does not include the one school that provided only baseline data.

**Two were members of the New Zealand Christian Counsellors Association.

Students:

Counselled students: Students participated by indicating their willingness to provide ORS scores at the beginning, possibly during (if the counsellor chose to use the ORS as ‘feedback’ during the sessions) and at the conclusion of their counselling. It is possible that a number of students may have been excluded from the study because the counsellor judged them to be incapacitated in some significant way; some may have themselves declined to participate; others may not have participated for other reasons. This is supposition on our part.

There were 574 cases submitted as counselling episodes. Thirty-one cases were excluded from the analysis because they did not include both the first and last session scores; two were excluded because of missing school or counsellor data; and 51 cases (those using the KORS scale) were excluded because there were too few to be usefully included in the main analysis (this is discussed in the Organisation of the Study section). This left a total of 490 counselling cases for analysis, a completion rate that supports the claim that the ORS is simple and easy to administer and score.

Table 4 sets out the characteristics of the counselled students, the majority of whom were from years 9, 10, 11 and 12. The percentage of students from those years who sought counselling is virtually identical to the percentage of the 1596 students from those same years who sought counselling in Hughes et al. (2019): 82.4% vs. 83%, respectively. There was considerable variation in their ages, but most were within the age range 13 to 17 years. They were predominantly female (70%) and were mostly Pākeha (64%), although there were significant numbers of Māori (14%), Asian (7%) and Pasifika (4%) students as well. Comparable figures from Hughes et al. (2019) were 64% female and predominantly Pākeha and Māori.

In regard to gender, it is interesting to note the small number of students who declared themselves as ‘other’ (a non-specified alternative to *female* or *male*). Although few in number (2% of the total), this figure no doubt indicates an important change in the way today’s students identify themselves in terms of their gender. A comparable figure in Hughes et al.’s recent study (2019) was 1% of the sample of 1596 students. This changing demographic needs to be tracked in future studies involving adolescents.

Table 4 Characteristics of counselled students: year in school, gender, age and ethnicity

Frequencies for Year in School

Year in School	Frequency	Percent	Valid Percent	Cumulative Percent
7	7	1.4	1.5	1.5
8	11	2.2	2.4	3.9
9	103	21.0	22.1	26.0
10	95	19.4	20.4	46.4
11	97	19.8	20.8	67.2
12	89	18.2	19.1	86.3
13	64	13.1	13.7	100.0
Missing	24	4.9		
Total	490	100.0		

Frequencies for Gender

Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Female	339	69.2	70.0	70.0
Male	136	27.8	28.1	98.1
Other	9	1.8	1.9	100.0
Missing	6	1.2		
Total	490	100.0		

Frequencies for Student Age

Student Age	Frequency	Percent	Valid Percent	Cumulative Percent
11	5	1.0	1.0	1.0
12	10	2.0	2.1	3.1
13	86	17.6	17.8	21.0
14	96	19.6	19.9	40.9
15	115	23.5	23.9	64.7
16	87	17.8	18.1	82.8
17	63	12.9	13.1	95.9
18	16	3.3	3.3	99.2
19	4	0.8	0.8	100.0
Missing	8	1.6		
Total	490	100.0		

Frequencies for Ethnicity

Ethnicity	Frequency	Percent	Valid Percent	Cumulative Percent
Pākeha	280	57.1	63.6	63.6
Māori	62	12.7	14.1	77.7
Pasifika	16	3.3	3.6	81.4
Indian	10	2.0	2.3	83.6
Asian	31	6.3	7.0	90.7
Other	41	8.4	9.3	100.0
Missing	50	10.2		
Total	490	100.0		

Baseline students: ORS scores for populations not seeking counselling (called *baseline* or *non-clinical* scores) are useful for comparing with *clinical* populations, i.e., those seeking or referred for counselling. Thus, ORS baseline scores were gathered in several schools from the student population-at-large by having one class from each year level complete the ORS only once and to do so anonymously. It was expected that these students (the *non-clinical sample*) would have significantly higher initial ORS scores than those who sought and received counselling (the *clinical sample*). Summary information about these students is presented in Table 5. The greater number of male students in the baseline group was due to the 125 scores (30% of the total baseline scores) furnished by one boys' school.

A total of 543 baseline scores was received from seven schools. However, the 122 baseline scores generated from two schools that used the KORS were excluded from the analysis.¹ The remaining 421 baseline students came from five schools, four of which were co-educational. The fifth school, a large single sex boys' school, provided baseline scores only.

¹ A brief research report comparing the KORS data with the CORS cases will be published separately.

The administration of the ORS to classes within the schools was managed by the counsellors. Although classes were not drawn at random, the resulting sample of baseline students did cover a range of years, ages and gender (see Table 5). Information on the students' ethnicity was not consistently provided, so it could not be analysed.

One difference between the counselled and baseline students was gender. Whereas 70 percent of the counselled students were female, the majority (66%) of the baseline students were male. The difference between the ORS scores of the 398-baseline female and male students was analysed. The means of the two groups on ORS were different, with males ($M=30.5$, $SD=6.4$) being significantly more positive ($t=-6.9$, $df=396$, $p<.001$, Cohens $d=-0.74$) than females ($M=25.1$, $SD=8.9$). This difference is important, because it suggests that the mean of the baseline students is inflated by the larger proportion of males. Assuming the baseline sample had been made up of equal numbers of females and males, its mean would be 27.8, i.e. $((25.1+30.5)/2)$.

Table 5 Characteristics of baseline/comparison students*

Frequencies for Student Age

Student Age	Frequency	Percent	Valid Percent	Cumulative Percent
11	22	5.2	5.5	5.5
12	30	7.1	7.5	13.1
13	84	20.0	21.1	34.2
14	75	17.8	18.8	53.0
15	53	12.6	13.3	66.3
16	60	14.2	15.1	81.4
17	64	15.2	16.1	97.5
18	8	1.9	2.0	99.5
19	2	0.5	0.5	100.0
Missing	23	5.5		
Total	421	100.0		

Frequencies for Year in School

Year in School	Frequency	Percent	Valid Percent	Cumulative Percent
7	22	5.2	7.5	7.5
8	28	6.7	9.5	17.0
9	58	13.8	19.7	36.7
10	67	15.9	22.8	59.5
11	34	8.1	11.6	71.1
12	49	11.6	16.7	87.8
13	36	8.6	12.2	100.0
Missing	127	29.9		
Total	421	100.0		

Frequencies for Gender

Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Female	131	31.1	32.6	32.6
Male	267	63.4	66.4	99.0
Other	4	1.0	1.0	100.0
Missing	19	4.5		
Total	421	100.0		

*All comparisons exclude scores generated using the Kaupapa Outcome Rating Scale. This is explained further in the Procedure section, below.

3 Outcome Measure

The Outcome Rating Scale (ORS), a client self-report measure of well-being, was used as the outcome measure for this research project (see Appendix 1 for copy of the ORS).² Gathering data directly from students was important because research has shown that counsellors themselves are not particularly good judges of how their clients do in counselling (Goodyear, Wampold, Tracey, & Lichtenberg, 2017, p.60). The ORS is part of the Partners for Change Outcome Management System (PCOMS) client feedback intervention—comprised of the ORS, the Session Rating Scale (SRS) and a version for young adolescents and children called the Children’s Outcome Rating Scale (CORS). In choosing a scale, it was essential that the measure met the four criteria listed in Attkisson and Zwick (1982): it had to be brief, low cost, simple to administer and easily summarised results.

Brevity is a key criterion if an outcome measure is to be widely used. If it is too long and seen to be too complicated, counsellors may not use even a well-researched and validated scale (Duncan & Reese, 2013). In the case of the 4-item ORS, it takes less than 2 minutes to complete; has a high completion rate; is simple to explain and administer; is not tied to any particular theoretical orientation (Anker, Duncan, & Sparks, 2009) and the results can be easily summarised, analysed and compared with multiple studies originating in several different countries. The four questions assess clients’ personal well-being, family and other close relationships, social relationships and overall sense of well-being.

The ORS is administered to clients at the beginning of the counselling session. It assesses change since the previous session (*Looking back over the last week, including today...*). Duncan, 2014, provides a clear and brief description of how it is to be used in practice. The four items are scored using a 10cm, visual analogue scale. Clients place a mark at the point on the scales at which they judge themselves to be feeling. The four lengths are then measured and summed to get an overall score (min = 0; max = 40). Since there is a high correlation among the four items, only the total ORS is used as a global measure of well-being (Miller, Duncan, Brown, Sparks, & Claud, 2003).

The ORS is nomothetic, which allows comparisons with other groups of respondents and generalisation of results to larger groups (Sales & Alves, 2012). The ORS has been widely used in many settings, has been translated into many languages and is becoming more popular in New Zealand. Several agencies now use it, including Methodist Mission Southern (Dunedin), Relationships Aotearoa (unfortunately PCOMS was never fully implemented before RA’s closure), WellElder (Wellington), Wesley Community Action (Wellington) (see Manthei, 2015) and the counsellor education programmes at AUT and Massey University.

A Māori version called the Kaupapa Outcome Rating Scale (KORS) appeared in the *New Zealand Journal of Counselling* (Drury, 2007). It was based on Durie’s Whare Tapu Whā model of health (Durie, 1994) in which the four cornerstones of health (*taha wairua*—spiritual; *taha hinengaro*—

² Thanks to Scott D. Miller, founder of the *International Center for Clinical Excellence*, for allowing the project to use the ORS without cost. The only requirement was that all participating counsellors registered online and were licensed to use the scale.

mental and emotional; *taha tinana*—physical and *taha whanua*—family considerations) formed the four questions that measured a client's sense of well-being. It is administered and scored in the same way as the ORS. Paired comparisons of the ORS and KORS, using 40 mental health clients over 125 paired administrations, revealed a high correlation (Pearson two-tailed correlation of .92). In addition, the interpersonal item on the ORS was found to correlate .87 with the whanau item on the KORS (Drury, 2007). In spite of it being in existence for over a decade, the measure has been used very little so data reporting outcomes, baseline scores and more detailed reliability and validity levels are not available. Its use here was 'experimental', that is, to see if enough data could be gathered to allow some useful comparisons with the ORS.

Duncan (2012, p.95) summarised the reliability and validity research related to the ORS as follows: four validity studies (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Miller et al., 2003) yielded average Cronbach's alpha coefficients for ORS scores of .85 for clinical samples and .95 for nonclinical samples. Internal consistency for the CORS was .93 for adolescents and .84 for children (Duncan et al., 2006). Both the ORS and the CORS were found to be sensitive to change from pre-counselling to post-counselling, yet fairly stable over time for nonclinical samples (Bringhurst et al., 2006; Duncan et al., 2006; Miller et al., 2003).

Concurrent validity was established via correlations of ORS scores with other outcome measures: the QR (average across three studies was .62); the Depression Anxiety Stress Scale, the Quality of Life Scale, the Rosenberg Self-Esteem Scale (with correlations ranging from .53 -.74) and, for CORS scores, with the Youth Outcome Questionnaire (for adolescents, $r = .53$ and for children, $r = .43$).

When using the ORS with adults (18+ years), **clinical populations** include people who seek or are referred for psychological help. Their ORS scores are expected to be less than 25 at the beginning of counselling. **Non-clinical populations** consist of people from the general population who are not presumed to need or desire psychological help. Their scores are expected to be 25 or higher. Thus, a score of 25 or more is called the **clinical cut-off point**, the dividing line between clinical and non-clinical populations (Miller & Bargmann, 2012).

Differences between pre- and post-counselling ORS scores indicate **clinically significant change** when pre-counselling scores are below 25 and improve at least 5 points to a score of at least 25 or more at the end of counselling. **Reliable change** indicates a gain of 5 points, but not exceeding the clinical cut off at the end of counselling. Clients showing **no change** are those failing to gain 5 points during counselling, and those who **deteriorate** or are worse off after counselling are those who record a drop of 5 or more points from pre to post-counselling (Anker et al., 2009).

Average intake scores on the ORS for those seeking or being referred for counselling are usually 18 - 22. Typical scores for the general (non-clinical) population seem to be 27-29 (Manthei, 2015; Miller & Bargmann, 2012). Between 25% and 33% of adults from a clinical population score above 25 at intake (the clinical cut-off point) (Miller & Bargmann, 2012). This rate was reported to be 27% (in Reese, Duncan, Bohanske, Owen, & Mina, 2014), 28.4% (in Reese, Norsworthy, & Rowlands, 2009) and 25% (in Miller, Duncan, Brown, Sorrell, & Chalk, 2006), all within the suggested range, indicating some consistency across studies.

Scoring above 25 at intake does not invalidate people from benefitting from counselling, but it might affect how they are treated and how their counselling might progress. It is also thought that they might be at a heightened risk for deterioration (Miller & Bargmann, 2012; Miller, Duncan, Sorrell & Brown, 2005) due to (a) perhaps having been mandated to attend and therefore possibly reluctant to participate in counselling; (b) wanting help with a quite specific problem; (c) being an already highly functioning person who wants to grow or actualise further or (d) having misunderstood the scale in some way (Miller & Bargmann, 2012).

In accordance with the PCOMS protocol of administering both scales in every session, a client's ratings are incorporated into the counselling process by the counsellor and client discussing the ratings for both scales (called the **feedback condition**). **Treatment-as-usual** (TAU) applies when no such discussion of ORS scores takes place during the counselling sessions. Research has shown that the ORS and SRS scales can be used with confidence to measure therapeutic change, both under the recommended 'feedback' condition and without use of 'feedback'. However, if within-session feedback is used, enhanced gains in counselling can be expected (Miller, Duncan, Brown, Sorrell & Chalk, 2006; Reese et al., 2009; Reese, Norsworthy, Toland, & Slone, 2010; Schuman, Slone, Reese, & Duncan, 2014).

There are several shortcomings associated with the ORS. Firstly, the available research, although growing, is still sparse, especially research using the ORS in New Zealand. Thus, any figures reported in published studies should still be used with care. Secondly, there is often a substantial shrinkage of subjects from intake to the completion of counselling. This has been reported to be as high as 50% or more overseas (Anker, Owen, Duncan, & Sparks, 2010; Cooper et al., 2015; Reese et al., 2014) and 31% in New Zealand (Bridgeman & Rosen, 2016). A proportion of this shrinkage is due to one-session clients who are routinely excluded from the analysis—often as high as 20% of the total (Reese et al., 2014). Loss of this data is regrettable since a telephone follow-up of a sample of one-session clients found that 80% reported positive change (Miller et al., 2006). The problem with single session clients lies in not being able to obtain a post-counselling ORS score. Since the scale's directions say "*Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life*", two administrations during the first (and only) session would not make sense. Thirdly, clients in clinical samples who score 25+ at intake are often excluded from analysis because they are already functioning at a high level and are generally not expected to attain 'clinically significant' gains (Reese et al., 2010; Reese et al., 2014; Miller et al., 2006).

PROCEDURE

1 Organisation of the study

A research manager for each of the four targeted urban areas (see Table 1) was appointed to act as recruiter, trainer, liaison person and project overseer for the schools and counsellors in those areas. Schools that met the criteria for inclusion in the study in each geographical area were identified and then approached in person or by phone. Exactly how this was done in each case was left to each research manager to decide. Usually printed information about the study (a description of the study, what would be required of participating schools, copies of the ORS and KORS, sample data collection sheets and consent forms) was sent to schools before a face-to-face meeting with the principal and/or counsellor(s) was arranged.

Once a school principal and the counsellors understood the research protocol, agreed to participate and signed the consent form, the research manager met with the counsellor(s) to explain the data collection process and the administration, scoring and within-counselling use of the ORS. Each school also received information about recording, storing and forwarding outcome data to be processed at NZAC's head office. Schools were told that their research manager would be available to answer any questions and help them resolve any problems that might arise during the study.

Information about each school and all participating counsellors was collected. For schools this included: location, decile rank, total enrolment and the official counsellor staffing allocation. From this information the counsellor to student ratio was calculated. Information from participating counsellors included: NZAC membership, clinical supervision, professional counselling qualification, employment status (full- or part-time), years of counselling experience and most-used counselling modality. This information is summarised in Tables 2 and 3.

Schools were informed that the data collection phase of the study would begin early in 2019 and continue for at least two school terms or until there were sufficient counselling episodes for analysis. It was hoped that this would be about 2000+ cases, a figure several counsellors indicated was realistic given most counsellors' heavy work-loads. Schools would be notified when they could cease gathering data. All counselling took place during school terms 2, 3 and 4 in 2019.

Counsellors also were asked to administer the ORS to a representative group of students so that a baseline/comparison group could be established. It was suggested that one class from each year level in the school be administered the ORS. Individual students were not identified in this project; therefore, it is possible that some of the baseline/comparison students may have sought counselling at a later date, but the actual number is unknown.

2 Administration of the ORS

The ORS was used to gather self-report, first and last session data on all students who sought or were referred for counselling. Counsellors asked all students who came to them for counselling if they would be willing to participate in the study. The procedure and the ORS were explained before obtaining a student's verbal or written consent. The only students who were excluded from the study were those who (a) did not sign the consent form or verbally declined to take part, or (b) were judged by the counsellor to be inappropriate for inclusion. 'Inappropriate' included any students who were judged to be too emotional, vulnerable or confused to fully understand the study procedure and the consent process; some whose situations were judged to be too sensitive; or those who were clearly reluctant to be involved. In these instances, no further invitations to participate were made. The decision to exclude a student was left to each counsellor. Students who were excluded were still offered counselling-as-usual. Because the number of excluded students was not tallied, there is no estimate of how many there were across all of the schools.

The ORS was administered as close as possible to the beginning of the first counselling session. Counsellors were told that they could use the ORS as they wished: (a) either as a straightforward pre and post-test measure administered at the beginning of the first and last counselling sessions (described earlier as the *TAU condition*), or (b) at the beginning of every counselling session so that the results of each administration could be discussed in subsequent counselling sessions (called the *feedback condition*). The decision was theirs to make and depended on their familiarity with the ORS, how they perceived the study would impact on their workload and their usual way of working with clients (for example, how flexible they might be about incorporating a new procedure into their work with clients). Whichever condition was used, counsellors understood that two administrations of the ORS were needed for each student's results to be included in the data analysis.

Counsellors were told that they could offer Māori and other students the option of completing the Kaupapa ORS. A number of KORS cases were submitted, all of them from two schools (n=51). This number was too small to be usefully included in the main analysis and, therefore, the data was excluded. This meant that 13 schools contributed counselling cases to the final analysis. There were 122 KORS baseline scores, all but three from two schools. These scores, too, were excluded from the baseline analyses, which reduced the number of schools contributing Baseline data to five.

One-session clients were problematic, as has been reported in other studies where they were typically excluded from the final data analysis (Reese et al., 2014). In an effort to minimise this type of data loss, counsellors were asked to find ways to follow up their one-session clients after a week or so and have them complete the ORS a second time. Obviously, this request placed an additional burden on counsellors, but it was thought that obtaining a second ORS score in as many cases as possible justified the extra work involved. In the end, there were only 4 one-session/one score cases (1% of 490 episodes). The absence of a second session and associated ORS score meant that these students were excluded from any analysis of change-in-wellbeing over time analyses.

Counsellors kept a record sheet for every student engaged in counselling. They were to record a student's age, gender, ethnicity and year in school; the number of counselling sessions scheduled and delivered and the ORS scores for every session the scale was administered, especially the first and last sessions.

3 Study design and setting of alpha

The sample size was expected to be in the region of 2000 students, and the intention was to run a straight forward analysis of changes in ORS scores over time by gender and ethnicity. However, the number (N=490) in the actual sample of counselled students, although large, was fewer than expected. This raised a serious issue, i.e. the numbers in some cells were too small to analyse as planned. As a compromise, two separate analyses were done: ORS over time by gender and ORS over time by ethnicity. This is a less elegant model, and interactions between gender and ethnicity over time could not be examined. Nevertheless, it still provides insights into the rate of change by critical student characteristics.

Typically, *alpha* is set at either .05 or .01 in social science quantitative research. The level chosen has risks attached. An *alpha* of .05 is less likely to *miss making a discovery* than an *alpha* of .01. On the other hand, an *alpha* of .01 is less likely to *make a false claim* than an *alpha* of .05. The decision, albeit conservative, was to set *alpha* at .01. Equally conservative tests are the two tailed tests of probability. The actual values of *p* are presented for all of the inferential tests within the tables, as are effect sizes. This will enable a more detailed examination of the statistics that contributed to the conclusions. As it turned out, the choice over which alpha level to use was redundant because the obtained critical values for *p* were less than .01 in all but one case.

RESULTS

1 Presenting problems

Analysis of data from approximately 150 counselling cases indicated that over 30 types of presenting problems were recorded (from straightforward to complicated, from physical to psychological, from self-focused to relationships-focused). They included self-destructive behaviours like suicide attempts and substance abuse; relationship problems with families and friends; classroom and learning problems; career issues and psychological problems such as phobias, anxiety and depression. Many of the problems had similar elements and therefore could be categorised under common headings, the most frequent being, in descending order:

- 1) family relationships and other family related problems such as family violence, family trauma and parental break-up
- 2) depression/low moods/suicidal ideation and talk
- 3) relationships with friends, classmates or peers
- 4) stress and anxiety
- 5) school-related matters such as attendance, bullying and stress over classroom concerns.

2 Number of sessions

The average number of sessions in this study was 4.0 with a range from 1 session to 16. The modal number was two (29%) with the next highest number being three (21%). Sixty-nine per cent of the counselled students had fewer than five sessions and 92% had fewer than eight sessions. Thus, the counselling these students received is accurately described as 'brief therapy'.

3 Counsellor/student ratios

Table 1 shows that the 16 participating schools had an average enrolment of 1437, an average counsellor/student ratio of 1:668 and an average of 2.4 counsellors per school. The counsellor-to-student ratios ranged from 1:487 to 1:1035, all of which are lower than recommendations from professional counselling associations in New Zealand and the USA.

4 Baseline ORS scores

ORS scores for populations not seeking counselling (called *baseline* or *non-clinical* scores) are useful for comparing with *clinical* populations, i.e., those seeking or referred for counselling. Usually, ORS baseline scores are higher than 1st session scores for clinical populations, which suggests those clients are less in need of counselling. In the present study five schools provided baseline ORS scores from a population of the student body at-large (N = 421). Table 6 shows the baseline mean score of 28.4 was higher than the mean 1st session average for counselled students of 17.2 and their final session score of 24.7.

Insight into the effect of counselling on the students can be gained by inspecting the relationship between the ORS scores over time with the ORS scores of the baseline students. Table 6 sets out the means and standard deviations for counselled and baseline students. The baseline students completed the ORS on only the one occasion. The trend in Table 6 is obvious. The baseline average of 28.4 exceeded the mean 1st session ORS of the counselled students by 11 points. Table 7 shows this difference is significant and the effect size of 1.4 is much greater than the figure of 0.8 that is customarily used to identify a large effect. The final session ORS mean for the counselled group of 24.7 is much closer to the mean of the baseline students, but still significantly lower, although the effect size is small to moderate.

The N of 490 for counselled students in both the paired and independent t-tests for pooled students is greater than the number of cases for the later analyses repeated measures ANOVA of gender by ORS over time (p20). This is because six cases in the repeated ANOVA did not have information on their gender and were thus treated as missing data, resulting in an N for this analysis of 484. A similar situation exists if the N of cases in the ANOVA of ethnicity by ORS over time (p22) is compared with the N in the pooled analysis.

Table 6 ORS means and standard deviations for counselled and baseline students

	Group	N	Mean	SD	SE
1 st session ORS	Counselled	490	17.2	8.0	0.36
	Baseline	421	28.4	8.0	0.39
Final session ORS	Counselled	490	24.7	8.6	0.39

Table 7 Independent samples t-tests of ORS for baseline students and counselled students at first and final administrations

	t	df	p	Cohen's d
1 st Session ORS	-21.1	909	<.001	1.40
Final session ORS	-6.6	909	<.001	-0.44

5 Gender

More females received, and presumably sought, counselling than males. Therefore, gender was examined as a variable on its own when examining the effects of counselling on students. Table 8 sets out the means and standard deviations for the three gender groups. There is a clear trend for the ORS means to increase significantly over time for each gender group.

Table 8 Means and standard deviations for gender by change over time

RM Factor 1	Gender	Mean	SD	N
1 st session ORS	F	16.0	7.6	339
	M	20.5	8.2	136
	Other	15.1	5.2	9
Final session ORS	F	24.0	8.6	339
	M	26.8	8.4	136
	Other	22.3	10.2	9

Table 9 sets out the ANOVA for ORS means over time by gender groups. Levene's test indicated that homogeneity assumptions have not been violated. There are significant main effects for gender and time. There is no significant interaction. In Figure 1, the plots set out the trend for the gender groups over time. Males begin and end counselling with mean ORS scores higher than the other two groups. The trend for females parallels the trend for males, but at a lower level; the group identifying as alternative gender parallels the trend for females, but again at a lower level. The slopes of the three lines are basically similar, indicating that the rate of progress in counselling is similar, with the mean gain ranging from about 6 to 8 points.

Table 9 Repeated measures ANOVA for gender by change over time

Within Subjects Effects

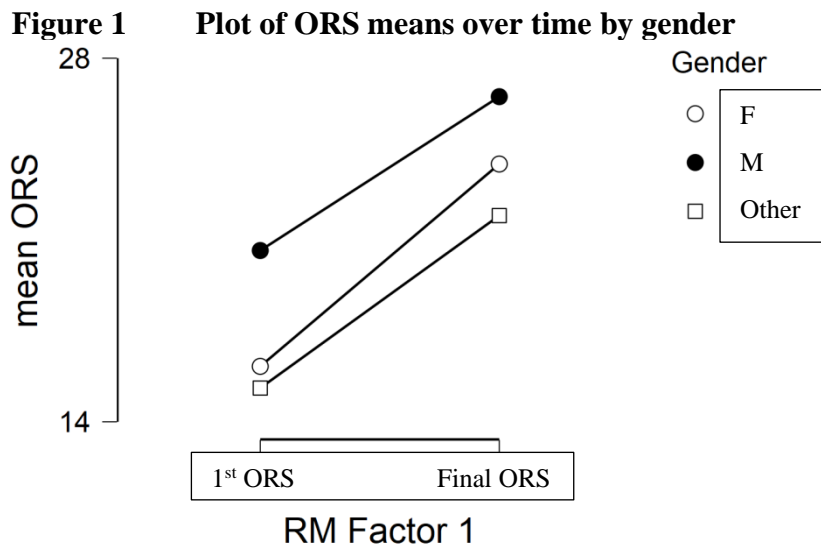
	Sum of Squares	df	Mean Square	F	P	η^2
RM Factor 1	1903.2	1	1903.2	51.9	<.001	0.03
RM Factor 1 * Gender	136.6	2	68.3	1.9	0.16	0.00
Residual	17652.4	481	36.7			

Note: Type III Sum of Squares

Between Subjects Effects

	Sum of Squares	df	Mean Square	F	P	η^2
Gender	2687.9	2	1343.9	14.0	<.001	0.06
Residual	46296.2	481	96.4			

Note: Type III Sum of Squares



6 Ethnicity

New Zealand as a nation was founded 180 years ago based on an agreement between two cultures, Māori and Pākeha. There has been significant immigration from other cultures since this agreement. In the current study there were 22997 students enrolled across the 16 schools that participated in the study (www.educationcounts.govt.nz/statistics/schooling/student-numbers/6028). The enrolment numbers were abstracted from the machine-readable rolls, July 1, 2019. Pākeha students are still in a majority (62.6%) in these schools. The next largest group of students are Māori (14.7%), followed by Asian (6.9%), Pasifika (4.1%), Indian (2.2%) and Other (9.5%). Thus, in today's society it seems prudent to include ethnicity as a variable of interest when examining processes within schools.

In the current study the ethnic categories adopted by the Ministry of Education were not used. There are schools in the study that have significant numbers of students who identified their ethnicity as either Chinese or Indian. In two schools these groups make up the majority of students. Thus, the categories adopted for this study follow those used by counsellors and students, which included Pākeha, Māori, Pasifika, Indian, Asian and Other. Table 10 sets out the means and standard deviations of ORS scores over time for the five identified ethnic groups: Pākeha, Māori, Pasifika, Indian and Asian. One obvious trend is apparent and this is the positive change in ORS means over time for all of the five ethnic groups.

Table 10 Means and standard deviations for ethnicity by change over time

RM Factor 1	Ethnicity	Mean	SD	N
1 st session ORS	Pākeha	17.2	8.0	280
	Māori	15.7	8.9	62
	Pasifika	15.5	7.1	16
	Indian	14.9	10.6	10
	Asian	18.0	9.0	31
RM Factor 2				
Final session ORS	Pākeha	25.9	8.2	280
	Māori	23.7	8.3	62
	Pasifika	27.4	7.9	16
	Indian	25.4	9.1	10
	Asian	21.8	9.4	31

Table 11 sets out the ANOVA for ethnicity by ORS over time. Levene's test indicates that homogeneity assumptions have not been violated. There is the expected main effect for positive changes in ORS means over time, no main effect for ethnicity, but the hint of a significant interaction

($p=.02$) between the rate of change over time for the five ethnic groups. The effect size for this interaction is very small, with $\eta^2=.007$. Table 11 shows that the Pasifika and Indian students had the lowest mean ORS scores at the first counselling session, but among the highest mean scores at the final counselling session. Consequently, they had the highest gain scores (11.9 and 10.5 points, respectively), indicating they made more progress through counselling than the other three ethnic groups. By contrast, the Asian students made relatively little gain over time (gain score = 3.8). This finding is also shown in the plot of the ethnic groups' scores over time (Figure 2). While this is an intriguing finding, given the small effect size and the value of p , perhaps too much should not be read into this result. However, the rapidly changing nature of the ethnicity of the school population in some areas makes it sensible to alert readers to the possibility of the interaction.

Table 11 Repeated measures ANOVA for ethnicity by changes over time

Within Subjects Effects

	Sum of Squares	df	Mean Square	F	p	η^2
RM Factor 1	4181.7	1	4181.7	120.4	< .001	0.07
RM Factor 1 * Ethnicity	433.6	4	108.4	3.1	0.02	0.01
Residual	13685.9	394	34.7			

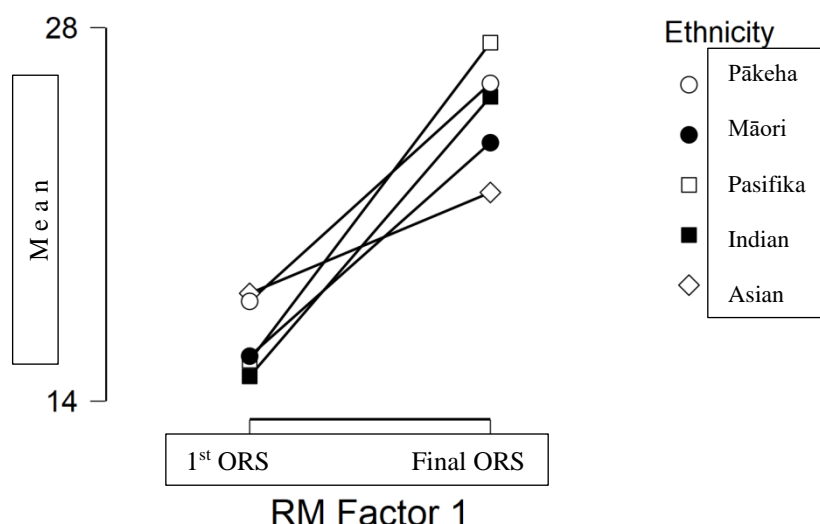
Note. Type III Sum of Squares

Between Subjects Effects

	Sum of Squares	df	Mean Square	F	p	η^2
Ethnicity	620.6	4	155.1	1.5	0.20	0.015
Residual	40406.4	394	102.6			

Note. Type III Sum of Squares

Figure 2 Plot of ORS means over time by ethnicity



7 Overall students' gains

Pre- and post-counselling scores, gain scores: Published studies tend to ignore gender and ethnicity as variables when examining the effects of counselling on students over time. To enable comparisons to be made between the present study and other published studies, the gender and ethnic groups were pooled, and pre- and post-counselling scores and gain scores calculated. A *gain score*

indicates how much a client improves or worsens over the course of counselling. With the ORS, a gain or loss of five or more points indicates significant improvement or deterioration (Miller et al. 2005), respectively. Table 12 sets out the means and standard deviations for the pooled group of students over time, and for the mean gains made after counselling. The counselled students on average gained 7.5 ORS points during counselling.

Table 12 Means and standard deviations of ORS over time for counselled students

	N	Mean	SD	SE
ORS 1	490	17.2	8.0	0.36
Final ORS	490	24.7	8.6	0.39
Gain score		7.5	8.6	

Effect size: Cohen's *d*, (Cohen, 1988) is a robust and relatively unbiased estimate used to assess effect size. Effect sizes of .2 are considered small, .5 medium and .8 or more large. An advantage of using effect sizes is that the statistic can be averaged over several studies, or directly compared among individual studies. The magnitude of this gain (Cohens *d* = .87, see Table 13) suggests the change is not only large but likely to be obvious to an observer.

Table 13 Paired samples t-test of ORS over time for counselled students

	t	df	P	Cohen's d
ORS 1 – Final ORS	-19.4	489	<.001	-0.87

8 **Stability and change across counselling sessions**

Table 14 sets out the means and standard deviations of the counselled students on ORS for sessions over time. There is a gain of 6.2 points from session 1 to session 4, but after that the trend is for the gains in mean ORS to decrease over time. There is a gain of 4.4 points from session 1 to session 2, a gain of just less than 1 point from session 2 to session 3, and a similar gain from session 3 to session 4. After that, the trend is for ORS scores to decrease from one session to the next, with exceptions in the final session when the number of clients is small. In this situation a large shift in one or two students has a significant impact on the mean.

Of the 490 students who began counselling, 205 (42%) had left before a third session, and 74% had left before a fifth session. By the ninth counselling session, there were only 13 students in counselling across the 13 schools. Inspections of the original data sheets found students who made gains across these later sessions, e.g. student 20 in School 1 had a gain of four ORS points from session 8 to session 9; another student 36 in the same school had a similar gain from session 8 through 10, but there were other students who made little or no gains across these sessions, e.g. student 56 in School 2 (a gain of one point from sessions 8 to session 9) and student 232 in School 10 (a decline of about 4 points from sessions 8 through 10).

Table 14 Means and standard deviations for ORS scores across counselling sessions

Session #	1	2	3	4	5	6	7	8	9	10	11	12
Valid	490	422	285	199	125	70	38	22	13	14	4	2
Missing	0	68	205	291	365	420	452	468	477	476	486	488
Mean ORS	17.2	21.6	22.5	23.4	23.0	22.8	22.7	20.9	19.8	23.8	20.6	22.9
SD	8.0	8.7	9.0	9.2	9.2	9.2	9.8	10.0	8.6	7.8	10.0	11.5

The correlations in Table 15 are both unexpected and surprising. What is expected is the correlation of 0.6 between the ORS scores for session 1 and 2, but what is unexpected is the trend for the correlations to increase in magnitude along the diagonal. This indicates that the ORS scores for those remaining in counselling become more stable, i.e. the ORS scores of individuals tend to increase or decrease by relatively small amounts over time. From another perspective, the scores of those students remaining begin to fluctuate less from one session to the next.

Table 15 Correlation matrix for ORS1 through ORS11

		ORS 1	ORS 2	ORS 3	ORS 4	ORS 5	ORS 6	ORS 7	ORS 8	ORS 9	ORS 10	ORS 11
ORS 1	Pearson's r	—										
	p-value	—										
ORS 2	Pearson's r	0.62	—									
	p-value	< .001	—									
ORS 3	Pearson's r	0.52	0.77	—								
	p-value	< .001	< .001	—								
ORS 4	Pearson's r	0.56	0.70	0.73	—							
	p-value	< .001	< .001	< .001	—							
ORS 5	Pearson's r	0.44	0.66	0.64	0.79	—						
	p-value	< .001	< .001	< .001	< .001	—						
ORS 6	Pearson's r	0.55	0.60	0.61	0.72	0.67	—					
	p-value	< .001	< .001	< .001	< .001	< .001	—					
ORS 7	Pearson's r	0.37	0.63	0.72	0.81	0.80	0.88	—				
	p-value	0.022	< .001	< .001	< .001	< .001	< .001	< .001	—			
ORS 8	Pearson's r	0.45	0.73	0.70	0.69	0.65	0.69	0.72	—			
	p-value	0.034	< .001	0.001	0.002	0.004	0.001	< .001	< .001	—		
ORS 9	Pearson's r	0.43	0.71	0.68	0.58	0.60	0.61	0.51	0.67	—		
	p-value	0.139	0.015	0.022	0.064	0.052	0.045	0.104	0.026	< .001	—	
ORS 10	Pearson's r	0.57	0.78	0.50	0.93	0.63	0.15	0.41	0.76	0.83	—	
	p-value	0.039	0.024	0.253	0.007	0.130	0.730	0.420	0.046	0.084	< .001	—
ORS 11	Pearson's r	-0.01	-0.16	-0.15	0.51	-0.73	-0.27	0.50	-0.19	0.11	0.73	—
	p-value	0.986	0.895	0.907	0.659	0.479	0.827	0.665	0.881	0.931	0.475	< .001

Note: The number of observations is less than 3 in ORS 12.

9 Proportions of students who gain or deteriorate

Another way of gauging the success of counselling when using the ORS is to calculate the percentage of clients who make significant gains, do not change, or deteriorate when measured at the end of their counselling. *Clinical change* occurs when clients who score below 25 at the 1st session move ≥ 5 points and are in the non-clinical range (≥ 25) at post-testing. *Reliable change* is an improvement of ≥ 5 points at final-testing. *No Change* describes clients who change less than ± 5 points at post-testing. *Deterioration* describes clients who regress ≥ -5 points at post-testing (see Miller et al., 2005).

In the present study 54% of students had a *clinical change*, 59% recorded a *reliable change*, 35% showed *no change*, and 6% were shown to have deteriorated. These proportions are comparable to those displayed later in Table 22.

10 Change related to different 1st session ORS scores

The proportion of those whose 1st session ORS score was below 25 was 82% and their average gain score was 8.8 (Table 16). Sixty-six percent of those students had gained 5 or more points by the end of their counselling, whereas only 4% had deteriorated.

It has been estimated that between 25% and 33% of adults from a clinical population score above 25 at their first session (Miller & Bargmann, 2012). In this study of adolescents, the proportion was lower at 18% (Table 16). Their average gain score was only 1.5 points and, therefore, the proportion of students in the ‘no change’ category was considerably higher than the corresponding figure for the group of students whose 1st session ORS scores were < 25. The rate of deterioration was similar at 6%.

Table 16 Change related to different 1st session scores

	# of cases	Ave gain score	% Clinical change	% Reliable change	% No change	% Deterioration
Students with 1 st Session ORS scores < 25	403, or 82%	8.8	66%		30%	4%
Students with 1 st Session ORS scores ≥ 25	87, or 18%	1.5		25%	69%	6%

11 Case studies

In order to give some context to the statistics and to illustrate the types of problems dealt with and the approaches used, counsellors were asked to supply two case studies: one that they thought was fairly typical of their work, and one that presented more difficulties. Five cases have been received from three counsellors. They appear in Appendix 2.

12 Counsellors’ reactions to participating in the study

At the end of the study all 31 counsellors were sent a brief, five-question survey designed to elicit their thoughts about participating in the research. Twelve replies were received. The questions and replies are summarized below.

Q1 Participation in the study was lower amongst counsellors than we had expected. Why was that so? What could we have done to increase participation rates?

There seemed to be two main reasons for the low participation rate. The first had to do with counsellors being already too busy to take on extra tasks such as this research project: “...with 60-70 clients at any given time...anything extra...is difficult to manage.” / “...counsellors are very busy meeting the needs of various stakeholders of the school...” / “...the workload on the counsellors in Term1 and 2 was overwhelming...” These comments mirror the main reasons people gave for not participating: they were already under significant stress and experiencing work overload.

A second set of reasons had to do with the research protocol and the scale used (the ORS). Typical comments suggested that the introduction of the research process was “shoddy, ill-prepared and too time consuming”, and that the process could have been explained more fully. In addition, it was suggested that the forms be “streamlined”, put online, made simpler. Two counsellors avoided using the ORS with certain students, those “...with severe depression and anxiety which affects their ability to think and manage life in general.” There was the concern that the scale would “...intensify [students’] sense of hopelessness, especially when looking at scoring ‘socially’ and ‘interpersonally’...” Another counsellor said “...the scale was unhelpful when dealing with students with severe mental health needs and there are a growing number of these students in our school”.

There were no comments about how we could increase participation.

Q2 How difficult was it to manage the extra demands that participation involved and where was its biggest impact on your workload? Could we have done anything to assist with these demands?

The responses to this question basically amplified the responses to Q1, namely that managing the research demands intensified their feelings of overload and stress: “...it was an extra thing to do...” / “...the study added paperwork load and that is something I did not enjoy.” / “Very difficult to manage the extra demands...” / “...had a noticeable impact on the workload.” There were also comments about difficulties in remembering to use the ORS with all students, the extra time it took out of the working day to process and collate the results and the extra paperwork involved. Finally, there were a couple of comments questioning the appropriateness of using the ORS with “clients in crisis...” or “...when a client was emotional on arrival...” There were no suggestions regarding how the researchers could have helped them manage those demands: “I don’t think there is anything the university could do to lessen the demands of a busy school environment.” / “I don’t think this is due to anything about your survey, just indicative of overload.”

Q3 What benefits, if any, did you experience for you own work as a counsellor by participating in the study?

Positive reactions overshadowed ‘no benefits’ ones, seven to five. Examples included “It was great to see students’ self-report improvements! Very heartening.” / “... a useful too when used [intermittently during counselling]” / “...[having] feedback about the conversation...”...was positive and enriching...” / “...I found it generally positive. Some students like doing a quick summary of where they’re at.” Criticisms again involved “Additional pressure of time.”, but also included things like “None really...the forms were [not] something the kids engaged with.” / “Hard to say...”. One counsellor said “There would have been a benefit if the [promised] koha had happened...”.

Note: This is something that was promised to all participating schools, but will not be carried out until the final research budget is known.

Q4 What benefits, if any, did you experience for your school in general by participating in the study?

Clearly, the most frequent reaction was ‘none’ or ‘don’t know’: “None really” / “There was no benefit for our school.” / “I am not sure. I feel getting formal [sic] report on the students’ perception of counselling would be useful.” The few positive comments indicated that the “...results of the research will be valuable and [I] will present the findings to our BOT next year.”, and that the project was “Helping the guidance department become more aware of the ORS tool.”

Note: All schools will receive a copy of this report and all participating counsellors will receive a condensed copy of their school’s performance data alongside a summary of the aggregated schools’ data.

Q5 How valuable do you judge such studies to be for the development of school counselling in New Zealand?

Most counsellors were positive about the value of this sort of research for the development of the profession: “Incredibly valuable.” / “Local studies are critical to identify trends particular to our country and to access funding.” / “...extremely valuable...” / “I think this would be the start of something that would benefit the profession as a whole.” / “Essential.”. Some had mixed reactions that both welcomed this type of research, but questioned this particular effort: “Very mixed. If the survey was to explore the effectiveness of school counsellors it needed to be expanded.” / “...our profession is lacking in good research...not sure that this method was the best though.” Finally, a couple questioned what use the research would be in practical terms: “Doubtful if it will change the stance of our Principal...” / “Valuable if they mean the govt funds more of us.”

DISCUSSION

This first systematic study of the effectiveness of counselling in New Zealand schools found that it has a significant and positive impact on students. Irrespective of how the data were analysed, the results were found to be positive and the magnitude of the impact was similar to that found in studies undertaken in secondary schools overseas. The findings are even more notable, given the high levels of stress reported by school counsellors in New Zealand and the very low staffing levels in schools compared with those overseas. In this section these results are compared with relevant overseas and New Zealand studies.

1 Presenting problems

The ranking of the top five problems in this study (see p18) closely mirrors the hierarchy found in New Zealand schools by Hughes et al. (2019). Their top five problems were, in order:

- 1) family issues
- 2) anxiety
- 3) school issues
- 4) peer friendships
- 5) depression.

Thus, although the exact order within the two rankings is different, the five most frequently mentioned categories of problems were the same in both studies. This consistency should be useful for counselling practice and professional training. In terms of counselling practice, both studies indicate the broad range of problems that every counsellor must be able to recognise and respond to, whether that means treatment or referral to an outside specialist. They do not have the option of screening out certain problems or focusing on a few issues to the exclusion of others. They are, of necessity, generalists who deal with all student requests.

2 Number of sessions

This study confirms the general finding that counselling, whatever the setting or age of clients, tends to be brief, that is, fewer than 7 or 8 sessions. As shown in Table 17, the average of four sessions per client in this study is similar to what has been reported elsewhere, whether overseas or in New Zealand. For example, the average for all 13 studies listed is 6.6, a figure that is inflated by three of the studies having averages over 10. The average for the five New Zealand studies is 3.8, a figure more in line with what was found in this study.

The finding that counselling tends to be brief should not surprise practitioners. In a recent interview (Young & Dryden, 2019) on the topic of single-session therapy, Young point out that “the most common number of service contacts that clients attend is one, followed by two, followed by three...irrespective of diagnosis, complexity, or the severity of their problem” (p. 646). This finding has important implications for practitioners and counsellor trainers in terms of how they approach the counselling relationship: expect it to be brief and to treat every session as if it will be the last one (Young & Dryden, 2019).

Table 17 Average number of sessions in studies using either the ORS/CORS or other outcome measures

LOCATION OF STUDIES	Number of subjects	Age of subjects	Setting	Ave # Sessions	Used ORS/CORS
Overseas					
1 Cooper (2009). Review of 30 UK studies	13 studies with this data	11-18; ave=13.9	Scot, Nth Ireland, English sec schools	6.4	No
2 Murphy et al (2012) Ireland	N = 110	18-59	Irish U Couns Centre	3.7	ORS
3 Cooper, Stewart et al. (2013)	N = 288	7-11 yrs	Nth Ireland schools	12.0	CORS
4 Cooper, Pybis et al. (2013)	N = 3613	11-18yrs	UK secondary schools	3.7	No
5 Janse et al (2014) Dutch	N = 543	18-71; ave = 41	Outpatient clinic	16	ORS
6 Ostergard et al (2019) Denmark	N = 492	University students	U Couns Centres	3.8	ORS
7 Kodet et al (2019)	N = 270	13-17	Pub health setting	10.9	ORS
8 Cooper (2009)	N= 2500+ from 13 studies	School age, m=13.9	UK secondary schools	6.4	No
New Zealand					
1 Bridgeman and Rosen, (2016)	N = 2632	11-95; ave=41.2	Problem Gamblers	4.2	ORS
2 Manthei and Norse (2012)	N = 635	Elderly, 55+	Agency	4.5	ORS
3 Manthei (2016)	N= 5670	Adults	Agency	4.6	No
4 Manthei (2017)	N = 762	Adults	Private Practice	3.1	No
5 Hughes, et al. (2019)	N = 1596	Secondary school age	11 secondary schools	2.5	No
Current Study	N = 490	11-19; m=14.9	13 secondary schools	4.0	ORS

3 **Counsellor/student ratios**

New Zealand schools are under-staffed. The average staffing level of one counsellor to every 668 students in the current study is considerably below what is desirable given the recommended staffing ratio in the USA, for example. A recent survey of 125 school counsellors (Andrews, Macfarland, & McFelin, 2019, p. 6) reported that all counsellors argued that “more counselling hours were needed to meet the needs of students”, with most claiming they required an additional 11 or more hours per week. Table 18 sets out the actual ratio for the study schools, the ratio recommended by other professional bodies and the level of staffing the 16 schools would be entitled to under each scenario.

The American School Counselor Association recommends a student to counsellor ratio of 1:250. This figure is based on research that has shown that higher ratios produce a range of positive outcomes for students, such as higher graduation rates; lower rates of absenteeism; higher SAT math, verbal and writing scores and fewer suspensions (see studies cited in the ASCA’s “Empirical research Studies supporting the value of school counseling”, 2019). Not one school in the present study was remotely close to the ASCA’s recommended ratio, but they still managed to provide effective counselling to their students in spite of their claims that they were stressed and overworked. One could ask ‘How much more could be accomplished by school counsellors if a more favourable staffing ratio was employed?’ Perhaps more staffing would enable them to work more effectively, experience less stress and burnout and reduce waiting times for students to see a counsellor.

Table 18 Actual and recommended counsellor/student ratios and staff levels for an enrolment of 1437

	Co/student ratio	Staffing level
Actual: current study	1:668	2.4
NZAC	1:400	3.6
American School Counselor Ass'n	1:250	5.7

4 Baseline scores

Typically, ORS baseline scores are higher than 1st session scores for clinical populations, meaning those clients are less in need of counselling or therapy. Other studies have usually reported average baseline scores ranging from 27 to 29. The score of 28.4 in this study was, as expected, higher than the average 1st session score for counselled students (17.2), and the same as those found in three overseas studies (Table 19).

Table 19 Non-clinical ORS scores for those not seeking counselling

LOCATION OF STUDIES	Number of subjects	Age of subjects	Setting	Non-clinical ORS score	Used ORS/CORS
Overseas					
1 Duncan et al (2006) USA	N = 45	Adolescents	Public school	29.5 sd=7.9	Yes
2 Janse et al (2014) Dutch	N = 116	11-71; ave = 41	Outpatient clinic	29.6 sd=6.0	Yes
3 Miller et al (2003) USA	N = 86	Masters Students	University	28.0 sd=6.8	Yes
New Zealand	No data				
Current Study	N = 421	11-19; m=14.5	5 secondary schools	28.4 sd=8.0	Yes

5 Gender

Although the significantly higher male mean ORS 1st and final session scores are interesting, there is no obvious explanation for them. Interestingly, males also had significantly higher baseline scores than females (30.5 vs 25.1), but, again, there is no obvious reason why males in the general school population were functioning at a higher level of well-being than females. Manthei's (2015) review of studies using the ORS found conflicting evidence regarding gender differences. Nevertheless, the size of the differences in this study certainly warrant further investigation.

6 Ethnicity

In Manthei's (2015) review of PCOMS research, some researchers reported probable cultural or national differences in ORS pre- and post-counselling scores (e.g., Hafhenschedn, Duncan & Miller, 2010; Janse, Boezen-Hilberdink, van Kijk, Verbraak & Hutschemaechers, 2014), but such literature is still sparse. Efforts to validate the ORS in other countries is ongoing (e.g., Maggie, Nina-Robles, Miller, & Fexias, 2018 in Spain; and She, Sun, & Jiang, 2017 in China). In the meantime, the scale continues to be used in different countries and with varying cultures as though it were culturally neutral. Our tentative findings plus the increasing cultural diversity of New Zealand makes it important that future researchers investigate ethnic differences in counselling process and outcome studies.

7 Overall student gains in counselling

Pre- and post-counselling scores, and gain scores: Table 20 shows mean pre-counselling ORS for clients in relevant overseas studies. It also includes the mean gain scores made by the clients. It is useful to compare this study's mean ORS scores with those from overseas studies where average 1st session ORS scores typically range between 18 and 22 (Manthei (2015). Table 20 shows this to be the case. It also lists the mean gain scores from previous research from several countries using clients of various ages. As can be seen, the mean gain score in this study compares very favourably with gain scores from other studies. More importantly, the size of the gain score is greater than 5 ORS points which researchers assert (Miller et al., 2005) indicates significant improvement.

Table 20 ORS pre- and post-counselling scores and resulting gain scores

LOCATION OF STUDIES	# of subjects	Age of subjects	Setting	Pre-ORS	Post-ORS/CORS	Gain Score
Overseas						
1 Duncan et al (2006) USA	N = 1495	Adolescents	Outpatient clinic	25.9	33.6	7.9
2 Mikeal et al (2016) USA	N = 94	University students	Univ couns centre	22.1	27.8	5.7
3 Kodet et al (2019) USA	N = 270	Adolescents	Agency, depressed youth	19.5	28.8	9.3
4 Murphy et al (2012) Ireland	N = 51	18-59; m=23	U Couns Centre	19.1	23.8	4.7
5 Ostergard et al (2019) Denmark	N = 492	University students	University Couns Centres	18.0	27.0	9.1
6 Kodet et al (2019) USA	N = 469	13-17; major depression	Public health setting	19.5	28.8	9.3
7 Cooper, Stewart et al (2013) N Ireland	N = 288	7-11yrs	Nth Ireland schools	25.3	37.9	12.7
8 Manthei (2015) 14 studies 5 countries; all using 'feedback' condition		Adults:	Various	20.2	27.4	7.2
		Students:		21.1	29.9	8.8
9 Manthei (2015) 8 studies 2 countries; all in 'no feedback'		Adults	Various	20.6	26.1	5.5
New Zealand						
1 Bridgeman and Rosen (2016)	N = 2632	11-95, ave 41.5	Problem Gamblers	24.4	30.1	6.6
2 Manthei and Nourse (2012)	N = 204	Elderly adults; 55+	Agency	19.7	28.2	8.5
Current study	N = 490	11-19; m=14.9	13 secondary schools	17.2	24.7	7.5

Effect size: In Table 21 effect sizes are shown for various studies using different client samples, outcome measures and age groups. The average for studies reported in the table was $d=.86$. The effect size in the current study ($d = .87$) indicates that the impact of counselling on clients in New Zealand is similar to those observed overseas. Bridgeman and Rosen (2016) is the only New Zealand study, and their calculated effect size ($d = .64$) is smaller than the current study's, but their sample of 'problem gamblers' makes its relevance questionable.

Table 21 Effect sizes from various studies using various populations, outcome measures and age groups

LOCATION OF STUDIES	Number of subjects	Age of subjects	Setting	Effect size	Used ORS/CORS
Overseas					
1 Cooper, Pybis et al. (2013)	N = 3613	11-18yrs	UK secondary schools	.93	No
2 Baskin et al. (2010) meta-analysis of 107 studies USA	No details given	7-18 yrs	Schools	>13 = .59	No
3 Cooper Stewart et al (2013)	N = 288	7-11yrs	Nth Ireland schools	1.49	CORS
4 Cooper (2009)—review of 30 UK studies	2164 in 16 studies; ave 135	11-18yrs	Scot, Nth Ireland, Eng secondary schools	.81	No
5 Ostergard et al (2019) Denmark	N = 492	University Students	U Couns Centres	1.05	CORS
6 Kodet et al (2019) USA	N = 270	13-17; major depression	Pub health setting	1.69	CORS
4 Murphy et al (2012) Ireland	N = 51	18-59; mean=23	U Couns Centre: two groups	.64	CORS
New Zealand					
1 Bridgeman and Rosen (2016)	N = 2632	11-95, ave 41.5	Problem Gamblers	.64	CORS
Current Study	N = 490	11-19; m=14.9	13 secondary schools	.87	CORS

8 Stability and change across counselling sessions

It would seem from the data in Table 14 that the more counselling they receive, the worse students become. Of course, this is nonsense. Rather, what is happening is that as students feel better about themselves and their situations, they leave the relationship, and a large proportion (74%) leave before the fifth session. This data also shows that ‘brief’ does not mean ineffective, since the greatest gains in counselling occurred in the first three sessions. After that, gains tended to diminish, and in some cases decrease.

There are probably two related reasons for this pattern: students leaving counselling when they had felt they had achieved enough, thus leaving students with more intransigent personal issues continuing in counselling. In regard to the latter, counsellors may be supporting them through difficult circumstances in which there are ongoing multiple stressors in their lives. Thus, while they register little progress on the ORS, counselling may in fact be helping to stabilise their lives. This possibility needs to be investigated further.

9 Proportions of students who gained or deteriorated

Unfortunately, various researchers have interpreted the concepts *clinical change*, *reliable change*, *no change*, and *deterioration* in different ways so direct comparisons across several studies is not always straightforward. The meaning of the various terms is given in footnotes at the end of Table 22. The table shows that proportions of students all four categories were similar to those from other studies, whether they originated in New Zealand or overseas.

It should be noted that the clinical cut off point—originally identified as 25 in the USA—might be different in other countries (e.g., reported to be 24 for the Netherlands) and for different age groups (e.g., 32 for children and 28 for adolescents) (Green & Latchford, 2012). However, without having any similar data for New Zealand clients, 25 was accepted as the working clinical cut off score in this study.

Manthei’s (2015) review of studies using the ORS found that one could expect at least 50% of clients to register gains of 5 points or more (*reliable change*). In this study the number was 59% (see Table 22). Similarly, fewer than 10% of clients would be expected to deteriorate during counselling, a figure that is higher than the 6% recorded for students in this study (Table 22). Thus, on both counts counselling in this study has produced figures that have exceeded those expectations.

Table 22 Percentages of clients achieving ‘clinical change’, ‘reliable change’, ‘no change’, or ‘deteriorating’ after counselling

LOCATION OF STUDIES	# of subjects	Age of subjects	Setting	Clinical change	Reliable change	No change	Deterioration
Overseas							
1 Cooper Stewart et al (2013)	N = 288	7-11yrs	Nth Ireland schools	88.7%*			3.9%**
2 Murphy et al (2012) Ireland	110	18-59; mean=23	U Couns Centre: two groups		55%^	38%***	7% #
3 Ostergard et al (2019) Denmark	N = 492	University Students	U Couns Centres		68%^	5.2%***	5.2% #
New Zealand							
1 Bridgeman and Rosen (2106)	N = 2632	11-95, ave 41.5	Problem Gamblers	63%*		40%***	7% #
2 Manthei and Nourse (2012)	N = 281	55+	Elderly couns centre		68.9%^	16%***	10.9% #
Current NZ study	N = 490	11-19; ave =14.9	13 secondary schools	54%	59%^	35%***	6%#

*Clinical change = % of subjects in clinical range at pre-counselling moving ≥ 5 points to non-clinical range at post-testing

^Reliable change = ≥ 5 -point improvement at post-testing

*** No Change = % of sample who changed less than ± 5 points at post-testing

**Deterioration = % of subjects in non-clinical range moving to clinical range at post-testing

Deterioration = % of sample who regressed ≥ -5 points at post-testing

10 Change related to different 1st session ORS scores

The fact that 82% of the students who received counselling in this study had an ORS score below the clinical cut off of 25 (Table 16) suggests that, in general, counselling was being delivered to those most in need of it. Once engaged in counselling, the chances of it being helpful were comparatively high judging by the proportions of who recorded ‘clinical’ (54%) or ‘reliable’ (59%) change. The 82% figure also suggests that most students seeking counselling were accurate in their self-assessment of needing help and were willing to seek the help of the school counsellor.

11 Case studies

The cases provide a better understanding about what actually takes place in a counselling episode and how student problems and concerns are identified, discussed, understood and, ultimately, managed. For both counsellor and student, the counselling process can be intense, demanding and, at times, frustrating. This is especially so if a school is understaffed or its community is subjected to unexpected, outside events such as natural disasters or acts of violence like Christchurch experienced with the terrorist massacre in March, 2019. All too often, school counselling might be forced to focus on crisis management rather than building planned, organised counselling strategies designed to help students manage personal, developmental and educational challenges more successfully.

12 Counsellors' reactions to participating in the study

Comments from the 12 counsellors suggest that future research on this topic needs to be planned collaboratively, set up more carefully, explained in more detail and supported regularly by a research team member during the data collection phase. More extensive training and greater 'oversight' of the process should be a priority. Getting counsellors fully 'on board' with the study aims and procedures is vital—and doing so without adding to counsellors' workloads. A challenging proposition indeed.

13 Summary

The study analysed counselling effectiveness in a number of ways, using both inferential statistics and clinical indicators of significance. No matter the approach, counselling was effective. This conclusion is consistent with those of overseas studies that used adolescents as subjects and/or the ORS as an outcome measure. Given the counsellors' comments regarding their high levels of job stress, work overload and the comparatively low level of counsellor staffing in their schools, these results are a tribute to their commitment and competence.

LIMITATIONS OF THIS STUDY

There are several limitations in the study, most of which could be mitigated by more collaboration with schools and counsellors, careful planning and ongoing oversight of the data collection process by researchers.

- 1) A number of schools declined to participate, with the explanation typically being that they could not create the 'time and space' to become involved. Any future study needs to engage the school counsellors at the design stage. They need to be more involved in the planning and management of the research and become active participants in the project.
- 2) The number of cases delivered from the 13 schools varied widely (from 5 to 86), as did the number from individual counsellors (from 2 to 59). This was partly due to the variation in the length of the data collection in the various schools (from three terms to just over one term), but it could also have been a function of the level of individual's commitment to the project.
- 3) The training phase of the project differed in length and detail among the team leaders, hence the occasional comments that the introduction was 'chaotic'. Future studies need to engage the counsellors and schools as active participants. The research team leaders and the counsellors need to be partners in the research. Counsellors need the time to become co-researchers so that the research becomes with counsellors and not of counsellors. This has implications for funding.

IMPLICATIONS and SUGGESTIONS

Several implications and suggestions can be made based on the data:

- 1) The high number of schools who declined to participate and the reasons they gave suggest that counsellors are experiencing very high levels of work-related stress. If this study had been undertaken in similar schools in the USA, there would have been between two and three times the number of counsellors in the schools. School counsellors provide a primary health service in a setting where the population is engaged in a 'normal' activity, schooling. The service is effective, but understaffed. The long-term effectiveness of school counselling is dependent on the mental health of its professionals. The inadequate staffing ratios need to be addressed.
- 2) Judging from their comments, there exists a dearth of knowledge about research and formative programme evaluation and the counsellors' role in the development of reflective practice. While it is not known to what degree training in research and evaluation features in counsellor education courses, it would be useful for trainers to review their curricula to ensure counsellors acquire a basic knowledge and understanding of research methods, research procedures and their role in the development of reflective practice and an accountable profession.
- 3) There is an urgent need for numerous follow-on studies to better understand the processes and outcomes of counselling with all gender and ethnic groups. At a very basic level, for example, more work needs to be done with measures such as the ORS and other scales like the YP-CORE (Hanley, Sofi, & Lennie, 2011) and PSYCHLOPS (Ashworth, 2007) to establish their validity and usefulness within the New Zealand context.
- 4) More work should be done with the Kaupapa ORS to establish its validity with Māori, Pasifika, and indeed, all students. In this study there were too few occasions of its use to include the results in the report, but since it was designed with Māori in mind, its face validity makes it an interesting scale to develop further.
- 5) Finally, this study and its results should not be seen as the final word on counselling effectiveness. It is a beginning, and there are many questions that arising from this research that need following up and investigation in their own right. New Zealand counselling needs to begin building its own research library of studies that examine the work from all angles and perspectives. The sooner this work starts the more productive and effective counselling will be for all clients.

REFERENCES

- American Counseling Association (2007). *Effectiveness of School Counselling*. [A summary of research findings.] www.counseling.org
- American School Counselor Association. (2019). *Empirical Research Studies Supporting the Value of School Counselling*. Downloaded on 13/6/19 from: <https://www.schoolcounselor.org/school-counselors/careers-roles/effectiveness-of-school-counseling>.
- Anderson, E. M., & Lambert, M. J. (1995). Short term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review*, 9, 503-514.
- Andrews, J., Macfarlane, C., & McFelin, A. (2019) NZAC secondary school guidance counsellor workforce survey: September 2019. www.nzac.org.nz/notice_board.efm
- Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, 77(4), 693-704.
- Anker, M., Owen, J., Duncan, B., & Sparks, J. (2010). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal of Consulting and Clinical Psychology*, 78(5), 635-645.
- Ashworth, M. (2007). PSYCHLOPS: A psychometric outcome measure that is finding a niche. *Counselling and Psychotherapy Research*, 7(4), 201-202.
- Attkisson, C. C., & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning*, 5, 233-237.
- Barclay, K., Crocket, K., Kotzé, E., & Peter, M. (2013). A window on school guidance counselling. *New Zealand Journal of Counselling*, 33(1), 13-35.
- Baskin, T. W., Slaten, C. D., Cosby, N. R., Pufahl, T., Schneller, C., & Ladell, M. (2010). Efficacy of counselling and psychotherapy in schools: A meta-analytic review of treatment outcomes. *The Counseling Psychologist*, 38(7), 878-903.
- Bridgeman, G., & Rosen, F. (2016). *Client-directed-Outcome-Informed approach to problem gambling interventions: Examination of ORS/SRS data for clients seeking assistance for gambling problems*. Presentation to International Gambling Conference, Auckland University of Technology, Auckland, 10-12 February, 2016.
- Bringhurst, D. L., Watson, C. W., Miller, S. D., & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: A replication study of a brief clinical measure. *Journal of Brief Therapy*, 5, 23-30.
- Campbell, A., & Hemsley, S. (2009). Outcome Rating Scale and Session Rating Scale in psychological practice: Clinical utility of ultra-brief measures. *Clinical Psychologist*, 13, 1-9.
- Carey, J. & Dimmitt, C. (2012). School Counseling and Student Outcomes: Summary of Six State-wide Studies. *Professional School Counseling*, 16(2), 146-153
- Carey, J. C., & Harrington, K. M. (2010a). Nebraska School Counselling Evaluation Report. Amherst, MA: Centre for School Counselling Outcome Research and Evaluation.
- Carey, J. C., & Harrington, K. M. (2010b). Utah School Counselling Evaluation Report. Amherst, MA: Centre for School Counselling Outcome Research and Evaluation.
- Cohen, J. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.
- Cooper, M. (2009). Counselling in UK secondary schools: A comprehensive review of audit and evaluation studies. *Counselling and Psychotherapy Research*, 9, 137-150.
- Cooper, M., Fugard, Andrew J. B., Pybis, J., McArthur, K., & Pearce, P. (2015). Estimating effectiveness of School-based counselling: Using data from controlled trials to predicting improvement over non-intervention change. *Counselling and Psychotherapy Research*, 15(4), 262-273.
- Cooper, M., Pybis, J., Hill, A., Jones, S., & Cromarty, K. (2013). Therapeutic outcomes in the Welsh Government's school-based counselling strategy: An evaluation. *Counselling and Psychotherapy Research* 13, 86-97.

- Cooper, M., Stewart, D., Sparks, J., & Bunting, L. (2013). School-based counselling using systematic feedback: A cohort study evaluating outcomes and predictors of change. *Psychotherapy Research, 23*(4), 474-488.
- Crocket, K., Kotzé, E., & Peter, M. (2015). Young people's perspectives on school counselling: A survey study. *New Zealand Journal of Counselling, 35*(1), 22-43.
1. Crowe, A., (2006). Guidance and counselling in New Zealand secondary schools: Exploring the issues, *New Zealand Journal of Counselling, 26*(3), 16-25.
- Cushman, P., Clelland, T., & Hornby, G. (2011). Health promoting schools and mental health issues: a survey of New Zealand schools. *Pastoral Care in Education 29*(4), 248.
- Drury, N. (2007). The Kaupapa Outcome Rating Scale. *New Zealand Journal of Counselling, 27*(1), 21-32.
- Duncan, B. L. (2012). The Partners for Change Outcome Management System (PCOMS): The Heart and Soul of Change Project. *Canadian Psychology, 53*(2), 93-104.
- Duncan, B. L. (2014). *On becoming a better therapist: Evidence-based practice one client at a time* (2nd Ed.). Washington, D. C.: American Psychological Association.
- Duncan, B., & Miller, S. (2000). *The heroic client: Client directed, Outcome informed therapy*. San Francisco, CA: Jossey-Bass.
- Duncan, B. L., & Reese, R. J. (2013). Clinical and scientific considerations in progress monitoring: When is a measure too long? *Canadian Psychology, 54*(2), 135-137.
- Duncan, B., Sparks, J., Miller, S., Bohanske, R., & Claud, D. (2006). Giving youth a voice: A preliminary study of the reliability and a brief outcome measure for children. *Journal of Brief Therapy, 5*, 5-22.
- Durie, M. (1994). *Whaiora: Māori Health Development*. Auckland, NZ: Oxford University Press.
- Education Review Office. (2013). *Improving Guidance and Counselling for Students in Secondary Schools*. Accessed from: <http://www.ero.govt.nz/assets/Uploads/Improving-Guidance-and-Counselling-for-Students-in-Secondary-Schools-December-2013.pdf>
- Education Review Office. (2015). *Wellbeing for Young People's Success at Secondary School*. Accessed from: <http://www.ero.govt.nz/assets/Uploads/ERO-Wellbeing-SecondSchools-web.pdf>
- Green, D., & Latchford, G. (2012). *Maximizing the benefits of psychotherapy: A practice-based approach*. Chichester, UK: John Wiley & Sons, Ltd.
- Goodyear, R. K., Wampold, B. E., Tracey, T. J. G., & Lichtenberg, J. W. (2017). Psychotherapy expertise should mean superior outcomes and demonstrable improvement over time. *The Counseling Psychologist, 45*(1), 54-65.
- Hafhenscheid, A., Duncan, B. L., & Miller, S. D. (2010). The Outcome and Session Rating Scale: A cross-cultural examination of the psychometric properties of the Dutch translation. *Journal of Brief Therapy 7*(1&2), 1-12.
- Hanley, T., Sefi, Aaron, & Lennie, C. (2011). Practice-based evidence in school-based counselling. *Counselling and Psychotherapy Research, 11*(4), 300-309.
- Hartman, A., Herzog, T., & Drinkman, A. (1992). Psychotherapy of bulimia nervosa: What is effective? A meta-analysis. *Journal of Psychosomatic Research, 36*, 159-167.
- Hermansson, G.L. (1980). The role of the school guidance counsellor: a selected review of the literature. *New Zealand Counselling and Guidance Association Journal, 3*(1), 13-25.
- Hughes C., Burke, A., Graham, J., Crocket, K., & Kotzé, E. (2013). School Counsellors and the Key Competencies: The Difference that makes the Difference, *New Zealand Journal of Counselling, 33*(1), 1-15.
- Hughes, C., Barr, A., & Graham, J. (2019). Who comes to the school counsellor and what do they talk about? *New Zealand Journal of Counselling, 39*(1), 40-70.
- Janse, P., Boezen-Hilberdink, L., van Dijk, M. K., Verbraak, M. J. P. M., & Hutschemaeckers, G. J. M. (2014). The psychometric properties of the Dutch Outcome Rating Scale and Session Rating Scale. *Journal of Psychological Assessment, 30*(2), 86-92.
- Kodet, J., Reese, R. J., Duncan, B. L., & Bohanske, R. T. (2019). Psychotherapy for depressed youth in poverty: Benchmarking outcomes in a public behavioural health setting. *Psychotherapy, 56*(2), 254-259.

- Lambert, M. J., & Cattani-Thompson, K. (1996). Current Findings regarding the effectiveness of counselling: Implications for practice. *Journal of Counseling and development*, 74(6), 522-656.
- Lapan, R.T., Gysbers, N.C., & Sun, Y. (1997). The impact of more fully implemented guidance programs on the school experiences of high school students: A statewide evaluation study. *Journal of Counseling & Development*, 75, 292-302.
- Manthei, R. J. (1991). Content analysis of the New Zealand Counselling and Guidance Association Journal: Volumes 1-12m 1976-1990, *New Zealand Journal of Counselling*, 13(1), 12-17.
- Manthei, R. J. (1999). School counselling in New Zealand. Part I: A profile of school counsellors and their work. Part II: Student problems and counsellor' use of outside agencies. *New Zealand Journal of Counselling*, 20(1), 24-46.
- Manthei, R. (2001). Content analysis of the New Zealand Journal of Counselling: volumes 13-21, 1991-2000. *New Zealand Journal of Counselling*, 22(1), 1-12.
- Manthei, R. (2009). *Review of Burnside High School Guidance Services*. Report to the Principal.
- Manthei, R. (2012). *Assessment of the counsellor's role at Hillmorton High School*. Report to the Principal.
- Manthei, R. (2015). Evaluating counselling outcome. Why is it necessary? How can it be done? *New Zealand Journal of Counselling*, 35(1), 60-85.
- Manthei, R. (2016). Revealing counselling: Things counselling agencies should know about their services. *New Zealand Journal of Counselling*, 36(1), 47-70.
- Manthei, R. (2017). A portrait of counselling: A comparison of private practice with agencies. *New Zealand Journal of Counselling*, 37(2), 20-36.
- Manthei, R. J., & Miller, J. (1991). New Zealand counselling, therapy and guidance-related literature, 1980-1989: A bibliography. *New Zealand Journal of Counselling*, 13(1), 35-71.
- Manthei, R., & Miller, J. (2001). New Zealand counselling, therapy and guidance-related literature published between 1990 and 1999: A bibliography. *New Zealand Journal of Counselling*, 22(1), 13-111.
- Manthei, R., & Nourse, R. (2012). Evaluation of a counselling service for the elderly. *New Zealand Journal of Counselling*, 32(2), 29-53.
- Mikeal, C. W., Gillaspay Jr., J.A., Scoles, M. T., & Murphy, J. J. (2016). A dismantling study of the Partners for Change Outcome Management System: Brief Report. *Journal of Counselling Psychology*, 63(6), 704-709.
- Miller, J., & Manthei, R. J. (1992). Part 2: New Zealand counselling, therapy and guidance-related literature, 1980-1989. Additional references. *New Zealand Journal of Counselling*, 14(1), 2-12.
- Miller, S. D., & Bargmann, S. (2012). The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). *Integrating Science and Practice*, 2(2), 20-22.
- Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy*, 5(1), 5-22.
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, 2, 91-100.
- Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The Partners for Change Outcome Management System, *Journal of Clinical Psychology/In Session*. 61(2), 198-208.
- Moggia, D., Nina-Robles, N., Miller, S. D., & Fexias, G. (2018). Psychometric properties of the Outcome Rating Scale (ORS) in a Spanish clinical sample. *The Spanish Journal of Psychology*, 2(e30), 1-7.
- Murphy, K. P., Rasleigh, C.M., & Timulak, L. (2012). The relationship between progress feedback and therapeutic outcome in student counselling: A randomized control trial. *Counselling Psychology Quarterly*, 25(1), 1-18.
- Ostergard, O. K., O'Toole, M. S., Svendsen, M. M., & Hougard, E. (2019). The effect of implementing the Partners for Change Management System in a nationwide student counselling service. *Journal of Counseling Psychology*. Downloaded from

- <http://dx.doi.org/10.1037/cou0000353> Advance online publication, pp.1-15.
- Pearce, P.; Sewell, R.; Cooper, M.; Osman, S.; Fugard, A. J. B.; & Pybis, Joanne. (2017). Effectiveness of school-based humanistic counselling for psychological distress in young people: Pilot randomized controlled trial with follow-up in an ethnically diverse sample. *Psychology and Psychotherapy: Theory, Research and Practice*, 90(2), 138-155.
- Reese, R.J., Duncan, B., Bohanske, R., Owen, J., & Mina I, T. (2014). Benchmarking outcomes in public a behavioral health setting: Feedback as a quality improvement strategy. *Journal of Consulting and Clinical Psychology* , 82(4), 731-742.
- Reese, R. J., Norsworthy, L. A., & Rowlands, S. (2009). Does a continuous feedback model improve psychotherapy outcomes? *Psychotherapy Theory, Research, Practice, Training* 46, 418-431.
- Reese, F. J., Norsworthy, I. A., Toland, M. D., & Slone, N. C. (2010). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy Theory, Research, Practice, Training*. 47(4), 616-639.
- Sales, C. M. D., & Alves, P. C. G. (2012). Individualized patient-progress systems: Why we need to move towards a personalized evaluation of psychological treatments. *Canadian Psychology*, 53(2), 115–121.
- Schuman, D. L., Slone, N. C., Reese, R. J., & Duncan, B. (2014). Efficacy of client feedback in group psychotherapy with soldiers referred for substance abuse treatment. *Psychotherapy Research*. Downloaded on 25/10/2014 from <http://dx.doi.org/10.1080/10503307.2014.900875>
- She, Z., Sun, Qi-wu, & Jiang, Guong-rong. (2017) Reliability and validity of Chinese version of Outcome Rating Scale. *Chinese Journal of Clinical Psychology*, 25(2), 272-275.
- Small, J. J. (1980). Guidance and counselling research in New Zealand. In Research in education in New Zealand: State of the art. *Delta, Research Monograph No. 3*. Palmerston North: New Zealand Association for Research in Education.
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore: Johns Hopkins University Press.
- The Press (2018). *Counselling 'in a crisis mode'*, December 3, 2018.
- Tuck, B., Adair, V., & Manthei, R. (1990). Guidance resource teachers in intermediate schools: A successful innovation. *New Zealand Association of Counsellors Journal*, 12(1), 73-79.
- UNICEF New Zealand, 2017. *Innocenti Report Card – New Zealand*. Accessible at: <https://www.unicef.org.nz/learn/advocacy/global-report-card>.
- Whiston, S.C., & Sexton, T.L. (1998). A review of school counseling outcome research: implications for practice. *Journal of Counseling & Development*, 76, 412-426.
- Young, J., & Dryden, W. (2019). Single-session therapy – past and future: an interview. *British Journal of Guidance and Counselling*, 47(5), 645-654.

APPENDIX 1: The Outcome Rating Scale

Outcome Rating Scale (ORS)

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually

(Personal well-being)

I-----

Interpersonally

(Family, close relationships)

I-----

Socially

(Work, school, friendships)

I-----

Overall

(General sense of well-being)

I-----

Institute for the Study of Therapeutic Change

<http://heartandsoulofchange.com/measures/>

© 2000, Scott D. Miller and Barry L. Duncan

APPENDIX 2: Typical and challenging case descriptions

I Typical Cases

Case 1: Tia (pseudonym) This example is of a first session with the intention of ongoing work next year.

Background:

I am teacher trained, a member of NZAC and have been in this role for 3 years. I am the sole counsellor in a co-ed school of 700. I am fully booked and have a waiting list of 3 weeks for terms 1, 2 and 3. I rarely can take non-contact time. Students in Year 12 are the largest consumers of school counselling at my school. Proportionally, I see a greater number of Māori students than other ethnicities and a greater number of female students and those who identify as LGBTQ

Tia is a 14-year-old Pākeha young woman who was new to the school in term 2. Tia lives with her mother and 10-year-old brother. She was referred by her Dean who reported that Tia's mother had raised concerns about her being anxious at school and wanting to avoid school. Tia was reportedly 'happy' to come in for an appointment. I saw her two weeks following the referral due to my waiting list. She was made aware of the ability to 'pop in' during group time if she needed urgent support.

Tia reported moderate levels of anxiety including worrying prior to school starting, feeling anxious about being called upon during class, increased heart rate, shaking hands and some mild hyperventilation. Tia engaged well in the session and became more relaxed as we talked. Tia reported having changed schools and homes eight times, though mainly residing in Christchurch. Because of her young age at the time of the earthquakes, she didn't report home displacement, or significant disruption or distress because of them.

Tia reports that her mother decided to move around for several reasons: her extended family live in Dunedin; Tia's father's friends had threatened Tia's mother. According to Tia, her father was violent and abusive towards her mother and is now in prison. He continues to try to contact her mother via friends and this has caused ongoing worry and stress within the family, resulting in several moves.

Tia reported that at intermediate school she was bullied, and that the bullying was underhanded (meaning subtle puts-downs and actions to exclusion her). This diminished her confidence and she tried to be more 'invisible' in the classroom and amongst her peers.

At school Tia has settled in well, has made good friends, has experienced no bullying of any kind and achieves well in class. However, she struggles with any attention from the teacher or the class and would rather not engage with people in public settings. For example, although she can go into town independently and talk to adults in shops, she does not want to take the bus.

We discussed a plan for addressing the anxiety and a list of possible interventions that she may find helpful. This plan included weekly sessions for 4-6 weeks and then review:

- Psychoeducation on anxiety and day-to-day strategies for coping.
- School based intervention, which may include involving teachers to support the strategies.
- Using narrative therapy to bring out/highlight a story of successful resilience
- Offer Emotional Freedom Technique (tapping).

Up to this point it was a typical presentation of anxiety in the context of psychosocial challenges. I was confident we could get this work completed fairly simply and quickly. However, after we discussed this plan, Tia started to tell me about her time in foster care, when she was 9 years old. She reported that her mother struggled to manage the interactions with her father and that Tia and her brother were fostered for two years. They subsequently had three changes in foster homes, but were

kept together during this period. When I asked her ‘What did it take for you to get through this?’, she became tearful and then disclosed that she was sexually abused by her last foster father. She had disclosed this to her brother a few days ago after attending the self-defence-for-women programme in our school. She spoke for several minutes about the abuse and how this was able to occur in a foster home. She does not want to tell her mother because of the stress it will cause and how her mother might respond. Tia did suggest that in time she will disclose to her older half-sister but that she is not yet ready.

This disclosure altered the plan to include:

- Information about reporting sexual abuse and sexual abuse counselling
- Slowing the pace of the work, allowing time and rapport and trust to build.
- Over time, with support and consent, working towards disclosing to her mother, though this is seen as a longer-term goal.
- Screen for PTSD and check mood more thoroughly.

Case 2: Aaron (pseudonym)

Aaron, an 11-year-old boy, was referred by his mother. We met for four sessions.

Initially I met with him and his mother to assess what was happening for him. She was concerned about his lashing out at school and home. He explained to me that his friends played “jokes on him. They would kick him, push his books off his desk, tell him he had “no friends”. In situations like this he would get extremely angry, sometimes kick back or punch and often be sent from the room or asked to sit away from others.

At home he would frequently get into heated arguments with his mother, particularly when she asked him to do something when he was watching a favourite TV programme and be sent to his room angry and upset.

He wanted to be on better terms with everyone. Both he and his mother wanted help for him to manage his anger.

I asked him to keep a diary of some of the good and bad events that occurred during the week and write down how he managed them. His mother initially helped with this. During our meetings we unpacked the situations that he had recorded. We discussed the context of each situation. He rated his stress levels at the time of the incident, rated how he felt he had managed the situation and rated how he felt after his management of the incident. We discussed further strategies for managing stressful situations that might come up.

He kept his diary well for three weeks. At school he had learned to step away and calm down before joining in again, ignore comments, speak assertively, make requests and tell people to stop doing something that annoyed him. He felt he was managing himself much better in stressful situations. At home he had found some options too. When his mother made requests, he simply recorded his programme for watching later and did what she asked. In week three he recorded no explosive episodes at home or school.

We agreed to meet again the following year to check that everything was continuing well.

Students are frequently referred for help to manage anxiety and anger. In this situation the young person was well supported at home, but highly reactive in a range of stressful peer situations. He was open to learning how to manage stressful situations more effectively.

Case 3: Ellen (pseudonym)

A Year 11 student was referred by her mother in late 2017. The mother said that Ellen used to be bubbly, happy, had good friends and enjoyed school. Recently, however, she had become anxious and unable to attend. Her daily tears had led to increasing days at home in bed. While both parents were supportive and encouraging, they had very little success in getting her to return to school.

I met with both mother and daughter. I asked if she was worried about missing school. She nodded so I asked if she would be happy for me to revise her timetable so she could start catching up with work at home and from my office until we understood where the anxiety came from and how to manage it. She looked at her mother with a faint smile and her mother said that this would be very helpful. Relieved that she would not be pushed back into class, Ellen's tears stopped, and I made an appointment so we could unpack her journey from loving school to fear of going to class.

We started the second session by rearranging her timetable and negotiating a process whereby she was able to be in communication with her teachers without having to go to class. I could see the excitement in her eyes, once she was assured that she could catch up with her work in the private area adjacent to our counselling offices without the pressure of having to socialise with others. By the end of the session we had developed a trusting relationship and the opportunity to unpack her story presented itself.

In our third and fourth sessions a picture of being bullied emerged. How she came to be bullied was a mystery for her, as the bullies were her best friends who had been her major source of support throughout most of her years at school. But since the middle of the year they had excluded her from their group and on-line conversations. The loss of friends and at the same time, the loss of a dearly loved aunt who had died, had compounded her distress, robbed her of her self-confidence and lowered her resilience, leaving her unable to cope at school.

In speaking with her teachers, it was clear that she was a talented artist and a capable, responsible and respectful student. These attributes were appreciated by her teachers, hence their willingness to support her while she was managing the grief that arose from the losses she had experienced.

Summary outcome: This student began to work in the secluded guidance area while engaging in counselling once a week. It was not until mid-2018 that she began to cope better with the loss of her aunt and began to attend a few of her classes, despite the presence of the friends who had become her bullies. During this time, our work included offering her a range of strategies to help her understand the rift and resolve the issues lingering between herself and her friends, including a restorative process.

Having a close relationship with her parents, she consulted them and despite her strong desire to go ahead with the restorative process, she decided that what she needed most was to continue with her learning (by now she was up to date with her work) and put her energy in preparing for her final year.

She began 2019 attending most of her classes and by the second term she was taking part in all of them without feeling anxious. She said: "You have supported me unconditionally, you have trusted me to make a decision that was right for me, you respected me for knowing my needs, so I am so much stronger in myself that now I see the behaviour of the girls as insignificant in my life."

This young woman completed Year 13 achieving all her credits, ready to embrace the external exams and an offer of a position in a tertiary institution of her choice. She returned after her exams with a magnificent gift: a painting of a peaceful garden with three doves representing the three counsellors who marked her attendance and managed her daily needs. It was obvious to us that we had built a lifelong relationship with this strong and talented young woman who now knows she can return for another dose of confirmation and encouragement when needed.

II Challenging cases

Case 1: May (pseudonym)

I have chosen this case because it reflects the real challenges we have with access to services in the mental health sector, the difficulty with communication and the failure of clients to engage. Many young people I see struggle to get appointments with services outside of school, as they are often during school time, not close to school and can have lengthy waiting lists. This case also reflects the longevity of the work that I sometimes do with students and how I sometimes support them on and off for years. They always know where to come when they need help. .

May is a 15-year-old Pākeha student who initially presented in year 9 with symptoms consistent with panic disorder. At the time May was struggling to attend some classes: she would not go to class if she was slightly late and would leave during class when she became anxious or worried, usually going to the female toilets when she was unable to be in class. I was asked by her teacher to develop a plan for managing the anxiety at school.

May achieved well in classes and when she participated, she contributed with insight. However, May was difficult to engage and often sat with her head down and hair covering her eyes. She was not able to describe what was happening for her and what we might be able to do to support her further. I requested that we involve her parents and she agreed.

We had a family meeting and developed a plan to manage the anxiety at school. We discussed options for counselling at school, or with an external agency. Both were declined by May. Her parents reported significant challenges at home trying to manage her excessive use of technology. It was surmised that this was impacting on her sleep and possibly her mood.

A week after this meeting, May's friends came to say they were very concerned about her. She had said several times that she wanted to kill herself, had shown them pictures of self-harm that she had done, and on one occasion a friend had stayed in contact with her all through the night fearing that she would kill herself. We developed a plan together about discussing this with May and about how to manage similar risk in the future.

When I next saw her, I assessed suicidal risk with May, and she reassured me that she was OK. With her consent I let her parents know. Over the next two weeks May arrived at school after taking an overdose. Fortunately, she had told a friend who knew how to respond. We took her to Accident and Emergency and she was admitted for several hours. A referral to youth specialty services was made. May came back to school, but her attendance and participation was deteriorating significantly. She would come to my room and we would talk briefly in the waiting room – she didn't want to engage further. She did not engage with the clinician at YSS and eventually refused to go back again. Within a month she had taken another 2 overdoses and was admitted into the YSS day programme, where she spent the next term. At the end of her time there she had decided to go to another school for a 'fresh start'. The following year she came back to our school giving us no notification of her return. We initiated a plan with YSS to support her attendance and safety at school but YSS had discharged her saying that the problems weren't mental health and that she failed to engage. Our plan included weekly check-ins with me. My rooms were to be the 'safe place' when she felt unsafe.

Our check-ins soon became regular meetings and May found it helpful to express herself in writing by text. She started to send me very long emails before our appointments and we used these to do our in-session work. May remained at risk and this collated with friendship problems.

Over the next year May's attendance continued to be sporadic, but she always came to her scheduled appointments – even when she wasn't attending school that day. I worked with her family. Their restrictions around technology were helpful, resulting in some improvement.

Later this year May stopped attending school and would come to her appointments with me in mufti. Her mood improved significantly when she stopped attending school and truancy services decided to support her into Alternative Education (AE). I referred her for a Truancy Family Group Conference, and she was enrolled for AE. While attending AE May has experienced some challenges around supporting a friend (also at this school) who was experiencing physical violence from her father. May and her friend accessed me quickly so that I could put supports in place immediately to keep her safe.

Over the past few 6 weeks we have had a family session and I have referred the family on for ongoing support. May's mood appears much improved and she can negotiate with her parents around chores and technology.

Case 2: Lea (pseudonym)

Lea, a 16-year-old girl, was referred to me following a stand down for smoking marijuana at school.

I contacted her mother, who after two attempts to persuade Lea to meet with me, brought the girl in herself. She came very unwillingly and initially refused to speak to me.

At our first meeting I learned from her mother about her concerns with her daughter's alcohol and drug use and her shock on discovering it. She also talked about Lea's difficulties with friendships and bullying at a previous school. When I asked her daughter about the worst time that she had experienced in the previous month she began to open up. We then discussed the best time that she had had. This led to a lot of laughter between mother and daughter as they shared a great time together and I gained her agreement to meet with me further. We also talked more about what I could offer and what she would like to gain from meeting with me.

Further meetings revealed a huge history of trauma, some of it still unknown to her mother. Rape, miscarriage, abusive relationship problems with boys, parental fighting and arguments leading to separation, depression, anxiety, panic attacks, suicide attempts (including a hospital admission) and drug and alcohol use. We arranged for further specialist mental health assessment and treatment.

I taught her mindful breathing and a range of relaxation techniques which we practised each time she came. I also encouraged her to write about her experiences and share them with me. It became clear as we shared that she was a young person of considerable talent.

After a number of sessions in which we gradually developed a more trusting, open relationship I became aware of her desire to achieve more with her studies. We discussed how we could salvage something from the year. With my support we met with the Dean and arranged for Lea to withdraw from some of her subjects and double up on others to give her the maximum opportunity to achieve credits towards NCEA before the year ended. Some of these she achieved with excellence.

When this young woman left school at the end of the year, she still had a long journey ahead of her. However, she was receiving specialist mental health support outside of school, had developed a trusting relationship with some supportive adults (including myself), had developed a little more compassion for herself, developed a range of skills to manage some of her stressors and had salvaged her studies sufficiently to provide a good base for an interesting course the following year.