What issues bring primary school children to counselling? A service evaluation of presenting issues across 291 schools working with Place2Be

Katalin Toth[1]

Lamiya Samad[1]

Sarah Golden[1]

Patrick Johnston[1]

Rachel Hayes[2]

Tamsin Ford [3]

[1] Place2Be

[2] University of Exeter Medical School

[3] University of Cambridge

Corresponding author

Dr Katalin Toth

Place2Be

175 St. John Street

London, England, EC1V 4LW

Phone: 0207 923 5577

katalin.toth@place2be.org.uk

Bibliographical notes

Dr Katalin Toth is the data analyst at Place2Be and an honorary senior researcher at Imperial College London, working with the Big Data and Analytical Unit team. She is interested in the statistical modelling of children's academic and mental health outcomes.

Dr Lamiya Samad is a medically qualified, post-doctoral researcher at the Norfolk and Suffolk NHS Foundation Trust. Her research interests are in international health, particularly applied mental health, surveillance systems and evaluating health interventions. Her Master's thesis assessed the Urdu language version of the Strengths and Difficulties Questionnaire for children's mental health. In addition to teaching, she has enjoyed working in research projects – from BASICS 'Basic Support for Institutionalising Child Survival' using a behaviour change method – to counselling South Asian women with anxiety or depression. Her recent experience with a mental health charity resulted in meaningful dissemination, including a TEDx-style talk.

Sarah Golden is Head of Evaluation at Place2Be, a large children's mental health charity providing mental health support for children and young people in Primary and Secondary schools in England, Scotland and Wales. Sarah has 24 years experience of conducting research into education, mental health and communities, initially in policy evaluations and more recently in charities. By combining qualitative and quantitative methodologies Sarah aims to provide

meaningful insight into the mental health of children and young people and the outcomes from interventions to support them.

Dr Patrick Johnston is Director of Learning and Practice at Place2Be. Patrick obtained his BSc in Physiology at the University of Ireland, Galway before completing a PhD in Psychological Medicine and Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. Alongside his research, Patrick has extensive experience working at the Behaviour Genetics Clinic at the South London and Maudsley Hospital. Before joining Place2Be, he was most recently Assistant Head at Highgate School, where his responsibilities included the strategic development of the school's pupil wellbeing and mental health strategy.

Dr Rachel Hayes is a senior research fellow with over 10 years' experience managing large trials of complex interventions to support the mental health of both children and adults. She has a background in developmental psychology and is interested in ways to support schools and families promote the mental health of children and young people.

Tamsin Ford is a Professor of Child and Adolescent Psychiatry at the University of Cambridge and the Research Chair for Place2Be. Her academic work focuses on the effectiveness of interventions and the efficiency of services in relation to the mental health of children and young people, with a particular focus on the interface between the education and health systems. She completed her PhD at the Institute of Psychiatry, and moved to Exeter in 2007,

where she set up the Child Mental Health Research Group. She moved to Cambridge in 2019.

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Abstract

Background: Poor mental health reduces children's ability to function at school, which in turn may undermine their mental health. The provision of school-based counselling aims to help schools to support their pupil's mental health. Most work on the types of difficulties brought to school counsellors has focused on secondary school pupils (aged 11 years or over) and to our knowledge, this is the first study of presenting issues in younger children.

Method: Data were systematically collected using a list of 21 potential presenting issues during assessment and formulation of 8,893 children referred for counselling in 291 UK primary schools over 3 years. We explored the number, severity and types of presenting issues recorded by counsellors in the whole sample by gender.

Results: The children assessed by counsellors had higher levels of known correlates for poor mental health than their peers in the same schools. Most children had multiple presenting issues, while 55% of children had at least one severe presenting issue. The commonest presenting issues were generalised anxiety, low self-esteem, family tensions and mood swings. Girls were more likely to present with all types of anxiety and family tensions, while attentional problems and mood swings were commoner among boys.

Conclusions: Children referred for counselling in primary schools often present with multiple difficulties, which are often severe. This indicates the need for systematic and detailed assessment, adequate training and supervision and good links with external agencies.

Implications for practice

1. Our findings suggest that primary school children referred for counselling in school often have multiple difficulties, and for a small majority at least one of these will be severe.
2. The most common presenting issues to counsellors working in 291 UK primary schools in 2015 to 2018 were generalised anxiety, low self-esteem, family tensions and mood swings.
3. For primary schools that lack support from counsellors, it may be useful to compile a list of local sources of support for these common presented difficulties that could be accessed by teachers, parents or pupils.

Implications for policy

Poor mental health at any age reduces children's ability to cope with school, which in turn may further undermine their mental health. As the most common school level response is to employ school counsellors, we should develop the evidence-base about the short and long-term effectiveness and cost-effectiveness. We should also consider training routes, peer support and continuing professional development for a group of practitioners who often work in relative isolation

Introduction

Mental health conditions in childhood are increasingly common, (Bor, Dean, Najman, & Hayatbakhsh, 2014; Collishaw, 2015; Lu, 2019; Sadler et al., 2018). A meta-analysis of 41 population-based mental health surveys of children and young people (*n* = 87,742) under the age of 18 years estimated the world wide prevalence of all mental disorders combined to be 13.4% [95% confidence interval (CI) 11.3% to 15.9%] (Polanczyk, Salum, Sugaya, Cave, Rohde, 2015). Meta-regression suggests that the substantial heterogeneity in these estimates was largely explained by methodological issues (sample frame, representativeness, type of mental health and impairment assessment) and not by the year (1985-2012) or location (27 countries). More recently, evidence suggests a deterioration in young people's mental health, with most reports suggesting increased levels of emotional difficulties, particularly among adolescents and girls (Bor et al., 2014; Collishaw, 2015; Lu, 2019; Sadler et al., 2018).

Population based studies suggest that there are differences in the patterns of mental health conditions experienced by age and gender (Sadler et al., 2018). The prevalence of diagnosable mental health conditions increases with age, and changes from more affected boys than girls in the pre-school (2-4) years and primary school-age children (5-10 years) to little discernible gender difference at secondary school age (11-15 years), and many more affected young women than young men among 16-19 year olds (Sadler et al., 2018). These gender variations in prevalence are largely explained by differences in the types of difficulties this and many other population-based studies found (Merikangas, He, Burstein, et al., 2010; Wesselhoeft, Pedersen, Mortensen,

Mors & Bilenberg, 2015). For example, the prevalence of neurodevelopmental and behavioural difficulties is higher among boys than girls and tend to be more common in early childhood, while girls are more likely to experience emotional disorders, which have their peak incidence in adolescence (Merikangas, He, Brody, et al., 2010; Rescorla et al., 2007; Sadler et al., 2018). Within these broad diagnostic groups, there are also differences in the types of mental health condition that present with age; for example, younger children are more likely to have oppositional defiant disorder and separation anxiety disorders, while depression, social phobia or conduct disorder are rare before adolescence (Costello, Egger, & Angold, 2005; Sadler et al., 2018).

In recent years referral rates to Child and Adolescent Mental Health Services (CAMHS) and waiting times have risen sharply (Children's Commissioner for England, 2016; 2018), even though only a quarter of those with diagnosable mental health condition access specialist CAMHS (Ford, Hamilton, Meltzer, & Goodman, 2007; Mandalia et al., 2018). Yet for each child or young person that meets diagnostic criteria, there are likely to be several more with subclinical but never-the-less impairing difficulties, who would be unlikely to meet the current thresholds for CAMHS treatment (Children's Commissioner for England, 2016; Ford & Parker, 2016). Their poor mental health may impair their ability to cope with school work, which in turn may further undermine their mental health (Deighton et al., 2018; Panayiotou & Humphrey, 2018). Annual surveys from England (1995-2014), Scotland (2003-2014) and Wales (2007-2014) suggest a consistent and significant increase in mental health conditions reported by parents/carers and young people (Pitchforth, Viner, & Hargreaves, 2016). In addition to the rising prevalence of

mental health difficulties among children, this potentially suggests an increased willingness to seek help, which is encouraging, *provided* we can offer access to effective interventions.

Schools are prominent front-line providers of mental health services by default (Ford et al., 2007; Mandalia et al., 2018; Newlove-Delgado, Moore, Ukoumunne, Stein, & Ford, 2015). However, the time and resources consumed by this provision, and also by mental health related contacts by educational specialists place a considerable burden on the education system (Snell et al., 2013). There is increasing recognition of the major role that schools play in supporting children with poor mental health (Fazel, Hoagwood, Stephan, & Ford, 2014), culminating in England with plans to introduce a designated mental health lead within schools and school-based mental health teams (Department of Health & Social Care & the Department for Education, 2017; 2018). The idea is to augment the provision of mental health support at Tiers 1 (non-specialist practitioners working with children in non-mental health settings) and 2 (uni-disciplinary or early intervention mental health services), with the expectation that earlier intervention will reduce the severer problems requiring intervention at Tier 3 and Tier 4 or specialist / supra-specialist mental health services later.

Two thirds of schools reported school-based counselling in a survey of how English schools supported the mental health of their pupils (Sharpe et al., 2016); although counselling was four times more commonly reported by secondary as opposed to primary schools. Counsellors working in primary schools require different approaches to those working with adolescents, given the developmental and cognitive abilities as well as the different mental health challenges of younger children, yet there is little research into how they work. A

series of reviews of primary school counselling conducted for the British Association of Counselling and Psychotherapy suggest that primary school counsellors work with more boys than girls, and that children with disabilities or facing social adversity are overrepresented (Daniunaite, Cooper, & Forster, 2015; Thompson, 2013). Importantly, an analysis of pre-and-post outcome data on a large sample of children attending individual counselling at primary school demonstrated clinically relevant levels of improvement (Daniunaite, Cooper, & Forster, 2015).

A meta-analysis of 30 studies about reasons for seeking counselling in UK secondary schools highlighted family tensions as the commonest, with anger, school issues, and relationships as the next most prevalent (Cooper, 2009; 2013). In order to train and support the continuing professional development of school-based counsellors, we need to know what types of difficulties children present with, and given age variations in the types of difficulties, we cannot assume that these will be the same in primary schools. School-based mental health services aim to identify and provide early intervention and as the training for these new roles is developed; it is timely to explore what kinds of difficulties children may present to them.

Place2Be (www.place2be.org.uk) is a charity established in 1994 that provides in-school mental health services, including one-to-one counselling in primary and secondary schools in England, Wales and Scotland. The charity provides play-based counselling on an individual basis using an evidence-based integrative approach (Cooper, & Swain-Cowper, 2018; Ray, Armstrong, Balkin, & Jayne, 2015). This approach is based on three principal therapeutic traditions: person-centred, psychodynamic, and systemic. The aims of the

counselling are to (a) enable the child to settle and find a place alongside their peers in the classroom, (b) understand, and manage more effectively, their emotions and behaviour, and (c) feel more free to be curious, to learn, and to make as much educational progress as possible. Before the intervention commences an assessment and formulation process is completed by the clinician, with all information gathered through liaison with parents and school staff being reviewed by a qualified therapist who oversees the delivery of the service. This clinician also provides clinical supervision at the end of every day for the counsellors.

Children are offered between 12 and 36 sessions of play-based counselling. The sessions are typically weekly, at the same time each week, in a playroom on the school site equipped with a range of toys and creative materials. At the start of the work, the counsellors agree a 'contract' with the child that sets out the rationale for the work, the nature of the therapeutic relationship, the agreed boundaries, and the hoped-for outcomes of the work. The contract is revisited periodically to review progress. In the room, the activities are led by the child and the counsellors use skills of empathic active listening, non-verbal attunement, verbal reflections, and the capacity to join dynamically with the child's play as required. Each counselling relationship is considered unique and the play-based counsellors are trained to communicate with the child in whatever way most suits that relationship. This is so that the child can use the relationship as a 'crucible' to evolve a coherent self-narrative and develop strategies to manage the challenges they are facing. The therapy usually ends by mutual agreement when both the therapist and child feel it is

appropriate. Therapy can also be terminated when a child leaves the school, is excluded, or if the parent or child chooses to end it.

The aim of this paper is to describe the type of problems children bring into counselling and explore whether they varied in type and severity by gender. To our knowledge this is the first study in the UK of the types of issues that bring primary school pupils into counselling.

Method

Ethical considerations

This study was conducted as a service evaluation that was registered with the charity's Research Advisory Group. As the children were under the age of 18 years old, parental/carer consent was gathered for the use of anonymised data in evaluation, including for publication or presentation. Only anonymised data were used for evaluation in line with charity's General Data Protection Regulations compliance.

Procedure

Children are usually referred to charity's one-to-one counselling by a member of school staff, but sometimes by parents/carers or the children themselves. The Charity's school-based counsellors are therapists who are qualified in counselling at Level 4 in the UK Qualifications framework (the equivalent of a university degree) and are members of a counselling professional body (for example, British Association of Counsellors and Psychotherapists). The counsellors undertake a systematic assessment and formulation, which involves meeting with the teachers, parents/carers and the child. Formulation follows a framework and aims to identify strengths as well as difficulties, the source of the presenting issue and the urgency of the case. The

clinician sets out their plan for the child / young person and the expected outcomes from the work and makes a recommendation of the type of intervention needed.

Presenting issues are selected once the counsellor has completed their assessment and formulation, and before the counselling commences, from a pre-defined bespoke list of 21 difficulties. Counsellors attend a two-day training on how to formulate the case and make clinical decisions and are provided with a guidance document that provides the definitions of each of the list of concerns as well as guidance on rating the severity of presenting issues taking into account the child's functioning and distress levels – from 0 – *not applicable or not yet known*, 1 *mild* (difficulties in a single context but able to function, situational or irregular distress); 2 - *moderate* (functioning impaired in at least one context, may be sporadic in several, distressed on most days of the week) to 3 – *severe* (impairment in at least one domain, distress constant and daily). There is no restriction on the number of difficulties that a counsellor can endorse for each child. This paper focused only on whether a particular issue was reported as existing at any level of severity and whether the issue was reported at severe level.

Measures

Presenting Issues List. In 2012, the Charity's research team developed and piloted a tool to record the presenting problems identified by the counsellors when conducting the assessment and formulation among the children referred to the service. The aim was to provide a standardised mechanism to summarise the information gathered from parents / carers, children and young people and their teacher to aid clinical discussion and then

allow an assessment of the prevalence and severity of the issues which children and young people presented to the service. The use of this internal assessment tool was introduced across the service from January 2016. The terms used below reflect the wording of the assessment tool and refer to common problems reported by the organisation's counsellors rather than formal diagnoses.

Background characteristics. Counsellors collected data in a bespoke database with pre-defined categories on age, gender, ethnic group, eligibility for free school meals, pupil premium, special educational needs (SEN) and household composition as part of their initial assessment. The pupil premium is a grant given by the government to schools each year to improve attainment of disadvantaged children decrease the attainment gap.

Participants. More than 8,000 primary school aged children (*n* = 8,893) received one-to-one counselling provided by the charity from 291 primary schools for 4 to 11 year olds in England (246 schools; *n* = 7,747), Wales (35 schools; *n* = 784) and Scotland (10 schools; *n* = 362) between August 2015 and July 2018. Most of the schools were state-funded schools. We excluded children with missing data on presenting issues, which provided a sample of 8,134.

The overall response rate for the presenting issues during the data collection period was 90%, and rose from 80%, when the current method of summarising the presenting issues was introduced in 2015-2016 academic year to 99% in the academic year 2016-2017 and 95% in 2017-2018. The lower response rate in 2015-2016 was largely attributable to the measure being introduced after some children's counselling has commenced, therefore

counsellors did not have the opportunity to select an issue for some cases. The data, therefore, is not missing at random.

Analysis

Data were analysed using STATA 14 (StataCorp, 2015). Inferential statistics were used to explore whether children with missing data on presenting issues differed from those with complete data. Chi-squared tests were used to explore the gender differences on the presence of particular issues being reported. Then, we examined the gender differences on the presenting issues that were reported only at severe level. Bonferroni correction was applied to the α levels in order to minimise the likelihood of Type I errors arising from multiple testing (Bonferroni corrected alpha = 0.0024). Finally, we tested whether the number of presenting issues varied between genders using *t*-test (any severity of presenting issues) and repeated this analysis for severe issues using non-parametric statistics (Kruskal Wallis) as the distribution of severe issues was highly positively skewed.

Results

Children with missing and complete data on presenting issues were not significantly different in age (missing M = 8.17, SD = 1.59, n = 759 versus completed M = 8.10 years, SD = 1.75, n = 8,133; $t(8,890)$ = 1.59, p = 0.11). There was no statistically significant differences in gender, ethnicity, receipt of pupil premium, English as an additional language, the child's main carer, and care order or child protection plan. Children with missing data were, however, statistically more likely to be in school year 3 or above, eligible for free school meals and to have SEN. Statistically significant differences were also found for the referral pathways and the extent to which the family had been involved

with other wider support services (such as social care) in the previous 12 months.

The children assessed by primary school counsellors during the study were mostly boys (56.5%), with a mean age of 8 years old (*SD* = 1.75). More than half were white British (57.5%), followed by black British (13.0%) and of mixed ethnicity (9.8%), while Chinese were the smallest ethnic group (1.5%). Over half of the pupils also had pupil premium status (51.1%) and approximately a third (32.0%) were classified as having SEN. Children who had counselling were more likely to have each of these three characteristics than would be expected given the profile of the pupils in their schools. For example, 45.9% of children in these schools were white British, 42.3% were eligible for pupil premium and 16.8% had SEN. A higher percentage of children in the sample lived only with their mother compared with 20.5% of children nationally, in the UK. The percentage of children living with both their parents (32.3%) was much lower than in the UK (61.0%, Office for National Statistics, 2018).

The number of presenting issues per child ranged from 0 (*n* = 87, 1.1%) to 21 (*n* = 99, 1.2%), with a mean of 9.93 (*SD* = 4.44). The mean number of presenting issues endorsed per child was statistically significantly higher among boys (*M* = 10.23, *SD* = 4.37, *n* = 4,592) than girls (*M* = 9.55, *SD* = 4.52, *n* = 3,542; $t(8,132) = 6.90$, $p<0.001$), but the actual difference is small and statistical significance is probably best explained by the statistical power available in such a large sample. The number of presenting issues rated as severe was highly positively skewed and ranged from 0 (*n* = 3,661, 45.0%) to 21 (1 child); 15.4% (*n* = 1,256) had one presenting issue rated as severe while 10.1% (*n* = 824) had two and just under 7% (*n* = 552) had three. Fewer than 5%

of the sample endorsed eight or more presenting issues, and boys had statistically significantly more problems rated as severe, than girls ($p<0.001$). The highest number of severe presenting issues reported among girls was 16 compared to 21 for boys, while 53% boys and 56% of girls had at least one severe issue on presentation.

Table 1 shows that overall, the most common presenting issue for primary school children was generalised anxiety (73.1%), followed by attention difficulties (71.3%), low self-esteem (70.6%), ongoing family tensions (67.2%) and mood swings (67.0%). The least common issues were suicidal ideation (5.2%), self-destructive thoughts (13.1%) and eating difficulties (15.2%) which may be related to these children being pre- adolescence when such issues are likely to emerge. Although very common when considering the presence of issues related to anxiety (73.1% generalised anxiety; 62.0% social anxiety and 55.9% separation anxiety in Table 1), severe anxiety was present in fewer cases (12.3% generalised anxiety; 10.2% social anxiety and 10.1% separation anxiety in Table 2).

The prevalence of some presenting issues did not differ between the genders (low self-esteem, poor peer relationships, depressed, traumatic events, being bullied, sleeping difficulties, identity, eating and suicidal ideation). However, girls were statistically significantly more likely to present issues related to anxiety than boys (generalised anxiety 76.8% vs. 70.3%, $\chi^2 = 42.39$, $p < 0.001$; social anxiety 64.3% vs. 60.3%, $\chi^2 = 13.00$, $p < 0.001$; and separation anxiety 60.1% vs. 52.6%, $\chi^2 = 45.54$, $p < 0.001$). The gender difference was not statistically significant when the comparison was restricted to only severe levels of anxiety (generalised anxiety 12.4% vs. 12.2%, $\chi^2 = 0.11$,

p = 0.74; social anxiety 9.5% vs. 10.8%, χ^2 = 3.48, p = 0.06, and separation anxiety 11.0% vs. 9.3% , χ^2 = 6.31, p = 0.012, see Table 2).

In contrast, family tensions were significantly more commonly identified among girls, even at severe level. Boys were statistically significantly more likely to present difficulties with attention (78.4% vs. 62.2%, χ^2 = 254.36, p < 0.001) and at severe level (22.1% v 10.9%, χ^2 = 175.93, p < 0.001) than girls. Similarly, boys were significantly more likely to present mood swings, emotional behaviour, impulsivity, anger, callous behaviour and self-destructive thoughts or acts than girls (see Table 1). For all but the latter, the gender difference was also statistically significant among severe presentations (see Table 2). There were statistically significant associations (although only at marginal level of significance) for any difficulties with bullying other children (commoner in boys) and eating difficulties (commoner in girls). When analysed for severe presentations only, the former was statistically significant, but there was no statistically significant association detected for the latter. Further details on the whole range of severity by presenting information and gender are available in supplementary Table A.

Insert Table 1 and 2 about here

Discussion

While much research focuses on the secondary aged range (11+), our findings illustrate the range, complexity and severity of the issues that primary-school aged children referred and accepted to counsellors working within UK schools present with. Notably, most children had more than one presenting issue, and more than half had one or more issues assessed as severe. The extensive nature of the presenting issues indicate the need for school staff to be

equipped with the skills to recognise when children present with mental health issues and also for them to have access to the appropriate clinical / professional support where the issues are severe (Department of Health & Social Care & the Department for Education, 2018). This level and complexity of problems also emphasises the need for counsellors to be adequately trained to assess and to have access to supervision and support as well as links to more specialist mental health services when required.

The most common presenting issues were generalised anxiety, low self-esteem, family tensions and mood swings, so it is essential that counsellors or mental health practitioners working in primary schools are skilled in managing these issues. Although less prevalent, some of these very young children presented with significant mental health issues, including eating difficulties, self-destructive thoughts or acts and suicidal ideation. That these were uncommon is not surprising as such issues tend to emerge in adolescence (Sadler et al., 2018; Merikangas, He, Brody, et al., 2010). Our findings, however, provide a reminder that school-based practitioners need to remain alert to the possibility of these issues among younger children and systematically assess children for them.

The issues presented by *this* cohort of children referred and assessed for counselling would not be expected to generalise to *all* primary aged pupils, but the significant differences in the presenting issues for boys and girls did reflect gender differences observed in prevalence of mental health issues in the general population. The most recent comparative data from England showed that among the younger age groups, mental health issues were more common among boys and these issues tended to be neurodevelopmental or behavioural

while girls presented more commonly with emotional issues (Sadler et al. 2018). That the issues presented to counsellors reflected the gender distribution of difficulties from the most recent large population-based survey suggests that our findings are robust.

The issues presented by primary school aged children contrast with the findings in Cooper's (2009) meta-analysis of presenting issues among secondary school students, suggesting that the nature of presenting issues may vary with age. The latter reported the most common presenting issue was family issues, while family tension was the fourth most common among primary aged students in the present research. Although, the greater prevalence of family issues that Cooper (2009) found among girls compared with boys was also detected in our sample of primary school children. Differences in presenting issues by primary and secondary school stage have implications for the nature of training and support provided for teachers and school counsellors working in these different settings. As counsellors in both primary and secondary schools served by the Charity adopt the same methods of assessment, a similar exploration of presenting issues among secondary school users of the charity's counselling service would provide a methodologically strong insight into the nature of the presenting issues among 11 to 16 year olds.

The children in our referred sample were more likely to be white, eligible for pupil premium, and to have SEN, compared to their school's population, which echoes other studies of children referred to primary school counsellors (Daniuate, Cooper, & Forster, 2015; Thompson, 2013;). All of these factors were associated with higher probability of having mental health issues in the recent UK general population survey (Sadler et al., 2018), which suggests that

the charity's counsellors are working with children vulnerable to poor mental health. In other words, our findings suggest that the service targeted appropriately. The importance of the role of school staff in supporting children's mental health is further illustrated by the evidence from Sadler (2018) that teaching staff were most commonly identified as a source of support and that they were said to have been helpful in 73% of cases.

The negative impact of mental health issues on children's school experiences is evident from previous research. Attention difficulties are associated with poor academic outcomes, lesser enjoyment of school, exclusion, poor attendance and school drop-out (Barkley, Fischer, Smallish, & Fletcher, 2006; Merrell & Tymms, 2005; Parker et al., 2018). Anxious or depressed children are also more likely to have lower academic attainment (Mazzone et al., 2007), poorer school attendance (Finning et al., 2019a; 2019b), and leave school earlier (Van Ameringen, Mancini, & Farvolden, 2003). School-based anxiety as well as depression can lead to oppositional behaviour, often linked in the case of anxiety to the child's effort to avoid triggers, although many anxious or depressed children are compliant and may conceal their feelings from others. Parents/carers and teachers might not be aware that the child is suffering from emotional difficulties or trivialise their seriousness (Donovan & Spence, 2000). Therefore, it is important that assessment systematically and actively seeks such difficulties. The assessment and formulation process also services to raise the awareness in parents/carers and school staff about the constellation of issues that may trouble children as well as how common anxiety is amongst primary school children at entrance to counselling.

Like us, others have reported significant gender differences in the nature of the presenting issues in both clinical and population-based samples (Crijnen et al., 1997; Merikangas, He, Brody, et al., 2010; Rescorla et al., 2007; Sadler et al., 2018). The fact that boys presented more externalising or behavioural issues and girls with internalising symptoms may reflect the perceptions of parents, teachers and counsellors as well as the difficulties of the child he gender ratio of ADHD in clinical samples (>10:1) is much higher than among population-based samples (4:1) (Ford, Fowler, Langley, Whittinger, & Thapar, 2008). Although girls are less likely to have ADHD than boys, girls that *do* have ADHD are less likely to be identified, referred and treated (Russell, Ford, & Russell, 2019), Counsellors and teachers need to be alert to these problems when they occur in the unexpected gender. The use of systematic assessment methods that incorporate validated measurement tools to support clinical judgement in the assessment and formulation process also protects against these perceptual biases.

This service evaluation has several strengths. Data were gathered systematically across all schools working with the charity over three years, with a high level of completeness and provides a large and comprehensive sample. Comparisons between years revealed few statistically significant differences, which given the large sample of schools and children, suggest that these findings are likely to be reflective of the issues children aged 5 to 11 present with in primary schools. Large changes from year to year would undermine the confidence that these findings are generalizable.

Nevertheless, there are also limitations. Large samples with such high levels of statistical power can lead to differences identified as statistically

significant that are of little clinical relevance. The presenting issues discussed in this paper are a subjective professional assessment of hundreds of counselling professionals who, despite guidance, might have perceived and categorised these issues differently to each other. These presenting issues are not objectively measured or a formal mental health diagnosis. Although some issues (such as attention difficulties or poor peer relationships) can be informed by the insight gathered from validated measures used before counselling starts, others, such as low self-esteem or eating difficulties are not. Moreover, the number and type of issues that a child can present with is somewhat dictated by the number of issues listed for the counsellor to select from.

In conclusion, the commonest problems that primary school age children were assessed to bring to school-based counsellors were generalised anxiety, low self-esteem, family tensions and mood swings. There were also pronounced gender differences in the type of problem. Many children present with more than one difficulty, and problems managed by school-based counsellors should not be assumed restricted to those that are mild or moderate. Mental health and education practitioners based in schools therefore need to be conscious of the possible complexity of issues that even young children may present with and ensure that strategies and interventions are in place within school, or through external agencies, to provide appropriate support for these presenting issues. They need adequate training and supervision in assessment and the management of the problems that children will present to them.

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Table 1: Gender differences in the prevalence of particular presenting issues (existence of issue reported) between 2015 and 2018

	Boys	Girls	Total	χ^2	*p*-value
	%	%	%		
Generalised anxiety	70.30	76.80	73.10	42.39	0.000***
Attention difficulties	78.40	62.20	71.30	254.36	0.000***
Low self-esteem	70.30	71.00	70.60	0.50	0.477
Ongoing family tensions	65.10	69.90	67.20	20.63	0.000***
Mood swings	71.60	61.10	67.00	99.97	0.000***
Poor peer relationships	67.80	65.60	66.90	4.37	0.037
Troublesome behaviour-emotional	72.00	54.70	64.40	261.58	0.000***
Social anxiety	60.30	64.30	62.00	13.00	0.000***
Impulsive	67.10	46.00	57.90	366.15	0.000***
Sustained feelings of anger	62.90	47.70	56.30	186.55	0.000***
Separation anxiety	52.60	60.10	55.90	45.54	0.000***
Depressed	50.40	52.10	51.20	2.32	0.127
Disturbed by traumatic event	48.20	54.20	50.80	28.66	0.000***
Troublesome behaviour-callous	40.70	29.20	35.70	115.81	0.000***
Bullied by other children	33.70	32.30	33.10	1.87	0.171
Bullies other children	33.30	25.00	29.70	64.59	0.000***
Sleeping difficulties	24.90	27.90	26.20	9.29	0.002
Identity issues	20.00	21.90	20.80	4.43	0.035
Eating difficulties	14.10	16.60	15.20	9.23	0.002
Self-destructive thoughts or acts	14.30	11.60	13.10	12.15	0.000***
Suicidal ideation	5.44	4.80	5.20	1.69	0.193
N	4,592	3,542	8,134		

*** p<.001 Bonferroni correction

Table 2: Gender differences in presenting issues which were rated as severe

	Boys	Girls	Total	χ^2	*p*-value
	%	%	%		
Ongoing family tensions	20.70	23.70	22.01	11.03	0.001***
Attention difficulties	22.10	10.90	17.19	175.93	0.000***
Disturbed by traumatic event	16.30	17.40	16.79	1.60	0.205
Mood swings	19.90	12.30	16.61	84.85	0.000***
Troublesome behaviour-emotional	20.10	10.50	15.91	138.49	0.000***
Impulsive	19.80	8.98	15.10	183.28	0.000***
Low self-esteem	13.50	12.70	13.14	1.19	0.275
Poor peer relationships	13.30	12.40	12.93	1.62	0.203
Sustained feelings of anger	15.60	8.24	12.42	100.46	0.000***
Generalised anxiety	12.20	12.40	12.26	0.11	0.741
Social anxiety	10.80	9.51	10.23	3.48	0.062
Separation anxiety	9.32	11.00	10.06	6.31	0.012
Troublesome behaviour-callous	8.60	4.55	6.84	51.66	0.000***
Depressed	6.23	5.62	5.96	1.32	0.249
Sleeping difficulties	4.25	4.71	4.45	1.03	0.310
Bullies other children	4.01	2.40	3.31	16.15	0.000***
Identity issues	3.05	3.44	3.22	1.00	0.316
Bullied by other children	2.53	2.80	2.64	0.56	0.454
Self-destructive thoughts or acts	2.64	1.98	2.35	3.78	0.052
Eating difficulties	1.79	2.00	1.88	0.51	0.471
Suicidal ideation	0.83	0.79	0.81	0.03	0.854
N	4,592	3,542	8,134		

*** p<.001 Bonferroni correction

Supplementary Table A: Distribution of presenting issues by gender and the full range of severity (*** p<.001)

	Boys		Female		Total		χ^2	*p*-value
	N	%	N	%	N	%		
Separation anxiety								
Not applicable	1,399	36.70	936	30.50	2,335	33.90	31.40	0.000***
Mild	1,014	26.60	841	27.40	1,855	27.00		
Moderate	974	25.50	898	29.30	1,872	27.20		
Severe	428	11.20	390	12.70	818	11.90		
Total	3,815	100.00	3,065	100.00	6,880	100.00		
Social anxiety								
Not applicable	1,117	28.70	822	26.50	1,939	27.80	13.73	0.003
Mild	1,067	27.40	940	30.30	2,007	28.70		
Moderate	1,209	31.10	999	32.20	2,208	31.60		
Severe	495	12.70	337	10.90	832	11.90		
Total	3,888	100.00	3,098	100.00	6,986	100.00		
Generalised anxiety								
Not applicable	795	19.80	480	15.00	1,275	17.60	29.46	0.000***
Mild	1,142	28.40	995	31.10	2,137	29.60		
Moderate	1,530	38.00	1,286	40.20	2,816	39.00		
Severe	558	13.90	439	13.70	997	13.80		
Total	4,025	100.00	3,200	100.00	7,225	100.00		
Low self-esteem								
Not applicable	610	15.90	483	16.10	1,093	16.00	3.99	0.262
Mild	1,132	29.50	942	31.40	2,074	30.40		

Moderate	1,474	38.40	1,123	37.50	2,597	38.00		
Severe	620	16.20	449	15.00	1,069	15.60		
Total	3,836	100.00	2,997	100.00	6,833	100.00		
Depressed								
Not applicable	1,502	39.40	1,153	38.40	2,655	39.00	3.67	0.299
Mild	1,128	29.60	937	31.20	2,065	30.30		
Moderate	901	23.60	710	23.70	1,611	23.60		
Severe	286	7.50	199	6.60	485	7.10		
Total	3,817	100.00	2,999	100.00	6,816	100.00		
Mood swings								
Not applicable	853	20.60	974	31.00	1,827	25.10	158.38	0.000***
Mild	961	23.20	801	25.50	1,762	24.20		
Moderate	1,410	34.10	927	29.60	2,337	32.10		
Severe	916	22.10	435	13.90	1,351	18.60		
Total	4,140	100.00	3,137	100.00	7,277	100.00		
Impulsive								
Not applicable	1,047	25.40	1,437	46.90	2,484	34.50	447.75	0.000***
Mild	868	21.00	664	21.70	1,532	21.30		
Moderate	1,304	31.60	647	21.10	1,951	27.10		
Severe	910	22.00	318	10.40	1,228	17.10		
Total	4,129	100.00	3,066	100.00	7,195	100.00		
Attention difficulties								
Not applicable	658	15.50	1,009	31.40	1,667	22.30	439.41	0.000***
Mild	997	23.40	964	30.00	1,961	26.30		

Moderate	1,588	37.30	855	26.60	2,443	32.70		
Severe	1,013	23.80	385	12.00	1,398	18.70		
Total	4,256	100.00	3,213	100.00	7,469	100.00		
Sustained feelings of anger								
Not applicable	874	23.20	1,070	38.80	1,944	29.80	250.39	0.000***
Mild	879	23.40	705	25.50	1,584	24.30		
Moderate	1,291	34.30	694	25.10	1,985	30.40		
Severe	718	19.10	292	10.60	1,010	15.50		
Total	3,762	100.00	2,761	100.00	6,523	100.00		
Troublesome behaviour-emotional								
Not applicable	969	22.70	1,284	39.90	2,253	30.10	335.22	0.000***
Mild	999	23.40	794	24.70	1,793	23.90		
Moderate	1,383	32.40	771	23.90	2,154	28.70		
Severe	923	21.60	371	11.50	1,294	17.30		
Total	4,274	100.00	3,220	100.00	7,494	100.00		
Troublesome behaviour-callous								
Not applicable	2,064	52.50	2,044	66.40	4,108	58.60	152.68	0.000***
Mild	789	20.10	494	16.00	1,283	18.30		
Moderate	686	17.40	379	12.30	1,065	15.20		
Severe	395	10.00	161	5.20	556	7.90		
Total	3,934	100.00	3,078	100.00	7,012	100.00		
Poor peer relationships								
Not applicable	1,147	26.90	1,004	30.20	2,151	28.30	11.00	0.012
Mild	1,295	30.40	1,001	30.10	2,296	30.30		

Moderate	1,206	28.30	884	26.60	2,090	27.50		
Severe	613	14.40	439	13.20	1,052	13.90		
Total	4,261	100.00	3,328	100.00	7,589	100.00		
Bullies other children								
Not applicable	2,427	61.40	2,230	71.50	4,657	65.90	101.12	0.000***
Mild	750	19.00	524	16.80	1,274	18.00		
Moderate	593	15.00	278	8.90	871	12.30		
Severe	184	4.70	85	2.70	269	3.80		
Total	3,954	100.00	3,117	100.00	7,071	100.00		
Bullied by other children								
Not applicable	2,266	59.40	1,887	62.30	4,153	60.70	12.77	0.005
Mild	914	24.00	715	23.60	1,629	23.80		
Moderate	518	13.60	329	10.90	847	12.40		
Severe	116	3.00	99	3.30	215	3.10		
Total	3,814	100.00	3,030	100.00	6,844	100.00		
Ongoing family tensions								
Not applicable	887	22.90	617	19.90	1,504	21.60	13.32	0.004
Mild	877	22.60	669	21.60	1,546	22.20		
Moderate	1,165	30.00	966	31.20	2,131	30.60		
Severe	949	24.50	841	27.20	1,790	25.70		
Total	3,878	100.00	3,093	100.00	6,971	100.00		
Disturbed by traumatic event								
Not applicable	1,132	33.80	791	29.20	1,923	31.80	17.08	0.001***
Mild	584	17.50	501	18.50	1,085	17.90		

Moderate	879	26.30	802	29.60	1,681	27.80		
Severe	750	22.40	616	22.70	1,366	22.60		
Total	3,345	100.00	2,710	100.00	6,055	100.00		
Eating difficulties								
Not applicable	2,583	79.90	1,874	76.10	4,457	78.30	12.57	0.006
Mild	359	11.10	340	13.80	699	12.30		
Moderate	208	6.40	176	7.20	384	6.70		
Severe	82	2.50	71	2.90	153	2.70		
Total	3,232	100.00	2,461	100.00	5,693	100.00		
Sleeping difficulties								
Not applicable	1,916	62.70	1,451	59.50	3,367	61.30	7.39	0.060
Mild	519	17.00	475	19.50	994	18.10		
Moderate	428	14.00	345	14.20	773	14.10		
Severe	195	6.40	167	6.80	362	6.60		
Total	3,058	100.00	2,438	100.00	5,496	100.00		
Identity issues								
Not applicable	2,154	70.10	1,701	68.70	3,855	69.50	3.08	0.379
Mild	433	14.10	386	15.60	819	14.80		
Moderate	344	11.20	267	10.80	611	11.00		
Severe	140	4.60	122	4.90	262	4.70		
Total	3,071	100.00	2,476	100.00	5,547	100.00		
Self-destructive thoughts or acts								
Not applicable	2,373	78.40	1,962	82.60	4,335	80.20	18.48	0.000***
Mild	313	10.30	220	9.30	533	9.90		

Moderate	221	7.30	122	5.10	343	6.30		
Severe	121	4.00	70	2.90	191	3.50		
Total	3,028	100.00	2,374	100.00	5,402	100.00		
Suicidal ideation								
Not applicable	2,857	92.00	2,279	93.10	5,136	92.40	3.44	0.328
Mild	155	5.00	97	4.00	252	4.50		
Moderate	57	1.80	45	1.80	102	1.80		
Severe	38	1.20	28	1.10	66	1.20		
Total	3,107	100.00	2,449	100.00	5,556	100.00		

*** p<.001 Bonferroni correction

Online Appendix

Presenting issues
Based on your formulation, please summarise the main presenting issues for this child/young person, and the level of severity, by ticking the boxes below.
ONLY TICK THE BOXES WHERE THIS IS A PRESENTING ISSUE FOR THE CHILD. PLEASE TICK NOT APPLICABLE IF IT IS NOT AN ISSUE. IF CURRENTLY UNKNOWN THEN TICK 'UNKNOWN AT THIS STAGE

[for more details on the issues and how to rate severity, please see guidance at the end of the form] #

	Presenting issue	**Mild**	**Moderate**	**Severe**	**Not applicable**	**Unknown at this stage**
1	Anxiety – separation from parents/carers	□	□	□	□	□
2	Anxiety – social and performance situations	□	□	□	□	□
3	Anxiety – general	□	□	□	□	□
4	Low self esteem	□	□	□	□	□
5	Depressed/withdrawn	□	□	□	□	□
6	Mood swings	□	□	□	□	□
7	Impulsive	□	□	□	□	□
8	Attention difficulties	□	□	□	□	□
9	Sustained feelings of anger	□	□	□	□	□
10	Troublesome behaviour – emotional/volatile	□	□	□	□	□

11	Troublesome behaviour – callous/deliberate	□	□	□	□	□
12	Poor peer relationships	□	□	□	□	□
13	Bullies other children	□	□	□	□	□
14	Bullied by other children	□	□	□	□	□
15	Ongoing family tensions	□	□	□	□	□
16	Disturbed by traumatic event	□	□	□	□	□
17	Eating difficulties	□	□	□	□	□
18	Sleeping difficulties	□	□	□	□	□
19	Identity issues	□	□	□	□	□
20	Self-destructive thoughts or acts	□	□	□	□	□
21	Suicide ideation	□	□	□	□	□
22	Other (please say what)	□	□	□	□	□

[*for more details on the issues and how to rate severity, please see guidance below*]

Presenting issue	Examples of types of behaviour and emotions
Anxiety – separation from parents/carers	Frightened or stressed by being left alone or separated from parent. Overly preoccupied with family life.
Anxiety – social and performance situations	Afraid of new or unstructured social situations. Fear of performance related situations e.g. answering questions in class. Concerns about transition between school years or starting a new school.
Anxiety – general	Many worries and fears about a range of issues in the past, present and/or future e.g. school, family, natural disasters. May be shy, withdrawn or lack confidence.
Low self esteem	Little self-worth. Frequent negative statements about self.

Depressed/withdrawn	Sad, tired, listless, lacking energy. Detached, day dreamy, vacant, emotionless. Passive, confused. Sulky, gloomy. Lacks confidence, cannot speak up for self.
Mood swings	Extreme changes in mood, e.g. defiant and co-operative, smiling and tearful, nice and nasty
Impulsive	Wants to move on from one thing to the next. Impaired ability to keep within boundaries or follow rules. Restless, agitated, alert, hyper vigilant. Taps hands and feet/cannot keep still.
Attention difficulties	Trouble paying attention, finishing tasks, or following directions. Difficulty in focusing/easily distracted. May appear forgetful, careless and disorganised.
Sustained feelings of anger	Feelings of anger, frustration, feeing hard done by, preoccupied by unjust situations.
Troublesome behaviour – emotional/volatile	Angry outbursts. Volatile. Temper tantrums, lashing out. Tearful, unstable, fluctuating emotions.
Troublesome behaviour – callous/deliberate	Provocative. May seek to hurt. Without empathy. Defiant, wilful opposition to teachers and parents/carers. Conscious determination to ignore boundaries. Causes criminal damage, steals, lies.
Poor peer relationships	No stable friends, falls out repeatedly with friends. Unpopular with peers because of behaviour or appearance. Tendency to be solitary, isolated, or excluded by peer group.
Bullies other children	Wants to be in control of other children.
Bullied by other children	Believes they are victimised/peer pressured.
Ongoing family tensions	Difficult family dynamics, strong sibling rivalry or conflict beyond the norm.
Disturbed by traumatic event	Extreme and prolonged distress following witnessing or experiencing a traumatic event. May repeatedly re-enact the event in play, have disrupted sleep, avoid reminders of the event.
Eating difficulties	Poor eating. Thin, losing weight. Self-induced vomiting. Overweight.
Sleeping difficulties	Child frequently wakes up during the night or struggles to get off to sleep. Child has nightmares or night terrors.
Identity – gender, sexuality, ethnicity, culture/cultural expectations	Range of emotions and behaviours associated with exploration of Identity issues
Self-destructive thoughts or acts	Actual or attempted self harm e.g. cuts, pinches and flicks at body. Self-destructive thoughts e.g. drawing an image of self with nails stuck in body.
Suicidal ideation	Refers directly or obliquely to struggling with life. Or explicitly refers to suicide.

Guidance for rating problem severity – take into account both the child/young person's level of functioning and their level of distress. If functioning and distress levels differ, then choose the higher rating.

	Functioning	Distress
Mild	Behaviour and/or attitude causes *occasional disruption* but do not undermine functioning and impact is only *in a single context*. All/most age appropriate activities could be completed given the opportunity. The child may have some meaningful personal relationships.	Distress may be *situational* and/or *occurs irregularly* less than once a week. Most people who do not know the child well would not consider him/her to have problems but those who do know him/her well might express concern.
Moderate	Functioning is impaired *in at least one context* but may be *variable with sporadic difficulties or symptoms in several* but not all domains.	Distress *occurs on most days in a week*. The problem would be *apparent* to those who encounter the child *in a relevant setting or time* but not to those who see the child in other settings.
Severe	Child is *completely unable to participate age-appropriately in daily activities in at least one domain* and may even be unable to function in all domains (e.g. stays at home or in bed all day without taking part in social activities, needing constant supervision due to level of difficulties).	Distress is *extreme and constant on a daily basis*. It would be *clear to anyone* that there is a problem.