Mental Health Difficulties and Children at Risk of Exclusion from Schools in England
A review from an educational perspective of policy, practice and research, 1997 to 2015

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All errors are our own.

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<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
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<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
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<td>ASB</td>
<td>Anti-social behaviour</td>
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<td>ASD</td>
<td>Autistic spectrum disorder</td>
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<td>BESD</td>
<td>Behavioural, emotional and social difficulties</td>
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<td>BEST</td>
<td>Behaviour and Education Support Team</td>
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<td>BSP</td>
<td>Behaviour support plan</td>
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<td>BPS</td>
<td>British Psychological Society</td>
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<td>CAMHS</td>
<td>Child and adolescent mental health services</td>
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<td>CBCL</td>
<td>Child behaviour check-list, the Achenbach…</td>
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<td>CBT</td>
<td>Cognitive behaviour therapy</td>
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<td>CD</td>
<td>Conduct disorder</td>
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<td>CLD Coalition</td>
<td>Conservative- Liberal Democrat Coalition government</td>
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<td>CPD</td>
<td>Continuing professional development</td>
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<tr>
<td>DCLG</td>
<td>Department of Communities and Local Government</td>
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<td>DES</td>
<td>Department of Education and Science</td>
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<td>DFE</td>
<td>Department for Education</td>
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<td>DFEE</td>
<td>Department for Education and Employment</td>
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<td>DFES</td>
<td>Department for Education and Science</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DS</td>
<td>Dinosaur School</td>
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<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual (5th edition) (APA)</td>
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<td>EBD</td>
<td>Emotional and behavioural difficulties</td>
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<td>ECM</td>
<td>‘Every Child Matters’ strategy/agenda of Labour Governments</td>
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<tr>
<td>EHWB</td>
<td>Emotional health and well-beings</td>
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<td>EP</td>
<td>Educational psychologist</td>
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<td>FFI</td>
<td>‘Framework for Intervention’</td>
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<td>FTE</td>
<td>Fixed-term (temporary) exclusion</td>
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<td>HWB</td>
<td>Health and Well-being Board</td>
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<td>IAPT</td>
<td>Improving access to psychological therapies</td>
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<td>ICD -10</td>
<td>International Classification of Diseases -10 (World Health Organisation)</td>
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<td>IT</td>
<td>Information technology</td>
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<td>IY</td>
<td>The ‘Incredible Years’ parenting and child social skills programmes</td>
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<td>LBP</td>
<td>Lead behaviour professional</td>
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<td>LSU</td>
<td>Learning support unit (in-school support centre)</td>
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<td>MHF</td>
<td>Mental Health Foundation</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>MLD</td>
<td>Moderate learning difficulties</td>
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<td>MST</td>
<td>Multi-systemic therapy</td>
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<tr>
<td>NEET</td>
<td>Not in education, employment or training</td>
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<td>NC</td>
<td>National Curriculum</td>
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<td>NESS</td>
<td>National Evaluation of Sure Start</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NPSLBA</td>
<td>National Programme for School Leaders in Behaviour and Attendance</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<td>OCC</td>
<td>Office of the Children’s Commissioner</td>
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<td>ODD</td>
<td>Oppositional defiance disorder</td>
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<td>OFSTED</td>
<td>Office for Standards in Education (also covers child care etc.)</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>PEIP</td>
<td>Parent early intervention pathfinder</td>
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<td>PEx</td>
<td>Permanent exclusion</td>
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<td>PRUs</td>
<td>Pupil referral units (special units/schools for excluded and other children)</td>
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<tr>
<td>PSHEE</td>
<td>Personal, social, health and economic education</td>
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<tr>
<td>QFT</td>
<td>‘Quality First Teaching’ (associated with National Curriculum Strategies)</td>
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<td>RCT</td>
<td>Random control trial</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration [US Government]</td>
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<td>SBC</td>
<td>School-based counselling</td>
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<td>SDQ</td>
<td>(Goodman’s) Strengths and Difficulties Questionnaire</td>
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<td>SEAL</td>
<td>Social and emotional aspects of learning</td>
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<td>SEBD</td>
<td>Social, emotional and behavioural difficulties</td>
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<td>SEBS</td>
<td>Social, emotional and behavioural skills</td>
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<td>SEMHD</td>
<td>Social, emotional and mental health difficulties</td>
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<td>SENCo</td>
<td>Special educational needs co-ordinator</td>
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<tr>
<td>SEN(D)</td>
<td>Special educational needs (and disability)</td>
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<tr>
<td>SEWB</td>
<td>Social and emotional well-being</td>
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<tr>
<td>SEU</td>
<td>Social Exclusions Unit</td>
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<td>SFBT</td>
<td>Solution focused brief therapy</td>
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<td>SFR</td>
<td>Statistical first release</td>
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<td>‘SHANARRI’</td>
<td>‘Safe, healthy, achieving, nurtured, active, respected, responsible, included’ [Scottish government acronym to guide schooling]</td>
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<td>SLCN</td>
<td>Speech, language and communication needs</td>
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<td>TaMHS</td>
<td>Targeted mental health in schools</td>
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<tr>
<td>TA</td>
<td>Teaching (or learning support) assistant</td>
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<tr>
<td>TDA</td>
<td>Teacher Development Agency</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

1. School exclusion, in its various forms, often has devastating effects on the lives of the young people involved and long-term costs for society. Schools clearly have a duty to reduce such exclusion to an absolute minimum.

2. Exclusion is seen in Parker and Ford (2013) as a ‘mental health issue’ (possibly including a biological/genetic component) but it is also:
   - a social issue, linked to disadvantage, family and societal difficulties;
   - a political issue, as schooling is influenced by national policies on ‘standards’ and the teaching of social, emotional and behavioural skills [SEBS];
   - an educational issue, linking to school organisation and staff values and skills

All these interacting factors require investigation in a portrayal of how schools can best minimise exclusion. This review examines policy, practice and research in relation to each of these areas from 1997 to the early months of 2015.

3. The term ‘children at risk of exclusion’ includes children and young people who have experienced exclusion from one or more schools as well as those who are at risk of, but have not actually experienced, fixed-term or permanent exclusion.

Overlapping, contested definitions

4. Providing succinct definitions is difficult although the inter-connectedness of disruptive behaviour in schools and emotional and psychological issues has been seen for many decades. Educationalists often resist the ‘medical’ language (associated with ‘deficits’ and ‘disease’) of ‘conduct disorder’ or ‘oppositional defiance disorder’, preferring other terms such as, in the early 2000s, ‘behavioural, emotional and social difficulties’ [BESD]. However, there is agreement that children at risk of exclusion display a lack of SEBS which place many within the categories of mental health disorders, as defined in ICD-10 and DSM-V. This situation is reflected in the new term for ‘BESD’, ‘social, emotional and mental health difficulties’ (SEMHD) adopted in the 2014 special educational needs and disability [SEND] Code of Practice (DFE, 2014b). These children experience many risk factors and lack protective resilience factors necessary for good mental health.

5. Green et al. (2005b) in their widely-cited ONS survey stress the sometimes temporary and environmentally-induced nature of ‘mental disorder’. Correlates are often of an educational and social nature (poor literacy skills, truanting, having poor social skills and few friends, lone parent or reconstituted families, poverty).

Prevalence

6. Given the above, precise numbers of children with mental health difficulties at risk of exclusion cannot be given. Pupils given ‘internal exclusions’ or ‘managed moves’ and of course illegal exclusions are not recorded. However HMG (2014) shows:
   - permanent exclusions per year falling from 12,300 (0.16% of the school population) in 1997/98 to 4630 (0.06%) in 2012/13;
   - fixed-term exclusions peaking at 425,600 (5.6%) in 2006/07, then falling to 267,520 (3.52%) in 2012/13;
   - boys were three times more likely than girls to be permanently excluded or to receive fixed-term exclusions.

7. As all children assigned to the BESD and many to the MLD categories of SENs present challenging behaviour, it is unsurprising that two thirds of children permanently excluded have SENs. Academies exclude more than other schools.
8. In 2013, 143,050 children either had a SENs statement for BESD or were placed on the ‘School Action Plus’ stage. 14,040 pupils, many with BESD, attended PRUs.

9. Green et al. (2005b) stress that their findings are estimates guided by their ‘concept’ of psychiatric morbidity, based on ICD-10 categories (doubts on the validity of this sort of approach exist - see BCP, 2013, Slee, 2013 and Norwich, 2014, on over-'medicalisation' of behavioural difficulties). Green et al. claimed to find that in a national sample of under 8000 families:
   - 9.6% had a ‘mental disorder’;
   - 5.8% had a conduct disorder (7.5% of boys and 3.9% of girls);
   - 1.5% had a hyperkinetic disorder (cf 0.5 to 1% estimated in DFEE, 2001b).

10. In conclusion, there is a similarity between the percentage of children who have experienced fixed term exclusion and Green et al.’s estimate of children having conduct disorders. If an extrapolation is made, perhaps 400,000 to 500,000 children in England could have BESD or conduct disorder placing them at risk of exclusion. There may be inaccurate assessments but claims that BESD is over diagnosed on a national scale (DFE, 2014b) are difficult to reconcile with this.

The Political, Educational and Mental Health Context, 1997 - 2015

11. The Labour government sought to promote mental health and to lessen social and school exclusion through the ‘Every Child Matters’ [ECM] strategy and ‘Healthy Schools’ initiative (DFES/DoH, 2004); the ‘social and emotional aspects of learning’ (SEAL) (DFES 2007); and the National Strategies Behaviour and Attendance Strand (DFES, 2003b). These stressed the need for a preventive, multi-agency approach to promoting well-being, creating appropriate school ethos, developing positive behaviour management and other school staff skills.

12. There was a change in government philosophy after the 2010 general election and terms such as ‘Every Child Matters’ and ‘inclusion’ were avoided. DFE (2010) asserted that the curriculum contained too much that was non-essential (by implication SEAL). The revised exclusions guidance (DFE, 2012) scarcely mentioned that exclusion could be a sign of unmet needs. The revised Special Educational Needs and Disability (SEND) Code of Practice (DFE/DoH, 2014) had a clinical rather than educational tone and was not based on an evidence-informed analysis of achievements of the previous administration (Norwich, 2014).

13. The lack of input by CAMHS into schooling was often noted (e.g. Wolpert et al., 2011). Promoting well-being/ good mental health in schools for children at risk of exclusion remained essentially a task for educationalists.

Beneficial school-based approaches

Whole school and class universal approaches (Wave 1)

14. Research indicates that what is best for a whole-school community also benefits groups of children and individuals at risk of exclusion. In low excluding schools that stress mental health promotion, inclusive values permeate policy and practice at the whole-school level. These values filter down to practice in the classroom and to relationships between staff and individual children, also to between pupil and pupil. This ‘ethos’ requires a ‘critical mass’ of staff to see exclusion as failure. There is a collegiate approach, with staff frequently talking to and listening to each other - and the voice of the child. This happens within well-thought out whole-school behaviour policies, operated according to Healthy Schools’ standards (DFES/DoH, 2004).

15. OFSTED (2005) saw the importance of:
   - positive classroom ethos with good relationships and strong teamwork;
   - staff knowing pupils well and planning lessons which take account of pupils’ different abilities, interests and learning styles.
   - staff respecting and having an interest in pupils showing challenging behaviour.

16. Guidance for BESD (DCSF, 2008a) recommended lesson content should be carefully sequenced to build on previous learning/experience and did not need to be taught in individual subjects (a themes and topic approach may be more appropriate). Teachers should:

- use highly interactive lessons;
- use groupwork to promote speaking and listening;
- use work-focused learning for 14-16 yr olds;
- find time to work at conflict resolution/building/keeping friendships.

17. The SEAL approach should permeate school life, thereby helping ‘at risk’ children to be better motivated and successful learners; to make and sustain friendships; deal with and resolve conflict effectively and fairly; solve problems with others or by themselves; to manage strong feelings such as frustration, anger and anxiety (DCSF, 2009a). SEAL should sit alongside anti-bullying policies.

18. Staff should regularly target the weaknesses in literacy, numeracy and IT abilities of ‘at risk’ children, thereby counteracting their feelings of worthlessness and failure. In addition, effective specific approaches to promoting SEBS include:

- ‘The Incredible Years: Dinosaur School’ [DS], a classroom-based programme designed to promote emotional self-regulation and social competence;
- Circle time/Circle of Friends, other approaches which promote SEBS;
- Nurture Groups, an effective compensatory experience in mainstream schools for children with BESD at risk of exclusion.

19. The quality of one-to-one relationships between staff members and child is clearly crucial to the mental health needs of those at risk of exclusion. Such relationships can be re-inforced as part of daily routine over a period of years. In individual work, school staff can draw on solution-focused brief therapy or other approaches based on cognitive behaviour therapy. ‘Mindfulness’ can be used to harness the body’s natural defence systems against feelings of stress, anger and other negative emotions. Mental health promoting approaches will involve ‘talking and listening’ and shared experiences, the bed-rock of relationship building. Many schools now offer school-based counselling by trained counsellors often employed directly by educational establishments.

20. The national evaluation of TaMHS (Wolpert et al., 2011) identified a range of interventions mainly covering the approaches made over decades by behaviour support, educational psychology and counselling services. Between 2008 and 2011, these continued to be offered by educationalists, rather than by CAMHS. There was limited referral to specialist CAMHS. Parents saw schools as the key point of contact for concerns about mental health. TaMHS funding sometimes substituted for rather than supplemented already existing mental health provision.

21. Teaching assistants are seen as promoters of inclusion for ‘at risk’ pupils. SENCo and other teachers with responsibility for pastoral care and behaviour management could also access help from local authority services including, in the early 2000s, multi-agency behaviour support services and educational psychologists. A decade later some LA services may have
been replaced by commissioning private enterprises or outreach services provided by PRUs or BESD schools.

Need for professional training, development and support
22. As it is mainly educational staff concerned, there should be better initial training and continuing professional development for educators, with a greater stress on child development and ‘positive’ approaches to behaviour management. Training should develop affective and communication skills to help staff to engage better with pupils with behaviour and mental health difficulties. Schools have the potential to deliver more of their own staff development, through coaching, peer observation, team teaching and mentoring.

Working with families and enhancing parenting skills
23. The value of schools working closely with the parents of children with BESD and others at risk of exclusion is widely recognised. Research supports training in parenting skills, such as The Incredible Years programme, particularly if delivered by educators guided by EPs in non-stigmatising neighbourhood school settings.

Working with ‘looked after children’ and their carers
24. While input from CAMHs has a valuable part to play, mental health promotion in looked after children relates closely to the human qualities, capacities and motivation of the adults with whom they interact hour in, day out, as part of their regular lives.

Promoting the inclusion of children with ADHD
25. The vulnerability to exclusion of such children is noted, given the social and behavioural difficulties presented in schools by children with ADHD. Researchers advocated a multi-modal approach applying educational and social interventions as well as involving medication.

How far can CAMHS provide support in school for children at risk of exclusion?
26. ‘School exclusion’ is a mental health issue but given limited time and resources of CAMHS (varying according to geography), CAMHS only rarely work directly in schools. There may also be issues of clinician preference and skills. A realistic role for CAMHS in support of children at risk of school exclusion consists of:

- making CAMHS expertise more easily available to individual children with the severest mental health difficulties through easily followed pathways, particularly giving more support to children in PRUs and to pupils with BESD (as DCSF/DoH, 2008, recommended);
- offering expert advice and filling gaps in some schools staff's knowledge.

Key to the above is having respected workers linking schools, PRUs and CAMHS.
Chapter 1: Introduction

1.1 Permanent exclusion from school, and to a lesser extent repeated fixed-term exclusions, can have devastating effects on the lives of the young people involved (Blyth and Milner, 1993; Haydn and Dunne, 2001; Daniels et al., 2003; Parsons, 2009). Parker and Ford (2013), in the title of a recent editorial in ‘Child Psychology and Psychiatry’, see it as a ‘mental health issue’. This contention is supported in this examination of policy, practice and research surrounding mental health and exclusions, from the election of the Labour government in 1997 to the closing months of the Conservative-Liberal Democrat [CLD] Coalition in 2015. However school exclusion must also be seen as a social issue, linked to disadvantage, family and societal difficulties; and an educational issue, connecting to how schools are run and the values and skills of their staff. School exclusion, influenced as it is by national policies on ‘discipline’, ‘academic standards’ and the merits or otherwise of teaching social and emotional skills in the classroom is also a political issue. In short, an array of factors require investigation if an accurate portrayal is to be given of the mental health difficulties of children at risk of exclusion and of effective responses to these needs.

1.2 Also, the extent to which school exclusion is seen as a mental health issue relates to the degree of validity accorded to common categories and sub-categories of mental health. Bilton and Cooper’s (2013) references to the ‘anti-psychiatry movement’ are relevant in this respect - as are Slei’s (in press) concerns on possible medical ‘over-reach’ and misapplication of knowledge. Is ‘conduct disorder’ as exemplified by defiant and disruptive behaviour in the classroom really evidence of intrinsic mental health problems/difficulties/disorders? Coghill (2013) and most ‘clinicians’ clearly believe it is, but there continues to be international concern over ‘diagnoses’ of non-physical conditions (e.g. BPS, 2013) and the over-reliance on diagnostic tools, which can be incorrectly used. The caveats of the developers of widely-used and recommended assessment tools such as the Child Behavior Checklist (Achenbach, 1991) and the qualifying comments of researchers (e.g. Green et al., 2005 a and b) when arriving at ‘estimates’ of prevalence of conduct disorder, can be ignored by governments, the media and campaigning charities who make firm statements that 10% (e.g. DFE, 2014a) or up to 20% (Audit Commission, 1999) of children have mental health difficulties. The detailed longitudinal study of excluded children by Daniels et al. (2003) and the literature review by Cole and Visser (2005) which informed and accompanied OFSTED (2005) indicate that - at least in the eyes of educationalists - many children presenting challenging behaviour (conduct disorder?) do not have pronounced mental health problems.

1.3 Reflecting the paragraphs above, this review will consist of:

- (Chapter 2) Defining and understanding the mental health needs of children at risk of school exclusion;
- (Chapter 3) Estimating the prevalence of children with mental health difficulties at risk of school exclusion;
- (Chapter 4) The social, educational and political context;
- (Chapter 5) School-based approaches to the mental health difficulties of children at risk of exclusion;
- (Chapter 6) Conclusion - making the most of an imperfect future?

1.4 This review examines policy and guidance documents produced by government, government agencies’ and non-government, as well as sketching some pertinent academic literature. There is a dearth of research of a quantitative nature which reaches acceptable medical methodological thresholds (see NICE, 2013, and its grading of research quality; also Parker and Ford, 2013a and Whear et al., 2013). This is regrettable but it is doubtful, given the complexity and width of the subject, that a body of such research could ever be assembled. It is also argued (as in Cole, Daniels and Visser, 2013) that a fuller and essentially accurate picture can be provided by reviewing a wide range of material, much of which consists of surveys.
of opinion or studies of a qualitative nature, supported by relevant government sponsored
documents (see Appendix 1 for further discussion of research method). This review’s focus is
England but occasional reference will be made to relevant material from Scotland and other
countries.

1.5 In this study, as in Cole et al. (2002), particular interest will be shown in children identified,
correctly or incorrectly (OFSTED 2005, 2010a; DFE, 2011a) as having ‘Behavioural, Emotional
and Social Difficulties’ 2. Most of these pupils attend mainstream schools but a minority are in
special schools and pupil referral units (PRUs). DCSF (2008a) offered guidance on identifying
these pupils and also on addressing their needs (including mental health problems). The CLD
Coalition Government’s Special Educational Needs and Disability [SEND] Code of Practice (DFE,
2014b) has replaced the descriptor ‘BESD’ with ‘SEMHD’ (‘social, emotional and mental health
difficulties’). However, as this review is mainly focussing on the years preceding the new Code’s
introduction, ‘BESD’ would seem the most appropriate acronym to use.

1.6 For ease of reference, the phrase ‘children at risk of exclusion’ will be used to encompass
not only the children who have not experienced the actual formal act of exclusion (but are
‘close to the edge’) but also those who have experienced exclusion from one or more schools.
Research (e.g. Daniels et al., 2003; HMG, 2014) clearly shows that a child can experience
multiple fixed-term (‘temporary’) exclusions - also that even when ‘permanently’ excluded
children are re-integrated into a mainstream school or placed in a PRU, they are liable to
experience further exclusions. Further, the obverse side of the exclusion coin, ‘inclusion’,
needs taking into account. As Norwich (2014) rightly notes, inclusion is multi-dimensional and
multi-layered. A child can experience differing degrees and types of inclusion/exclusion while
remaining in an educational establishment (mainstream or special). The child might be ‘excluded’
in terms of being placed for a time in an special class or on-site exclusion room (which might
be called an ‘Inclusion Room’) or part-time in a nurture group (see Chapter 5). A nuanced view
of both the terms ‘school exclusion’ and ‘school inclusion’ is necessary. For some, the risk of
school exclusion only disappears when statutory leaving age is reached and they leave school,
thereby escaping in Slee’s terms ‘the hidden injuries of schooling’ often unwittingly inflicted on
them by a society demanding nothing stands in the way of the examination-results dominated,
academic credentialing system.

1.7 To avoid frequent repetition of the phrase ‘children and young people’, the term ‘children’ is
used to describe boys and girls from pre-school age through to eighteen years old.

1.8 The importance of ethnicity and gender to mental health and school exclusions is
acknowledged, but it was not possible to investigate these areas in detail in this review. It is
hoped that others will follow up on the work of, for instance, Major, Gillborn and Sewell (1998),
Osler and Hill (1999) and OFSTED (2008a).

1. In this review, many references are made to a string of research projects in the late 1990s and early 2000s by the
University of Birmingham EBD Research Team, whose key members were Professor Harry Daniels, Professor John Visser
and the present writer. These projects include Daniels et al., (2003), a longitudinal study of nearly 200 Key Stage 4 pupils
permanently excluded from schools in 10 contrasting English LEAs, and Cole et al.(2002), a study of the mental health
needs of children with behaviour difficulties, a part of the Mental Health Foundation ‘Bright Futures’ project..

2. Cole, Daniels and Visser (2013) and Cole and Knowles (2011) discuss the various combinations of initials (e.g. ‘EBD’,
‘SEBD’, ‘BESD’), essentially denoting the same group of children, in common parlance in the 1980s/90s and in the present
century. For simplicity ‘BESD’ is used in this review to represent any one of these combination of letters.

3. PRUs are special units, catering primarily for pupils excluded from mainstream and special schools. They are usually ‘off-
site’ i.e. situated in premises that are separated from mainstream schooling.
Chapter 2: Defining and Understanding the Mental Health Needs of Children at Risk of Exclusion

‘Far from being deranged and dangerous, the majority of the children I worked with were tired, despairing, underachieving and invariably desperately sad about their circumstances. They had a bundle of other stuff on their minds which had little to do with individual teachers but more to do with a general disaffection from conventional teaching and learning, with a good measure of domestic hassle thrown in.’ Giles Barrow, behaviour support teacher/behaviour adviser

(Barrow, 2002, p.1)

What is maladjustment? ‘Angry ‘cos of lack of love mostly.’ A.S. Neill

(cited in Bridgeland, 1971, p.30)

2.1. Introduction

2.1.1 Discussing the meaning of the term ‘mental health needs’ and its links to ‘children at risk of school exclusion’ is a necessary precursor to estimating the numbers of the children involved. Also this exploration of terms and their constituent parts helps to provide a rationale for the choice of literature cited later in this review.

2.2. Conduct disorder/ODD or BESD or challenging behaviour?

2.2.1 Providing succinct definitions in this area has long proved challenging. In the 1950s there was a major government enquiry into ‘troubled and troublesome’ children, then called ‘maladjusted’ (many of whom would now have been diagnosed as having mental health difficulties and ‘BESD’). This Underwood Report noted the confusion that could arise around the term and also the mix of nurture and nature that led to this uncertain category, brought into being by the 1944 Education Act. In part maladjustment was seen as ‘a term describing an individual’s relation at a particular time to the people and circumstances which make up his environment’ (Ministry of Education, 1995, p.22). However, in calling for greater input from mental health professionals in multi-disciplinary child guidance clinics the Underwood Report clearly saw the inter-connectedness of disruptive behaviour in schools and emotional and psychological issues. It is clear that this connectedness and overlap remain today.

2.2.2 The terms ‘conduct disorder’ [CD] and ‘oppositional defiance disorder’ [ODD] came later but are now believed by most health researchers/bodies (American Psychiatric Association, 2013; WHO, 1992; Green et al., 2005 a and b; NICE, 2013; Coghill, 2013) to lie firmly within the borders of ‘mental health disorders’ (or in less acute form ‘mental health problems’). They are also accepted by the CLD Coalition and used in guidance for educationalists (DFE, 2014a). It is clear that aggression, defiance and other apparently key aspects of CD will have been displayed by nearly every child prior to school exclusion.

2.2.3 However, educational professionals in Britain often resist what they see as the medical language (associated with ‘deficits’ and disease) of CD (Bilton and Cooper, 2013), preferring other terms notably since the publication of the 2001 revised SEN Code of Practice, ‘BESD’. The clinicians and researchers who drew up the guidance for health and social care professionals on anti-social behaviour and conduct disorder in children (NICE, 2013) do not mention ‘BESD’, thereby illustrating the very real challenges remaining in the way of interdisciplinary understanding and multi-agency working (DCSF/DoH, 2008a; Macleod, 2010; Vostanis et al., 2010, 2012) that would likely be of benefit to children at risk of exclusions.

2.2.4 Cole, Sellman, Daniels and Visser (2002), DCSF/DoH (2008) and Macleod (2006, 2010) note how ‘mental health difficulties’ (including CD) overlap substantially with BESD or ‘Social,
Emotional and Behaviour Difficulties’ or the more internationally recognised descriptor ‘EBD' (chosen as the most appropriate term in Clough, Garner, Pardeck and Yuen, 2005 and Cole, Daniels and Visser, 2013). Further, mental health difficulties (or ‘problems’ or ‘disorders’) also overlap with descriptors such as ‘challenging behaviour’ (OFSTED, 2005) and ‘disaffection’ or ‘disengagement from school’ or in explaining ‘disruptive behaviour’. To highlight this overlap, key points from various definitions are reproduced in Table 1.

Table 1: Overlapping definitions of ‘Conduct Disorders’, ‘BESD’, ‘Challenging Behaviour’ and ‘Disaffection’

<table>
<thead>
<tr>
<th>Conduct disorder traits (Green et al. 2005,a and b, ONS survey - drawing on DSM IV and ICD -reflected in DFE, 2014a)</th>
<th>Behavioural Emotional and Social Difficulties traits (as described in DCSF, 2008)</th>
<th>Challenging behaviour (as described in OFSTED, 2005)</th>
<th>Disaffected behaviour (as described in OFSTED, 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a.) oppositional defiance disorder [diagnosis relates to frequency and intensity] - temper outbursts - arguing with adults - disobedience - deliberately annoying others - passing on blame - easily annoyed - angry - resentful - spiteful - vindictive (b.) Other CD: - telling lies - fighting - bullying - truanting - cruelty - robbery - shoplifting - stealing cars - lacking friends - anti-social behaviour</td>
<td>[ascription to BESD category relates to frequency and intensity] - oppositional defiance disorder - conduct disorder - disruptive - challenging - disturbing - aggressive behaviour, sometimes leading to exclusion from class or from school - low self-esteem - poor relationships affecting classroom learning - language, literacy and numeracy difficulties - early attachment difficulties - parental conflict - parents separated - parental neglect or erratic discipline</td>
<td>Persistent disruptive behaviour, sometime leading to exclusion. Overtly aggressive behaviour e.g. biting, scratching, assaulting others Mainly verbal aggression: - streams of abuse - temper tantrums - threatening invasion of others’ personal space - loud and raucous behaviour of boys Communication, literacy and numeracy difficulties: - overlap with special educational needs, particularly BESD Family conflict and breakdown Sometimes association with gangs, carrying weapons, offending</td>
<td>- regularly non-compliant - disruptive and/or challenging behaviour that can lead to fixed term exclusions - sometimes involved in gangs and drug taking - parents reluctant to support/work with the school</td>
</tr>
</tbody>
</table>

Anxiety, depression, Self-harm, eating disorders Anxiety, depression, Self-harm, eating disorders Withdrawn, anxious, depressed (challenging ‘internalised’ behaviours) Quiet, withdrawn behaviours

Attention deficit hyperactivity disorders [ADHD] ADHD Children on medication for mental health disorders
Table 1 is based on the Office of National Statistics survey of mental health disorders in children (Green et al., 2005 and b) - cited, for instance, in Brown, Khan, Parsonage (2012), NICE (2013) and DFE (2014 a); the 1997 - 2010 Labour government's BESD guidance (DCSF, 2008); OFSTED's detailed national study into children demonstrating ‘challenging behaviour’ (OFSTED, 2005); the inspectorate’s enquiry into disaffected pupils (OFSTED, 2008).

Table 1 indicates the need for this review to consider the literature relating to each of the four columns.

**2.3. Good mental health and well-being**

**2.3.1 A different route to identifying mental health needs is to consider definitions of good mental health or the alternative term ‘emotional health and well-being’. Use of a descriptor such as this can help to avoid the stigma commonly attached to terms including ‘mental’ or the prefix ‘psycho’ (see DoH, 2011; Heflinger and Hinshaw, 2012; Brown, Khan and Parsonage, 2012).** It is clear from research into the circumstances and character traits of children excluded from school (e.g. Berridge et al., 2001; Daniels et al., 2003; Pirrie et al. 2011) that many excludees’ lives are permeated by a lack of the ingredients of emotional health and well-being.

**2.3.2 Emotional health and well-being can be seen as ‘a holistic, subjective state which is present when a range of feelings, among them energy, confidence, openness, enjoyment, happiness, calm, and caring, are combined and balanced’ (Weare and Gray, 2003 cited in DFES/ DoH, 2004, p7). This important document then outlines a range of social, emotional and behavioural skills [SEBS] often lacking in many children deemed BESD and/or at risk of exclusion.

This range of SEBS includes:

- being an effective and successful learner
- making and sustaining friendships
- dealing with and resolving conflict effectively and fairly
- being able to solve problems with others and alone
- managing strong feelings such as frustration, anger and anxiety
- recovering from setbacks and persisting in the face of difficulties
- working and playing cooperatively
- competing fairly and losing with dignity and respect for competitors
- recognising and standing up for your rights and the rights of others
- understanding and valuing the differences between people and respecting the right of others to have different beliefs and values.

DFES/DoH(2004) claim that the factors which children themselves say have the biggest impact on their emotional wellbeing are having people to talk to, personal achievement, being praised and generally feeling positive about oneself. The key issues that make them feel stressed are conflict, confrontation with authority; restriction of autonomy and exclusion by their peers.

**2.3.3 An enduring definition of good mental health, cited in DFE (2014a), was given in Mental Health Foundation reports (1999, 2002): children who are mentally healthy as able to:**

- develop psychologically, emotionally, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;
- develop a sense of right and wrong; and
- resolve (face) problems and setbacks and learn from them.

MHF note the clear evidence that children who are emotionally or mentally healthy achieve more at school and are able to participate more fully with their peers and in school and community life. Cole et al. (2002), in their study for the MHF, see the opposite in relation to children deemed BESD.
2.4. Risk factors and ‘multiplicative effects’

2.4.1 Another way to understand mental health difficulties associated with school exclusion is to look at the risk factors generally prominent in the lives of the children concerned. Based on wide international research, accounts of risk factors are given in, for example, MUF (1999); Audit Commission, (1999); DFES/DoH (2004); SAMHSA (2007); DCSF (2008b); Cole and Knowles (2011), Murphy and Fonagy (2012) and NICE (2013). The following list draws together some key components:

**Individual risk factors include**
- academic failure
- low self-esteem
- communication problems
- difficult temperament
- genetic influences

**Family factors include:**
- frequent, open and serious conflict between parents/partners;
- family breakdown (separation, divorce, lone parent or reconstituted families);
- inconsistent, unclear ‘discipline’;
- neglect or ‘laissez-faire’ approach to child-care;
- hostile and rejecting relationships;
- failure to adapt to the child’s changing development needs;
- abuse - physical, sexual and/or emotional;
- severe parental mental health problems;
- unemployment or low family income
- parental criminality or substance addiction;
- death and loss - including loss of friendships
- family live in disadvantaged, impoverished communities
- other traumatic life events.

**Community or environmental factors:**
- socio-economic disadvantage i.e. poverty;
- poor housing or homelessness;
- ongoing and serious discrimination

2.4.2 Also to be considered are the ‘multiplicative effects’ of facing more than one type of risk. Brown, Khan and Parsons, (2012) report that rates of conduct disorder increase exponentially for every added risk factor. An analysis of data for 16,000 children in the 1970 British Cohort Study indicated that boys with five or more risk factors were almost eleven times more likely to develop conduct disorder under the age of ten than boys with no risk factors (Murray et al., 2010). Earlier, Talbot (2002) had reported that the presence of two factors more than doubles the impact on a child; the presence of three risk factors more than quadruples the bad effects. DCSF/DoH (2008) notes that children who face three or more stressful life events, such as family bereavement, divorce or serious illness are three times more likely than other children to develop emotional and behavioural disorders. Studies of excluded children have found that multiple risk factors frequently occur in the lives of the young people involved (Berridge et al., 2001; Daniels et al., 2003; Pinnie et al., 2011).

2.5. Resilience factors

2.5.1 Conversely key factors that help to protect and to develop the resilience of children tend to be absent from the lives of children at risk of exclusion. These crucial social, psychological and economic factors have also been widely explored - see for instance, MUF (1999); Audit Commission, (1999), DFES/DoH, (2004); Cefai (2008), SAMHSA, (2007; DCSF, (2008b); Daniels and Cole, 2010). These factors can be placed in three groups (DCSF/DoH 2008a);

**Within-child protective/resilience factors include:**
- gender (being female);
• higher intelligence;
• an easy temperament when an infant;
• secure attachment to parent(s), carer and/or others;
• positive attitude, problem-solving approach;
• good communication skills;
• planner, belief in control;
• sense of humour;
• religious faith;
• capacity to reflect.

Within-family’ protective/ resilience factors include:
• at least one good parent-child relationship;
• affection;
• authoritative (i.e. neither too lax nor too strict) parenting/discipline;
• parental support for education;
• supportive parental relationship/absence of severe discord;
• supportive extended family.

Community/environmental protective/resilience factors include:
• wide supportive network around the family and child;
• good housing;
• high standard of living;
• good schooling with strong pastoral and academic sides;
• range of sport and leisure activities.

2.6. Biological factors

2.6.1 An exploration of the factors impacting on the mental health of children at risk of exclusion must also refer to biological development and the functioning of the human brain. Coghill (2013) notes how much recent medical research on CD refers to ‘the significant biological contributions to causality’ (p.921). Bernstein (undated) refers to recent medical research indicating that ‘conduct-disordered youth’:

‘exhibit a decreased dopamine response to reward and increased risk-taking behaviours related to abnormally disrupted frontal activity in the anterior cingulated cortex , orbitofrontal cortices and dorsolateral prefrontal cortex that worsens over time due to dysphoria activation of brain stress systems and increases in corticotrophin-releasing factor’.

She cites studies purporting to show the effects of negative childhood experiences on other areas of the brain, for instance, the amygdala (see also Fonagy, Butler and Ellison, 2014). Cooper, Bilton and Kakos (2013) similarly stress the importance of biology in the development of behavioural difficulties. However, they stress that the effects of inherited genes are not immutable and that one can no longer attribute causation to ‘nature’ or ‘nurture’:

‘From the earliest stages of life, the development of biological systems are affected by environmental factors, such as nutrition, and experiential factors, including parenting styles, peer influences and the kinds of stimuli to which the developing individual is exposed… neurological development of children can be adversely affected by prolonged exposure to abuse, neglect or lack of stimulation, leading to cognitive and social impairments.’ (p.90)

2.6.2 Accepting this standpoint, Gerhardt (2013) looks at neuroscientific evidence on the development of children’s brains, the emergence of emotional regulation, the role played by crucial neurotransmitters such as serotonin, dopamine and cortisol. In an earlier publication, Gerhardt (2004, p.19) had seen the newborn baby as an ‘external foetus’ coming into the world unfinished with its brain ready to be programmed and customised to suit the child’s environment, capable of adaptation to its particular family and social group. Synapses would seem to develop and connect in neural pathways and are culled according to the circumstances surrounding the growing child (Cole and Knowles, 2011). The brain retains a degree of plasticity
and crucially, a susceptibility to good or adverse influences through the teenage years and potentially into adulthood. Caution is needed on how studies based on neuro-imaging are interpreted, as Rose (2005) has warned, but the evidence is increasingly robust.

2.6.3 The paragraphs above clearly provide encouragement to professionals working with children at risk of exclusion. For those in health and social care professions, the response could well be a mix of social, psychological and at times, pharmacological interventions (Coghill, 2013; Fonagy, Butler and Ellison, 2014). The use of some medicines (notably methylphenidate for children with hyperkinetic disorders/ADHD) can augment temporarily, neurological dysfunctions that are associated with specific cognitive deficits. Such an approach is seen as necessary by some educationalists as well as clinicians. Perhaps in the light of further research, ‘Risperidone’ will become as well known as ‘Ritalin’, given its cautious endorsement in NICE (2013) and Coghill (2013) for treating aggression in ‘conduct disordered’ children. Teachers will need to keep informed about advances in medical research as the work and decisions of doctors and clinicians could have an increasingly important impact on school staff’s work. Less controversially for many educationalists, powerful ways that impact on biological factors and promote emotional well-being will often be of a social and/or educational nature. As Cooper, Bilton and Kakos (2013) and NICE (2013) stress, adjustments to a child’s environment (at school and/or home) can reverse negative biological effects on children’s mental health.

2.7. Attention deficit/ hyperactivity - hyperkinetic disorders

2.7.1 As Bilton and Cooper (2013) remind us, ADHD is a clinical diagnosis described in the Diagnostic and Statistical Manual of Mental Disorders, now appearing in its fifth edition (APA, 2013) as well as in the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (WHO, 1992). Hyperkinetic disorder is a more restrictive diagnosis used by clinicians, which is ‘broadly similar to severe combined type ADHD’ i.e. where children show symptoms of both attention deficits and hyperactivity (DFE, 2014a, p.40). ADHD should only be diagnosed by physicians (not informally by school staff - see Hjorne and Saljo, 2013, for an instructive Swedish example of poor practice), after a thorough assessment of a child according to the criteria set out in these publications. Symptoms must have been present before the age of seven, and must be evident in two or more settings (DFE, 2014a).

2.7.2 Doubts about whether ADHD is a valid construct persist (see Visser and Jehan, 2009; and BCP, 2013) and would seem to be associated with ‘the anti-psychiatry movement’ by Bilton and Cooper (2013) who comment:

‘Among the criticism of anti-psychiatry are assertions that diagnostic criteria are vague, arbitrary and imprecise; treatments are more damaging than helpful, especially related to stigmatising patients; normal human traits are pathologised as a means of social control by the medical establishment, unduly influenced by pharmaceutical companies…’ (p34)

It is beyond the scope of this review to delve further into this topic, but it does seem likely that ADHD is a ‘real’ condition but prone to inaccurate and excessive diagnosis. If the latter is true, it would help to explain the wide variations (see Chapter 3) in reported prevalence rates both world-wide and within different areas of single countries. Achenbach’s (1991) caveats about the use of checklists (see Chapter 1) come again to mind. Also, that resort to medication as a first and sole response is too common (Visser and Jehan, 2009). Note also Slee’s plea (in press) for more attention to be paid to without-child social factors which undoubtedly contribute to medical ‘disorders’.

2.7.3 From a clinical perspective, ADHD clearly overlaps substantially with conduct disorders, and given the array of challenging behaviours it apparently gives rise to in the classroom and playground, it can put children who are diagnosed as ADHD at risk of varying degrees of exclusion. Their anti-social behaviours can lead to children with ADHD being isolated from and disliked by peer groups (social exclusion within a school). Repeated disruptive and at times aggressive behaviours can prove beyond the control of staff, leading to full school exclusion.
On a more positive note, pharmacological and (preferably) psycho-social interventions can relieve the situation (see Chapter 5) as both biological and environmental factors play a part.

2.8. A biopsychosocial perspective or simply meeting human needs?

2.8.1 When responding to mental health difficulties in children at risk of exclusion, it is clear that taking a broad ecological (Bronfenbrenner, 1979; Apter, 1982) or ecosystemic perspective, posited in Cooper, Smith and Upton (1994), is appropriate. In the last twenty years these concepts have evolved into calls for a ‘biopsychosocial’ stance (e.g. Cooper, 2005). This term found favour in the National CAMHS Review (DCSF/DoH, 2008) which regretted ‘an ongoing tendency to use the terms ‘medical model’ and ‘social model’ to characterise and polarise practice within health and education/social care.’ (p.61) before writing:

‘While there are legitimate issues to debate about how best to conceptualise, categorise and classify mental health problems, we found such references to be unhelpful and inaccurate. In reality, good practice in any discipline will consider the individual's situation, their strengths as well as their problems, and their sources of resilience alongside risk factors. The most effective approach is one that considers all aspects of need – in effect, a biopsychosocial approach. Where the biological, psychological or social needs are paramount, particular emphasis is given to addressing these aspects.’ (p.61)

As Cole, Daniels and Visser (2013) argued, a biopsychosocial perspective would seem appropriate and yet even that remains incomplete, or at least - as Slee (in press) postulates - can underestimate the contribution of the social. For the fullest explanation of how best to work with children, it could be necessary to draw more consciously on socio-cultural theories and the work of Vygotsky (see for example, Daniels, 2001).

2.8.2 In contrast, might there be an argument for simplifying the theory that should guide educationalists in their work with children at risk of exclusion? DfES/DoH (2004) saw the continuing relevance of the humanist approach, focusing again on addressing the needs of children identified in Maslow's (1943) 'Theory of Motivation'. He proposed that a series of different levels exist in human need, from basic satisfaction of physical wants (i.e. hunger, thirst, warmth), through safety needs, belongingness and love needs, esteem needs to achievement of goals and life challenges (a process that Maslow called 'self-actualisation'). These needs are seen as hierarchical, lower level needs must be satisfied before a person would be concerned about high level. The ‘Every Child Matters’ Green Paper (DFES 2003a) also gave a view of children's needs, which when met, issue in key outcomes (e.g. being healthy, being safe, enjoying and achieving). These needs overlap substantially with Maslow's view. NICE (2009) in their advice on social and emotional well-being for secondary schools similarly refer to the need to provide safety and security for pupils and to promote self-worth, self-efficacy, motivation and management of feelings.

2.8.3 An elaborated version of ‘needs theory’, which seems of high relevance to children at risk of exclusion, was given by Porter (2014) (see Figure 1).

When, in Chapter 5, this review moves to discussing effective means of counteracting and lessening the mental health difficulties of children at risk of exclusion it will be seen that many of the outlined approaches relate to items in Porter's model. Needs ‘theory’ uses a language, which is found helpful and is easily understood by educationists who appreciate that to engage and motivate ‘troubled and troublesome’ children, teaching the ‘academic’ should be embedded in a sensitive, appreciation of children's social and emotional needs. Such an approach, as will be argued later, helps to minimise the need for school exclusions.
Figure 1: A Model of Human Needs  (Porter, 2014, p.140)
Chapter 3: Estimating the Prevalence of Children with Mental Health Difficulties at Risk of School Exclusion

3.1. Introduction
3.1 Given the problems of definition, possible ‘medical over-reach’ (Slee, in press) and a consequent lack of accurate data, it is not possible to give a precise portrayal of the numbers of children with mental health difficulties at risk of exclusion. However, the approaches outlined below give some insight into the numbers and percentages of the school population involved, including information on gender and ethnicity. These approaches also highlight the inextricable links between exclusion, well-being, social disadvantage and educational difficulties. The difficulties facing that particularly vulnerable group, ‘looked after’ children, are briefly outlined near the end of the chapter.

3.2. Government Exclusions Data
3.2.1 First, the government continues to collate annual data on the numbers of recorded permanent and fixed-term exclusions. DfEE (1999) showed the numbers of permanently excluded pupils rising from 2900 in 1990/91 to a peak of 12,605 in 1996/1997. This four-fold increase, accompanied by a 64% growth in the numbers of pupils places in PRUs from 5043 in 1995 to 8263 in 1998, made exclusions a prominent political issue leading to initiatives outlined below in Chapter 4.

The numbers did fall as shown in Table 2, which compares the situation in 1997/8 with that of 2003/04, 2006/07 (the peak year for recorded fixed-term exclusions) and 2012/13 (the year in which the excluding school had its funding reduced when it permanently excluded a child). The total school population was 7,631,900 in 1997/98 and 7,593,280 in 2012/13.

Table 2: Permanent and Fixed Term Exclusions from state-funded primary, secondary and special schools in England

<table>
<thead>
<tr>
<th></th>
<th>1997/8</th>
<th>2003/04</th>
<th>2006/07</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent exclusions</td>
<td>12,300</td>
<td>9,990</td>
<td>8,680</td>
<td>4630</td>
</tr>
<tr>
<td>(% of school population)</td>
<td>0.16%</td>
<td>0.13%</td>
<td>0.12%</td>
<td>0.06%</td>
</tr>
<tr>
<td>Fixed Term Exclusions</td>
<td>-----</td>
<td>344,510</td>
<td>425,600</td>
<td>267,520</td>
</tr>
<tr>
<td>(% of school population)</td>
<td>-----</td>
<td>4.49%</td>
<td>5.66%</td>
<td>3.52%</td>
</tr>
</tbody>
</table>


Caution is needed in using these figures as they do depend on the sometimes dubious accuracy of schools’ annual returns. Cole, Daniels and Visser (1999), Daniels et al.(2003) and Smith (2009) are amongst researchers who have found flaws in school and local authority reporting systems in relation to exclusions. The Office of the Children’s Commissioner enquiries (OCC, 2012, 2013a and b) have drawn attention to the practice of unofficial exclusions, illegal though these are (see DFE, 2012). Also these figures give no indication of ‘internal exclusions’ for example using
austere and regimented ‘inclusion rooms’ as an alternative to fixed-term exclusions (Gilmore, 2013), a practice that has probably increased.

3.2.2 The government figures for 2012/13 confirm other well-established trends:

- [Table 3] boys are more than three times more likely to be permanently excluded than girls (0.09% of the school population compared to 0.03% for girls);
- [Table 4a] boys are nearly three times more likely to receive fixed-term exclusions than girls (5.15% of the school population compared to 1.83% for girls);
- [Table 4b] The number of fixed-term exclusions [FTEs] increases with the age of the pupils (for boys and girls) from age 4 or under (870 FTEs or 0.09% of the school population), through age 10 (4610 FTEs or 0.97% of the school population) to a peak at age 14 (33,070 FTEs or 5.88% of the school population).
- [Table 7] 42.8% of FTEs are for one day, 24.8% for 2 days, 14.7 for 3 days and 11.5% for five days - a school week; 0.8% for 10 days - 2 school weeks.
- [Table 9] The percentage of children with statements for special educational needs [SENs] who were permanently excluded has fallen from 0.36% in 2006/07 to 0.15% in 2012/13. However, this rate of exclusion is far greater than the percentage for pupils with no SEN (0.06% in 2012/13). 68% of children permanently excluded in 2012/13 were said to have SENs.

3.2.3 The officially-given reasons for exclusion are also provided but should be viewed with caution, if Daniels et al.’s (2003) findings still apply. Table 11 reports the most common reasons for permanent exclusion [PEx] and fixed-term exclusions were:

- ‘persistent disruptive behaviour’ (30.8% PEx; 24.2% FTE)
- ‘physical assault against a pupil’ (16.2% PEx; 19.4% FTE)
- ‘physical assault against an adult’ (10.5% PEx; 6.4% FTE)
- ‘verbal abuse/threatening behaviour against an adult’ (9.2% PEx; 18.9% FTE)
- ‘drug and alcohol related’ (7.8% PEx; 2.6% FTE)
- ‘verbal abuse/threatening behaviour against a pupil’ (4.2% PEx; 4.2% FTE)

3.2.4 Continuing the concerns of, for example, Osler and Hill (1999) and Harris, Eden with Blair (2000) some ethnic groups remain over-represented in the permanent exclusion figures: 0.07% of white British children compared to 0.35% of travellers of Irish heritage; 0.26% of Gypsy/Roma; 0.19% of Mixed Heritage (White and Black Caribbean) and 0.22% of Black Caribbean. Percentages for those of Pakistani, Bangladeshi and Indian heritage are less than those for white British children [see Table 14] Similar Osler et al.’s (2001) noting the over-representation of travellers in the exclusion figures, is still seen a decade later. Travellers of Irish heritage boys are 5 times more likely to receive a permanent exclusion than White British boys. Black Caribbean boys are three and a half times more likely and White and Black Caribbean boys two and a half times more likely. Similarly some ethnic groups remain over-represented in the fixed-term exclusion figures, although the slight over-representation of White and Black African children should also be noted [Table 15].

3.2.5 In the present era of fragmented types of schooling, Table 16a shows the rate of permanent exclusions from secondary academies is 0.12% overall (compared to the 0.06% rate for all schools i.e. mainly schools run by local authorities). Schools which chose to become academies (‘converter’) academies had a rate of 0.09% while schools in difficulties made by government to become academies (‘sponsored’) had a high rate of 0.23%. The rate for free schools (0.14%) was also high. It seems that where schools have greater control over their intakes they exclude more. As Norwich (2014) notes, this could be seen to undermine the ‘greater choice of schools for parents’ argument for the existence of academies. Research could usefully investigate whether some academies are less tolerant and have a less inclusive ethos in relation to children at risk of exclusion than local authority run schools.

3.2.6 Links between poverty (suggested by the proxy-indicator ‘free school meal’ entitlement) and exclusions are again suggested. Table 17 shows:
• 0.16% of children eligible for free school meals were permanently excluded (compared to 0.06% of all pupils);
• 8.43% of FSM eligible pupils received fixed-term exclusions (compared to 3.53% of all pupils).

3.3. Data on pupils with BESD, MLD and those attending PRUs
3.3.1 Similar to the scepticism needed when studying the exclusion data, limited faith should be placed in the numbers identified as having BESD. OFSTED (2010) reported differing rates of identification of SENs including BESD (particularly for children without statements) between schools and across local authorities. The CLD Coalition’s Green Paper on SENs (DFE, 2011) noted that the numbers of pupils with BESD increased by 23% between 2005 and 2010 and again cast doubt on the accuracy of categorisation. The CLD Coalition believed the explanation for the increase lay in funding mechanisms for schools and methods of measuring schools’ performance. The abolition of ‘School Action’ and ‘School Action Plus’, stages brought in by the 2014 SEND Code of Practice (DFE, 2014b), was a somewhat crude response to these perceived problems.

3.3.2 Nevertheless, the numbers of children said by their schools to have ‘BESD’ (either holding a statement or being placed at 2001 SENs Code of Practice ‘School Action Plus’) are of interest. There were 143,050 such children (HMG, 2014) i.e. 1.88% of the school age population and they constitute 21.1% of all the children said to have SENs. A small percentage of these pupils attended the 548 maintained and non-maintained special schools registered for BESD but most were placed in mainstream provision.

3.3.3 Given a key - but not exclusive - function of PRUs is to provide alternative education for children excluded or at risk of exclusion from schools, the figures for these are also of interest. In January, 2013, there were 14,050 pupils in PRUs, of whom 1430 pupils had BESD statements (10.18% of the PRU population) and 9405 (67%) were identified as having SENs which merited either ‘School Action’ or ‘School Action Plus’ status (SFR, 2014, Tables 1b, 2 and 10a). In short, the vast majority of children in PRUs have serious behaviour problems, associated with earlier exclusions and risk of renewed exclusion. Therefore research into the needs of children in PRUs is highly relevant to this review.

3.3.4 Children who in fact have significant BESD might also populate schools or units or mainstream lower-set classes catering primarily for children with moderate learning difficulties (MLD). After BESD (which accounts for 21.1% of all SENs), MLD is the second most common sub-category (accounting for 20.4%). The cross-over of moderate learning and behaviour difficulties has a long history (see Cole, 1989 and discussion of children with ‘mental deficiency’ in the 1920s and 1930s; also the ‘educationally sub-normal’ and the ‘maladjusted’ in the 1950s noted in the Underwood Report, Min. of Ed., 1955). We can reasonably speculate that many, who have been assigned the MLD label, could also be at risk of exclusion because of their challenging behaviour - and a high percentage of these children could have significant mental health problems. Combining the numbers of children with BESD and those with MLD and behaviour problems would go a long way to explaining why such a high percentage of children with SENs, noted for example in OCC (2012) and Whear et al. (2014) are excluded from school. This is an area meritng detailed research.

3.4. ONS figures on conduct disorders
3.4.1 This section focuses on the national survey of mental health disorder prevalence in children carried out in 2004 by the Office for National Statistics for the English Department of Health and the Scottish Executive (Green et al., 2005a and b). This study has become the key source of information on child mental health disorders, for instance DCSF/DoH (2008), Murphy and Fonagy (2012), NICE (2013) and DFE (2014a). However, the caution of the original study has been somewhat cast aside in the retelling of its headline findings - particularly its estimate that one in ten children in their sample could, according to their criteria and methodology, be said to have a mental health disorder. The need for caution is again suggested by Fonagy et al.’s (2014) recent presentation which notes estimates of conduct disorder (CD) in boys varying from 1.8%
to 16%, in girls from 0.8% to 9.2% and for oppositional defiance disorder (ODD) from 2.6% and 15.6%. Supporters of ‘the anti-psychiatry movement’ (Bilton and Cooper, 2013) could possibly make more of this confusing array of statistics.

3.4.2 However, Green et al.’s (2005a and b) detailed study involved a sample of nearly 8000 families, 90 to 120 minute interviews with a parent (the mother in 95% of cases), 3344 interviews with parent and child, questionnaires and interviews and questionnaires with over 6000 teachers, nominated by the parent. It enrolled a small number of children and their parents from nearly every post code area of the country. Interviews and analysis were guided by the ICD-10 Classification of Mental and Behavioural Disorders (WHO, 1992). In short, it is difficult to see a more careful study being funded and undertaken. It repeated research that had used the same methodology in 1999 (Meltzer et al., 2000) which had produced very similar results.

3.4.3 One key finding in terms of relevance to this review, was that 5.8% of the children in their sample were found to have a conduct disorder. This figure is close, although not directly comparable, to the 5.9% fixed-term exclusion rate for 14 year olds (see above). The 5.8% figure would fall within the 3-6% range suggested for children in the United States by Kauffman (2001 - seen as credible by Cole, Daniels and Visser, 2013) as having the American equivalent of ‘BESD’ or the 1-6% range estimated by Cole (2005) for children with BESD in English schools. If a crude extrapolation is made and it is hypothesised that 5.8% of the total school population (7,593,280, in 2012/13) might have conduct disorders, then a figure in the region of 440,000 children would be produced. It seems likely that most of the children making up this 5.8% could be at risk of school exclusion.

3.4.4 Other of Green et al.’s (2005a and b) findings are presented in Table 3. It is unlikely that those said to have only emotional difficulties and many of those whose hyperkinetic behaviours (or ADHD) are managed effectively through medication will be at risk of exclusion. Not shown in Table 3 is the common coexistence of anxiety disorder and CD as well of ADHD (hyperkinetic disorders) and CD, said by NICE (2013) to be ‘particularly high’ (up to 40% of those with CD). Pritchett et al. (2014) also noted the overlap between hyperactivity and behaviour problems. These children could remain at risk of exclusion.

3.4.5 As noted earlier, it is important to use these figures with caution. The figure for hyperkinetic disorder (1.5%) compares to the 0.5% to 1% estimate given in DfEE (2001b) for prevalence of ADHD. In contrast, Montague and Castro (2005) claim that in an American context, 2% to 5% of children are diagnosed as having ADHD. This illustrates the striking world-wide differences in the prevalence rates claimed for ADHD noted in Bilton and Cooper (2013). It is important to remember that Green et al. (2005b) saw their figures as ‘estimates’ (as did Coghill, 2013) which replicated their team’s estimates from 1999. In the introduction to their full report Green et al. (2005 b) write:

‘estimates of the prevalence of psychiatric morbidity among young people depend on the choice of concepts as well as how they are operationalised. These, in turn depend on the particular purposes and aims of the study. This point needs emphasising because it means the estimates from this survey will not necessarily be comparable with those obtained from other studies using different concepts, sampling design, assessment instruments or analytic methods.’ (p.8)

They concede that theirs is just one ‘concept’ of mental disorder - albeit adhering closely to concepts in ICD-10. They also describe how they fell short of their aim of assessing over 12000 children, how their attempts to achieve a more reliable multi-respondent view from parent, child and teacher often failed, and that other practical difficulties led to compromises in their research method. Their sample (including the Scottish children involved) amounted to less than 0.1% of the school age population at that time (total in 2003/04 for England: 7695820). They do not discuss the extrapolation of their findings to Great Britain as a whole. Neither did they discuss the possible implication of only involving fathers in a handful of cases. This gender imbalance could be significant given the Action for Children survey, which
indicated that mothers are far more likely to perceive and worry about mental health difficulties in their children than fathers (47% of mothers compared to 32% of fathers; poll of 2000 UK parents - Action for Children, 2015).

Table 3: Green et al. (2005 a and b) Prevalence of Mental Disorders by Age and Sex

<table>
<thead>
<tr>
<th></th>
<th>5-10 year olds</th>
<th>11 -16 year olds</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
<td>All</td>
</tr>
<tr>
<td>Percentage of children with each disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>2.2</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>6.9</td>
<td>2.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>2.7</td>
<td>0.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>2.2</td>
<td>0.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Any disorder</td>
<td>10.2</td>
<td>5.1</td>
<td>7.7</td>
</tr>
<tr>
<td>Numbers of children</td>
<td>2010</td>
<td>1916</td>
<td>3926</td>
</tr>
</tbody>
</table>

3.4.6 Green et al. (2005b) also highlight the sometimes temporary and environmentally-induced nature of their chosen term ‘mental disorder’ (preferred to ‘psychiatric disorders’ and ‘mental health problems’). ‘Mental disorder’, they write:

‘should not be taken to indicate that the problem is entirely within the child. Disorders arise for a variety of reasons, often interacting. In certain circumstances, mental disorder, which describes a constellation or syndrome of features, may indicate the reactions of a young person to external circumstances, which, if changed, could largely resolve the problem.’

(Green et al., 2005b, p.8)

This seems a very significant statement in relation to children at risk of exclusion. Episodes of severe psychiatric disorders (manic depression, bipolar disorders etc.) tend to occur in sufferers throughout their lives. Also mental health problems in childhood tend to lead to similar difficulties as adults. However, the ONS researchers are aware that much can be done to change the ‘external circumstances’ and thus ‘largely resolve the problem’. This implies that many apparent mental health problems can be cured without pharmacological intervention, indeed probably without the need for input from CAMHS. The onus for bringing about change, as will be described in Chapter 5, will most commonly fall on non-health professionals or, on occasion, peers and family members. This is neither surprising nor inappropriate, see Table 1 above, given so many of the factors in the ICD and DSM ‘conduct disorder’ categories are of a primarily social and educational nature.

3.4.7 Some of these key social factors are highlighted by Green et al. (2005a). The prevalence of mental disorders, including CD, was greater among children:
- in lone parent (16%) compared with two parent families (8 per cent);
- in reconstituted families (14%) compared with families containing no stepchildren (9%);
- in families whose interviewed parent had no educational qualifications (17%) compared with those who had a degree level qualification;
• in families with neither parent working (20%) compared with those in which both parents worked (8%);
• in families with a gross weekly household income of less than £100 (16 per cent) compared with those with an income of £600 or more (5%);
• in households in which someone received disability benefit (24%) compared with those that received no disability benefit (8%);
• in families where the household reference person was in a routine occupational group (15%) compared with those with a reference person in the higher professional group (4%).

3.4.8 Green et al. (2005a) also noted significant educational factors. In relation to the children in their sample who had a conduct disorder:
• 56% of were rated as ‘behind with their schooling’ with 36% two or more years behind;
• 52% were said by their teachers to have SENs;
• 42% had had 5 days and 14% more than 15 days absence from school in the previous term, compared to 21% and 4% for those without CD;
• 55% were considered by their teachers to be definite or possible truants;
• 33% had been excluded from school at some time and 22% more than once (cf 2 and 1% for sample children without CD);
• 77% had scores in the bottom quartile measuring their ‘social functioning’ strengths and 69% had scores in the bottom quartile on a scale measuring their social aptitude;
• had more difficulty making and keeping friends.

3.4.9 Green et al.’s (2005b) and Coghill’s (2013) cautious stressing that these figures are estimates is well-founded. Others go further. The Canadian psychiatrist Barker (1996) saw the DSM (and ICD?) approach as ‘a commendable attempt to bring order out of chaos’ (p.13) but felt that diagnostic categories were ‘essentially both arbitrary and artificial and have serious limitations, particularly as guides to treatment and prognosis.’ This view found new expression in the recent call of the Division of Clinical Psychologists of the British Psychological Society (BPS, 2013) for ‘a paradigm shift’ away from ‘a disease model’, expressing profound doubts about the wisdom of basing research, policy and practice on, what they saw as, the shaky foundations of the DSM and ICD categories. The authors believe DSM5 and ICD-10

‘are, and remain, works in progress. The need for revision [of DSM] is a consequence not only of the need to accommodate evidence-based advances in thinking and practice, but also reflects more fundamental concerns about the development, personal impact and core assumptions of the systems themselves…Many of the issues that arise in relation to psychiatric diagnoses stem from applying physical disease models and medical classification to the realms of thoughts, feeling and behaviours, as implied by terms such as “symptoms” and “mental illness” or “psychiatric disease”.’ (p.1)

3.4.10 Also to bear in mind are the words of Thomas Achenbach, the lead developer of one of the world’s most validated assessment tools, the Child Behavior Checklist [CBCL], which is recommended for use by clinicians in NICE (2013). He noted the difficulties of distinguishing between children who are ‘normal’ and those who are ‘abnormal’ and that with respect to mental health syndromes, ‘children are continually changing ’ (Achenbach, 1991, p.45):

‘All assessment procedures are subject to errors of measurement and other limitations. No single score precisely indicates a child’s status. Instead, a child’s score on a syndrome scale should be considered an approximation of the child’s status as seen by a particular informant at the time the informant completes the CBCL.’ (p.45 - 6)

Simpler and much shorter tools such as the Strengths and Difficulties Questionnaire (Goodman, 1997), whose 25 point scale is designed to indicate a range of ‘disorders’, are recommended for use by teachers in NICE (2013) and DFE (2014a). Much work has been done to check the reliability and validity of this tool in its various forms (e.g. Goodman, Meltzer and Bailey, 2003). However, the SDQ is seen as mainly an initial screening tool to establish which children should
be referred for comprehensive assessment by clinicians. In short, the faith apparently placed in its use as a firm measure of mental health problems either in individuals, groups or large populations of children seems somewhat surprising. Consequently, it might be expected that research using the SDQ as its main measure of mental health difficulties should be viewed with more circumspection.

3.4.11 The paragraphs above could resonate with BCP (2013) but also with those who agree with, for example, Macleod's (2010) worries about an apparent ‘medicalisation’ of behaviour or Slee’s (2013) concerns in relation to mental health and ‘net widening’ and ‘accelerated disablement’. The latter is

‘where the gravity of the model presses diagnosticians, administrators, teachers and parents to emphasise and overstate impairments in order to secure additional or basic resource entitlements. This is made all the more possible where psychiatrists and psychologists allow for the assignation of patients to ‘shadow syndromes’ when the symptoms do not conform precisely to the DSM schedule’ (Slee, 2013, p.24).

3.4.12 Finally, looking beyond ONS estimates, the greater apparent prevalence of mental health difficulties of children in special schools for children with BESD (at least as determined by use of the SDQ) was again suggested by Hackett et al. (2010). This finding could be seen to provide further evidence in support of Cole et al.’s (1998) and DCSF/DoH’s (2008) more general claims on this topic.

3.5. ONS figures on ‘looked after’ children

3.5.1 Over-representation in the exclusion figures of children in the legal care of local government authorities was noted in Brodie (2000), Osler et al. (2001) and Daniels et al. (2003). Meltzer et al. (2003) give figures which are likely to explain why this is the case. This ONS national survey of the mental health of 1039 looked after children found:

- 45% of those aged 5–17 years, were assessed as having a mental disorder: 37% had clinically significant conduct disorders; 12% were assessed as having emotional disorders - anxiety and depression – and 7% were rated as hyperactive (ADHD).
- The most common, specific, conduct disorders were socialised conduct disorder – 22% among 11- to 15-year-old boys; and Oppositional Defiant Disorder (ODD) – 18% among 5- to 10-year-old boys.
- The highest rate of hyperkinetic [ADHD type] disorders, 16%, was also found among 5- to 10-year-old boys.
- About two-thirds of children living in residential care were assessed as having a mental disorder, compared with a half of those living independently, and about four in ten of those placed with foster carers or with their natural parents.
- About 60% of all looked after children had difficulty with either reading, mathematics or spelling as assessed by their teachers.
- Difficulties in reading and maths were more prevalent among children in residential care than in any other placement: 82% had difficulties with maths and 70% had reading difficulties.
- 44% of children with a mental disorder were in contact with child mental health specialists and a third accessed special education services.
- Children with hyperkinetic disorders or their carers were much more likely than those with any other disorder to have contacted a teacher for help, 68%, or seen a specialist in child mental health, 62%, and almost half, 47%, had been seen by professionals working in SENs.
- 38% of independent living young people were reported to have been in trouble with the police and 30% of those in residential care.
- Carers of children with a mental disorder were over five times more likely than carers of those with no disorder to report that the children had been in trouble with the police (26% compared with 5%). Children with a conduct disorder were the most likely to have had this experience (29%) and this group were also most frequently reported as having been in trouble three or more times, (14%).
Ford et al. (2007) produced findings which also highlighted links between being looked after, psychiatric and educational difficulties, particularly for children living in residential care. Luke et al. (2014) were also struck by the acute social and psychological needs of young people looked after.

3.5.2 Even allowing for possible doubts over methods of assessment and the fact that difficulties can pass, it seems reasonable to conclude, as did the National CAMHS review of 2008, that looked after children are a particularly vulnerable group, meriting substantial, easily-accessed input from CAMHS (2008 DCSF/DoH) and specialist help from their schools to boost their well-being and lessen the likelihood of exclusion.

3.6. Concluding comments

3.6.1 The stark decline in the number of recorded permanent exclusions (not necessarily brought about by making children more ‘included’) has been noted. The rise (to 5.66% of the school population in 2006/07) and then decline of overall rates of fixed-term exclusions, have been reported. However, 5.88% of 14 year olds were subject to fixed-term exclusion in 2012/13. Boys remain three times more likely to be excluded than girls and certain ethnic groups, notably travellers of Irish descent, black Caribbean and children of mixed ethnicity (white and black Caribbean heritage), are at a disproportionate risk of exclusion. It has been reported that 143,050 children were identified, correctly or incorrectly, as having significant BESD (‘statemented’ or placed on the ‘school action plus’ stage), a grouping highly susceptible to exclusions. This figure equates to 1.88% of the total school population. We have focused on Green et al.’s (2005 a and b) benchmark study for conduct disorders, reporting their estimate that 5.8% of their sample had conduct disorder (7.5% of boys; 3.9% of girls). A large majority of these children could be at risk of exclusion from school. Extrapolating this 5.8% figure to the total school population could mean that over 400,000 children are quite feasibly the concern of this present review. Many children diagnosed as ADHD could also be at risk of exclusion.

3.6.2 While perhaps a large majority of these 400,000 to perhaps 500,000 children could be said to have conduct disorders (perhaps BESD?), the nature of their apparent difficulties should not necessarily be viewed as a disease, for which medical input is required. Green et al (2005,a and b) clearly demonstrate the many social and educational components of conduct disorder (as defined in at least ICD-10, WHO, 1992). They allow for the fact that if these components are adjusted then the conduct disorder can diminish or pass. In Chapters 4 and 5 it will be argued that it is usually professionals employed by non-medical services, who are best placed to bring about beneficial change for the majority of children at risk of exclusion. The contribution of CAMHS will be of great importance, but only for a minority of these vulnerable children.
4.1. The Labour Governments, 1997-2010

4.1.1 Elected in 1997, the Labour government embarked on ambitious plans to promote social cohesion and to tackle disadvantage. Committed to raising both academic and behaviour standards, the administration was worried by rising disaffection and school exclusions (DFEE, 1997; SEU, 1998a). Circular 10/99 (‘Social Inclusion: Pupil Support’ - DFEE, 1999a) set the target of reducing unauthorised absence and exclusions by a third by 2002 and instigated pastoral support programmes, individualised plans designed to address the needs of children at risk of exclusion. In 1998, new guidance had urged local authorities to produce ‘Behaviour Support Plans’, which were to be ‘comprehensive and well-understood local arrangements for tackling pupil behaviour and discipline problems that cover the full range of needs’ (DFEE, 1998a, p.4). Constructing BSPs was to involve social services, mental health services, youth justice’ (see Cole, Daniels and Visser, 1999 for national overview of BSPs; also Cole, Daniels, Visser, 2003). There was an ongoing recognition of the need for improved multi-agency working. Under the ‘Quality Protects Programme’ (DoH, 1998) and ‘Working Together Under the Children Act, 1989’ (DOH, 1999), children’s services were to be ‘transformed’ with particular attention paid to looked after children. The links between emotional well-being and school improvement were seen in DFEE (2000, 2001a).


‘All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have [i.e. were to have] access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.’ (DoH, 2004)

DCSF/DoH (2008) reported that limited though discernible progress was being made towards this ambitious target, with waiting times falling and improved CAMHS in some areas.

4.1.3 These years also witnessed the establishment of a major national programme in England addressing the ‘social and emotional aspects of learning’ (SEAL) (DFES 2007). This was a logical extension of DFES/DoH (2004) ‘healthy schools’ initiative. It was also a reflection of considerable focus at this time on ‘emotional literacy’ (see for example, Weare and Grey 2003 or Cowie et al., 2004). SEAL was described as ‘a comprehensive, whole-school approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools’ (DCSF, 2007, p.4). By 2010 SEAL was being implemented in 90% of primary schools and 70% of secondary schools (Humphrey, Lendrum and Wigelsworth, 2010).

4.1.5 Also relevant to children at risk of exclusion (fixed-term exclusions were to peak in 2006/07), were the National Strategies Behaviour and Attendance Strand (DFES, 2003b). This evolved from the Behaviour Improvement Programme, started in 2002, and earlier pilot initiatives. Each LEA was to have a Behaviour and Attendance Consultant, for local schools
to call upon (Frost, 2009). Hallam, Castle, Rogers, 2005 (a and b) were to report on other key features of BIP, along with offering guidance on ‘best practice’. These documents stressed the need for a preventive approach through creating appropriate school ethos, addressing underlying causes of poor behaviour, promoting positive behaviour management and enhancing staff skills. Schools would benefit from conducting regular audits of behaviour, attaching learning mentors and key workers to children presenting challenging behaviour. ‘Lead behaviour professionals’, with influence on their school leaders if not part of the senior management group, were to help to raise the status of pastoral support in schools. LBPs could be the link workers to multi-agency Behaviour and Education Support Teams. Working with families was seen as a crucial role for school linkworkers and for BESTs (Hallam, Castle, Rogers, 2005 a and b; Halsey et al., 2005; Cole, 2007).

4.1.6 Stealing the limelight from OFSTED (2005) was the first Steer Report (DFES, 2005a). While calling for separate studies into pupils with the most challenging behaviour and BESD (resulting in new guidance on BESD: DCSF, 2008), the main Steer report had much to say on creating school environments that would discourage disaffection and consequently help to reduce exclusions. The next Steer Report (DFES, 2006) gave a condensed version (with case studies) of good general practice. Messages included:

- The need for effective, high status pastoral systems,
- The need to teach social, emotional and behavioural skills.
- The value of Learning Support Units (i.e. in-school centres for children displaying challenging behaviour) to provide short term and preventive intervention, reducing the need for exclusions.
- The value of behaviour audits as part of a ‘do, review, apply’ cycle.
- Respect had to be given by teachers in order to be received. Parents and carers, pupils and teachers all need to operate in a culture of mutual regard.
- The need to enhance staff pastoral and behaviour management skills;
- The need for good links to specialist support, particularly educational psychologists (whose input into schools should be increased), education welfare officers and CAMHS.
- The value of ‘Lead Behaviour Professionals’ (but they sometimes lacked expertise).
- The value of ‘Pupil Parent Support Workers’ to engage with families.

4.1.7 There followed new guidance on discipline and behaviour in schools (DfES, 2007) which again recommended audits of behaviour and approaches to positive behaviour management, rewarding, praising and encouraging pupils while spotting worrying signs and trends to allow early intervention. DfES (2007b) brought in the new requirement that schools were required to arrange full-time education for pupils excluded for a fixed period from the sixth day of exclusion and local authorities likewise from the sixth day of a permanent exclusion. Part 1 of the guidance is titled ‘Promoting positive behaviour and early intervention’, stating that exclusion should be a last resort after a range of measures have been tried. Alternatives to exclusion are suggested: restorative justice, mediation, internal exclusion and ‘managed moves’. Near the end of the Labour Government there was a review of how Pastoral Support Plans (DSCF, 2010a) were working.

4.1.8 There were also insightful and pertinent reports from the schools inspectorate on:

- addressing ‘Challenging Behaviour’, the inspectorate’s term for disruptive behaviour/ BESD (OFSTED, 2005);
- successful practice in PRUs (OFSTED, 2007);
- reducing the numbers of black pupils excluded (OFSTED, 2008a);
- good practice in re-engaging disaffected children (OFSTED, 2008b);
- exclusions of children aged 4 to 7 years (OFSTED, 2009a);
- children ‘missing’ from education (OFSTED, 2010b);
- good practice in reducing the numbers of young people not in education, employment or training (NEETs) (OFSTED, 2010c);
4.1.9 Calls for better training of teachers to improve their effectiveness in responding to disruptive behaviour, sometimes linked to the need to promote social, emotional and behavioural skills in the classroom, were made in many publications (DfES, 2003a, 2004 a and b; 2005a; OFSTED, 2005; HMG, 2006; DFES, 2007 and DCSF, 2008a). Part of the government’s own response was the commissioning of the web-based National Programme for Leaders in Behaviour and Attendance training materials, linking to accredited courses (HMG, 2006) and the web-based introductory training programme in BESD, a key component of the Inclusion Development Programme (DCSF, 2010b). Staff development could also be brought about by encouraging schools to group together and share expertise in behaviour partnerships/school improvement partnerships (HMG, 2006).

4.1.10 Garner (2013), who worked at the heart of some of these activities is well placed to comment on teacher training and BESD. He judged the years of the Labour governments as ‘a period of enlightenment’:

‘The period from 1997 to 2010 was unusual in that there was a widespread recognition and accompanying policy enactment that overtly sought to tackle the social dimensions of learning. The pupil became the central focus. The emergence of new legislation as part of the ‘Every Child Matters’ (DFES 2003a) strategy placed an emphasis on the well-being of young people and recognised that their academic attainment and social progress were inextricably linked. The focus on pupil behaviour shifted towards promoting positive approaches in managing behaviour and a resurgent emphasis on linking learning and behaviour.’ (p332)

4.1.11 Garner saw a beneficial impact resulting from the application of a ‘behaviour for learning’ approach to teacher training/education (Ellis and Tod, 2009). Greater understanding of child and adolescent development was placed at the heart of a ‘positive approach to pupil behaviour’, as opposed to a reactive ‘behaviour management’ approach (Garner, 2013, p.332). Initial teacher training courses were able to re-introduce aspects of a ‘behaviour curriculum’ that had previously been overshadowed by an emphasis on subject knowledge. He went on:

‘The development of a more holistic version of what comprises ‘pupil behaviour’ within teacher education resulted in some important gains being made in addressing an endemic issue in pre-service courses in England—that of the ‘bolt-on’ component … Input on behaviour in general was regarded as the preserve of a specialist tutor, often delivering sessions the content of which appeared to be divorced from the ‘real life’ of the classroom and the reality of teaching a curriculum subject’ (Garner, 2013, p.332).

The ‘behaviour for learning’ approach, he noted, stressed the need ‘to enhance the synergy between academic, vocational, affective and social curricular intentions and outcomes for individuals’, links that needed to be emphasized in teacher training. He claimed this approach evoked a positive response from students and that the Teacher Development Agency (2009) reported an increase in the level of confidence on the part of new teachers to addressing behaviour issues. Dwelling on the appropriateness of particular components of teacher training is warranted here by our stress in Chapter 5 on the importance of teachers’ understanding and knowing how to respond to the social and emotional difficulties of children if exclusions are to be minimised.

4.1.12 In summary, the Labour governments’ strategy saw early intervention, inter-agency collaboration, a stress on addressing social and emotional needs in schools and staff development as key. Their approach was supported by reports that saw early investment by government as saving considerably larger sums of money later when the costs of consequent adult mental health difficulties, social services and crime (e.g. Audit Commission, 1999) were considered. The Sainsbury Centre for Mental Health (2009) estimated that 80% of all criminal activity was attributable to people who had conduct problems in childhood and adolescence. Documents published after the 2010 general election were to give a similar message e.g. SCMH (2010); Allen (2011); Knapp, McDaid and Parsonage (2011); Murphy and Fonagy (2012) and Brown, Khan, Parsonage (2012).
4.2. The Conservative and Liberal Coalition, 2010-2015

4.2.1 By 2010, a sustained and deep recession had impacted on international and British government finances, the latter already under pressure from the increase in public spending under the Labour governments after 2003. Public sector current expenditure increased from £430.6 billion (35.7% of gross domestic product) in 1997/98 to £652.8b (42.2% of GDP) in 2009/10 (HM Treasury, 2013). Chantrill (undated) shows total UK government spending on education increasing from £54.74bn for fiscal year ending 2003 to £88.48bn in 2009. In an age of austerity, the maintenance of some of Labour’s initiatives could not be sustained. Also, evidence was emerging of limits to the effectiveness of some key Labour initiatives - see for instance Humphrey et al (2010) on SEAL; and NESS (2012) on Sure Start.

4.2.2 Reduced funding was accompanied by a stark change in government philosophy. On taking power, the ‘Department for Children, Schools and Families’, a title which recognised the inter-connectedness of education, family life and wider social care - also the importance of social work professionals - was replaced by the unrepresentative title ‘Department for Education’. The inter-agency approach that characterised policy after the 2004 Children Act retreated in prominence - and terms such as ‘Every Child Matters’ and ‘inclusion’ avoided. In relation to teacher training - but alluding to wider issues - Garner (2013, p.332) claimed:

‘In spite of the benefits of locating a training response to pupil behaviour in a positive and holistic way, the advent of a new political administration in England in 2010 brought a significant change in policy direction. A crude, revisionist response was instigated under the pretext of reducing costs, bureaucracy, paperwork, and making advice and guidance more accessible. The government removed a massive repertoire of professionally informed and practical web-based resources on pupil behaviour [including the NPSLBA materials]. These were decommissioned and subsequently located in a national archive, which was beyond the sight-line of most trainee teachers or their tutors. Amongst the materials that became obscured were substantial documents promoting positive strategies for behaviour change, including social and emotional aspects of learning... For many teacher educators this was a case of professional and intellectual vandalism.’

4.2.3 DFE (2010) promised ‘to increase the authority of teachers to discipline pupils’ (p.9) and asserted that the curriculum ‘contains too much that is non-essential and too little which stretches them [pupils] to achieve standards matching the best in the world’ (p.8). New guidance on dealing with pupil behaviour (DFE, 2011b) was seen by Garner (2013) as ‘back-to-basics’ and ‘a retrogressive approach’ (p.332):

‘The agenda presented was uncompromisingly about control and ‘discipline’, and a preoccupation with the legal powers and duties of school staff. It provided information on such measures as ‘detentions, punishment’ and the powers that teachers had to use ‘reasonable force’. The document was stripped bare of reference to relationship-building and to the social and emotional aspects of learning—both of which comprised hopeful developments from the earlier decade. Nor was there mention of the link between academic and social learning.’ (p.332)

The same comments can be applied to the DFE (2014c): schools’ behaviour policies should include details on pupil support systems, but no detail is given. ‘Punishing poor behaviour’ is a bold heading, under which it is briefly allowed that disruptive behaviour might result from unmet needs, requiring not specialist educational support (e.g. from local authority behaviour support services or educational psychologists) but rather ‘a multi-agency assessment’. Legal punishments and correct usage of seclusion rooms are outlined. In the ‘legislative links’ at the end there is an absence of references to the work of the Labour governments described above. PSHE, was no longer a compulsory part of the national curriculum, and Government guidance on it reduced to under two pages, with reference made instead to materials provided by a voluntary association (DFE, 2013).

Inspiration from the School of Psychology, University of Oxford
4.2.4 Also characteristic of the DFE and its preference for ‘small government’ (Norwich, 2014) was the revised exclusions guidance (DFE, 2012). This, in contrast to its Scottish equivalent, was mainly a statement of legal duties. It makes only brief one-sentence references to unmet needs, early intervention, SENs, mental health issues, multi-agency assessments and the vulnerability of looked-after children. It might be argued in the CLD Coalition’s defence that more detailed guidance was now unnecessary, given falling exclusion rates and the fact that school leaders could construct their own policies without central guidance. However, in this writer’s view, recognition of and cross-reference to informative, evidence-based materials of the Labour period was merited.

4.2.5 Norwich and Eaton (in press), further discussed the changed outlook and practice of the CLD Coalition. They observed an increased emphasis on encouraging market forces to influence the delivery of public services. They also noticed a return to a medical (rather than a social) model of viewing special education, disability and emotional health and well-being. The CLD Coalition’s strategy for mental health (DoH, 2011) acknowledged this last issue in the following defensive paragraph:

‘Mental health problems … manifest themselves in different ways at different ages and may (for example in children and young people) present as behavioural problems. Some people object to the use of terms such as ‘mental health problems’ on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative.’ (p.7)

4.2.6 DoH (2011) is prefaced by a description of the audience for which this strategy is designed. Educationalists are not mentioned in the circulation list. This possible lack of awareness of the mental health role of the education sector is in contrast to the National CAMHS review, commissioned and published jointly by DCSF/DOH (2008), an investigation not mentioned or referenced in DoH (2011). The CAMHS review openly discussed the role of schools and was acquainted with the language of DCSF and teachers, commenting on the Behaviour and Attendance strategy, PRUs and children with BESD.

4.2.7 However, DoH (2011) does commit to various approaches that could impact positively on mental health in children at risk of school exclusion. It

- acknowledges links between mental health and social disadvantage;
- accepts that money spent on early intervention saves costs later;
- pledges to increase the health visitor workforce;
- announces that DFE will bring together funding for a number of early intervention and preventative services, including Sure Start children’s centres;
- notes schools and local areas report significant benefits from the Targeted Mental Health in Schools (TaMHS) programme, a programme that would still be supported.

Parent training programmes (see Chapter 5 below) are also advocated. There would also be what proved to be limited funding for a scheme called ‘Improving Access to Psychological Therapies’ (IAPT). For adolescents, it recommended multi-systemic interventions that involve young people, parents, schools and the community (see for instance, Fonagy et al., 2014). These, it claims

‘have been shown to reduce conduct disorder, improve family relationships and reduce costs to the social care, youth justice, education and health systems. Evaluation of family intervention has shown reductions in mental health problems, drug or substance misuse and domestic violence.’ (DFE, 2011, p.40)

Also of likely relevance to school exclusions, was the national campaign to turn around the lives of families with multiple problems. It was claimed that 2% of families in England (117,000) had at least five or more ‘problems’, which often included mental health problems). Further details on
this scheme were given in DCLG (2014), which claimed 33% of the children in these families had a mental health problem.

4.2.8 In 2012, The Heath and Social Care Act established Health and Wellbeing Boards (HWBs). Each local board (DoH, 2012) was to be ‘a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities’. Oddly the title includes the arguably non-medical term ‘wellbeing’ rather than ‘mental health’. Also strangely, while the ‘key leaders’ to take part include the local authority director for children’s services, it seems it is this person’s social care remit, rather than their responsibility for schools, that merits their place on the HWBs. Furthermore, while the CLD Coalition at this time, championed self-governing academy schools (over 40% of secondary schools are ‘academies’ - Bolton, 2014) and free schools, no place on these boards is seen for head teacher representatives. The words ‘education’ and ‘schools’ are not mentioned in this document. This might be seen as another example of the CLD Coalition government under-recognising the key role that educational staff have played, and continue to play, in promoting emotional health and wellbeing in children, particularly those in vulnerable groups at risk of exclusion.

4.2.9 Further pointers to the possible ‘medicalisation of behaviour’ might be perceived in DFE (2014a) ‘Mental health and behaviour in schools - Departmental advice for school staff.’ One might have expected the perspective of educationalists to be prominently voiced in this and the mental health/ emotional well-being initiatives run by educationalists, described earlier in this chapter, at least acknowledged - but they are not. Every foot-note in DFE (2014a) is to medical research other than a sole reference to ‘Healthy Schools’ information, now relegated to the National Archive.

4.2.10 DFE (2014a) does cover risk and resilience factors, as well as life events which can precipitate mental problems. There is passing reference to the need for effective pastoral systems in schools, and for pupils to feel safe and ‘a sense of belonging and feel able to trust and talk openly with adults about their problems’ (p.7). There is a two sentence paragraph stating ‘deficits [sic] in social skills and competence play a significant role in the development and maintenance of many emotional and behavioural disorders in childhood and adolescence’. This is accompanied by a lone reference to an article, published in 2003, in a mental health journal while the wealth of advice, built on extensive research, contained in DFES/DoH (2004) on healthy schools and the SEAL programme guidance (DCSF, 2007, 2009a) escapes attention.

4.2.11 DFE (2014a) mentions the importance of school ethos. However, this is ‘an ethos of setting high expectations of attainment for all pupils with consistently applied support’ (p.10). It is not the ethos of an ‘emotionally literate’, SEAL promoting inclusive school (see Chapter 5 below).

4.2.12 This guidance recognises that ‘form tutors and class teachers see their pupils day in, day out. They know them well and are well placed to spot changes in behaviour that might indicate a problem’ (DFE, 2014a, p.8). Note the phrase ‘spot changes’, rather than a sentence recognising that teachers can be trusted to respond/address changes, using their own resources and/or the expertise or the skills of educational support staff, within their school or in educational services beyond their school (e.g. from the local authority - or now privatised- behaviour support, psychology or outreach services from a BESD school or PRU). There is no mention of ‘lead behaviour professionals’, behaviour support staff or even educational psychologists - or primary mental health workers whose valuable role had been recognised in DCSF/DoH (2008).

4.2.13 DFE (2014a) sees a need for ‘continuous’ professional development to ensure school staff understand that they all have a responsibility to promote good mental health and which ‘informs them about the early signs of mental health problems, what is and what isn’t a cause for concern’ (p.9). There seems limited awareness of the contribution school staff and educational support services make to promoting emotional health and well-being in schools.
There is however, some recognition of the role counselling can play - and the potential of CAMHS workers to offer one-to-one therapeutic work.

4.2.14 To complete this look at CLD Coalition initiatives, we mention the 2011 Green Paper, apparently ‘a new approach to special educational needs and disability’ (DFE, 2011a). The Green Paper re-iterated the fact that children with SENs were frequently excluded, indeed, in 2008/09, 64% of all permanently excluded pupils had SENs. Once again the link between this figure and BESD and MLD/BESD (i.e. children likely to be displaying the most challenging behaviour) being the commonest forms of SENs was not explored. The growth in numbers of children said to have BESD, noted by OFSTED (2010), was re-iterated, as were claims about over-diagnosis. In the era of austerity, as Norwich (2014) noted, concerns about over-diagnosis could actually primarily be concerns about incurring arguably unnecessary public spending.

4.2.15 The Green Paper preceded the 2014 Children and Family Act and the revised Special Educational Needs and Disability (SEND) Code of Practice (DFE/DoH, 2014). The latter was seen by Norwich (2014) as an uneven document, in many respects unlikely to improve on - indeed to be less helpful than - the 2001 Code (DFEE, 2001b). He goes further in his criticisms when he says the Code:

‘is not based on a balanced and evidence-informed analysis of what was achieved by the previous Labour Government nor of the unresolved issues of that time. The opportunity was also lost to integrate the special educational needs and disability legislative systems, thus perpetuating the confusion and waste of having two different systems of provision responsibility.’ (p.421)

4.2.16 The new Code seemed concerned and somewhat confused about the differences between disruptive pupils, mental health issues and children deemed ‘BESD’ - a term it was to abolish. Paragraph 6.21 said: ‘Persistent disruptive or withdrawn behaviours do not necessarily mean that a child or young person has SEN.’ However, sometimes these behaviours apparently do indicate SENs and should be assessed:

‘to determine whether there are any causal factors such as undiagnosed learning difficulties, difficulties with communication or mental health issues. If it is thought housing, family or other domestic circumstances may be contributing to the presenting behaviour a multi-agency approach…may be appropriate. In all cases, early identification and intervention can significantly reduce the use of more costly intervention at a later stage.’ (DFE, 2014b, p.96)

4.2.17 The subsequent paragraph says schools ‘should have clear processes to support children and young people, including how they will manage the effect of any disruptive behaviour so it does not adversely affect other pupils’ (p.98) followed by referring readers to DFE (2014a). High quality teaching will, it says, help to minimise difficulties and underachievement. Schools should also work closely with parents, the local authority and other providers of specialist services. Input from educational psychologists and CAMHS might be commissioned.

4.2.18 In place of ‘BESD’ is the new ‘broad area of need’, ‘Social, Emotional and Mental Health Difficulties’. ‘SEMHD’ are defined in the following:

‘Children and young people may experience a wide range of social and emotional difficulties which manifest themselves in many ways. These may include becoming withdrawn or isolated, as well as displaying challenging, disruptive or disturbing behaviour. These behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children and young people may have disorders such as attention deficit disorder, attention deficit hyperactive disorder or attachment disorder’. (DFE, 2014b, 6.32, p.98)

Norwich and Eaton (in press) see this wording as being as vague as ‘BESD’. Norwich (2014) also notes the lack of any mention for ‘the parallel and often connected area of MLD’ (p.419)
in either the Green Paper or the Code of Practice. The authors of these two papers are also concerned about the psychiatric language used, seeing a continuation of unresolved conflicts between a medical and social model of explaining difficulties/ disabilities seen in schools.

4.2.19 Parental complaints about the difficulties associated with the statementing process were reported in both Green Paper and acted upon in the Code. ‘Statements’ for SENs were abolished and those with the severest needs were now to be given an ‘Education, Health and Care Plan’, doubts about which were also voiced by Norwich (2014). Also abolished, with the ending of ‘School Action’ and ‘School Action Plus’, was the staged approach of the 2001 SENs Code of Practice.

4.2.20 In the present post-LEA era of disempowered local authorities, funding devolved to head teachers, academies and (at least during the lifetime of the CLD Coalition), the encouragement of ‘academies’ and ‘free schools’, it is hard to establish how the Code of Practice and government guidance on behaviour and mental health are now impacting on schooling across England. It could be that, particularly in relation to children at risk of exclusion, the practice encouraged by the Labour administrations, 1997-2010, is still proving beneficial and has become embedded in schools where exclusions are infrequent.

4.2.21 Finally - an unanswered question - pupils deemed ‘BESD’ amounted, before the 2014 Code of Practice, to 1.88% of the school population (see Chapter 3). But if this figure represents an over-identification, how can ‘SEMHD’, a title stressing ‘mental health’, include the 5.8% of the school population, accepted elsewhere by the government (in DFE 2014a), as having ‘conduct disorders’?

4.1. CAMHS and the education of children at risk of exclusion

4.3.1 To set the scene for Chapter 5, discussion now moves to the interface between CAMHS and schooling in relation to children with behavioural problems at risk of exclusion, between 1997 and 2015.

4.3.2 In their national study of BESD schools, Cole et al. (1998) found contact between these schools and CAMHS was often minimal and OFSTED (1999) noted that the input of psychiatrists into LEA BESD schools was almost non-existent - and this was for the children with arguably the highest level of need. DFEE (2003c) noted a similar situation as did OFSTED (2005, 2006) and HMG (2006). Halsey et al. (2005) found most multi-agency behaviour and support teams in their sample were led by educationalists and were local authority or school based, although with valuable input from the CAMHS representative on them. A little later, in a brief period of increased funding, there was some evidence of increased staffing and availability of support from CAMHS to schools (DCSF/DoH, 2008), which was seen as worth-while by front-line workers with children with BESD (Cole, 2008). However, the national CAMHS review (DCSF/DoH, 2008) painted a continuing mixed situation, with a lack of CAMHS availability for vulnerable groups in PRUs and BESD schools and for looked-after children - as well as continuing lack of inter-professional understanding. Continuing difficulties in accessing CAMHS was also seen in OFSTED (2008b, 2009). Where interventions from CAMHS existed, they were often a desirable add-on service rather than an integral part of children’s daily experiences at school or PRU a situation recognised by OFSTED:

‘Any therapy designed to support a young person’s emotional well-being was more effective when it was integrated into the rest of the provision and took account of the child or young person's family and social context.’ (OFSTED, 2010a, paragraph 78 on support for BESD).

4.3.3 Moving beyond the election of the CLD Coalition and into the era of austerity, a similar picture of limited access to CAMHS is painted (DFE, 2011; Murphy and Fonagy, 2012; Crow, 2014). Also noted were the inconvenient location of clinics making access to CAMHS services difficult (Brown, Khan, Parsonage, 2012) and at times poor relationships between CAMHS and other services continuing as a problem (Wolpert et al., 2011). The key role for CAMHS in
relation to schools (as seen in NICE, 2013 and DFE, 2014a) was seen as being a provider of CPD, consultations and individual therapies (e.g. under the IAPT programme). It seems that extra resources for mental health work in educational settings would be used for the ‘add on’ peripheral approaches, which TaMHS might have delivered. Even these, as Wolpert et al, 2011 report, were mainly provided by specialist educational staff rather than CAMHS professionals.

4.3.4 TaMHS promotion of links between educationalists and mental health service workers clearly had value, and was often appreciated by both groups of these workers (Wolpert et al., 2011). However, its worth seems to consist of not so much the help given directly to ‘at risk’ children but rather as a way of building relationships, knowledge, understanding and trust between educationalists and clinicians - seen by Vostanis et al. (2010). This side effect of joint-working had also been observed some years earlier in Daniels et al.(1999), Pettitt (2003) and Daniels et al. (2003). Trust and mutual respect was needed so that either CAMHS worker, having a good relationship with the school, or senior teacher (perhaps ‘Pastoral Manager’, Deputy Head or SENCo), well known to local CAMHS, could make phone calls about appropriate referrals or for advice that would be respectfully received and acted upon. The Mental Health Foundation (1999) and Cole et al.(2002) recommendation for mental health co-ordinators in schools, well-known and respected by CAMHS, who could act as a link-worker, would still seem sensible, and probably an idea that has been adopted by many schools and local CAMHS.
Chapter 5: School-based Approaches to the Mental Health Difficulties of Children at Risk of Exclusion

“What determined a school’s rate of exclusion was a combination of its philosophy, capacity to meet the challenges presented and, sometimes, the response received from the local authority and outside agencies when the school asked for help.”

(OFSTED, 2009, p4-5)

‘Schools have an idea that CAMHS can cure everything and wave a magic wand.’

(mental health worker to Vostanis et al., 2012, p.116)

5.1. Introduction

5.1.1 Addressing the mental health difficulties of children at risk of exclusion from educational settings remains - and is likely to remain - primarily a task for the schools themselves (whether mainstream, special or PRUs). The first line of approach is staff, with the right values and skills, creating an inclusive school environment. Secondly, continuing the English experience of many decades, it is pastoral and behaviour support staff and at times educational psychology services - despite cuts to these services in recent years - who provide most of the additional help. This situation was recognised in OFSTED (2010a) as well as in Wolpert et al.’s (2011) national evaluation of the Targeted Mental Health in Schools (TaMHS) programme. Interventions from CAMHS are sought and welcomed by many teachers but can only be of a limited nature, assisting particularly troubled individuals or offering schools expert consultancy and training. Such CAMHS help can rarely reach into the regular daily life in schools of many children at risk of exclusion. Saying this is not to undervalue the need for multi-agency collaboration and working: teachers can learn much from CAMHS and the research of clinicians reported for example, in NICE (2013) and Fonagy et al. (2014) is clearly of importance to educationalists. However, the major onus, in relation to the emotional health and well-being of children at risk of exclusion, will continue to rest on educational services.

5.1.2 Following DCSF/DoH (2008) or the three wave model of SEAL (DCSF, 2007a - see Figure 2 below), three levels of school-based approaches are considered:

- universal (i.e. whole school/whole class attitudes and practice);
- targeted (i.e. small class/group interventions, designed for vulnerable children);
- specialist (i.e. individual interventions to assist the child who is close to being excluded or has experienced school exclusion).

Research in this area indicates that what is best for a whole-school community also benefits groups of children and individuals at risk of exclusion (DCSF, 2007) but that second (targeted) and third wave (specialist) interventions are necessary and can have significant impact.

5.1.3 The effectiveness of the response to pupil well-being, links in large measure to school staff's and educational support services’ values, understanding, motivation as well their capabilities. Hence initial training, continuing professional development and support for staff are key issues discussed in a separate section.

5.1.4 Recognising the ecosystemic nature of mental health, proven approaches to improving parenting skills are also examined. These overlap with a school's work and take place on school sites (e.g. the ‘Incredible Years’ [IY] approach - see for example, Webster-Stratton, Reid and Stoolmiller, 2008). This is clearly a key early intervention strategy which can help children’s well-being and lessen difficulties that typically lead to school exclusion.
5.1.5 Finally, further consideration is given to the role of CAMHS. Their contribution to direct work with children on school premises is sought and appreciated (DCSF/ DoH, 2008; Wolpert et al., 2011) but it seems their major responsibility will remain the provision of specialist interventions for the children with the severest difficulties (particularly at Tiers 3 and 4 of the HAS, 1995, model). Contrary to the possible expectations of some teachers and politicians, CAMHS cannot wave a magic wand to solve the challenges presented by the mental health of children at risk of exclusion.

Figure 2: Three waves of mental health and emotional well-being support (taken from DCSF, 2008b).

5.2. Whole-school ethos, values and attitudes

5.2.1 When the CLD Coalition came to power in 2010, the ‘Every Child Matters’ strategy, with its stress on holistic, multi-agency approaches, was relegated to the National Archive. Soon after, stark guidance on school discipline (DfE, 2011b) and exclusions (DFE, 2012) was issued. At that time - and continuing through to 2015 - the Scottish Government was pursuing an approach similar to the ECM strategy, directly linking this to how schools should minimise exclusions. The Scottish Government (2011) offered a detailed document with the meaningful title ‘Included, Engaged and Involved... a positive approach to managing school exclusions.’ The ministerial foreword made reference to ‘SHANARRI™’, the acronym associated with the key components of health and well-being and linked to the promotion of resilience: ‘safe, healthy, achieving, nurtured, active, respected, responsible, included’ (Scottish Government, 2012). The guidance recognised that where schools espoused the values underpinning these eight words, then greater inclusion for all pupils was likely to occur.

5.2.2 These values have been similarly identified in literature in England from this period on good practice in relation to children with behaviour difficulties. These values should permeate policy and practice at the whole-school level, thereby shaping ethos, then filter down to practice in the classroom and to relationships between staff and individual children, also to between pupil and pupil. The values make for an understanding and inclusive ethos where indeed ‘every child matters’ (Daniels et al. 1999; OFSTED 2003; 2008b, 2009; Tew and Park, 2013). After extensive research, OFSTED (2005) referred to this ethos:
A school’s ethos provides the context within which children feel secure, know they are valued as individuals, are safe from emotional and physical harm and are able to discuss their interests and voice their fears in a supportive atmosphere. The development of a school’s ethos falls to the senior management team but its growth and maintenance depend on the involvement and co-operation of the whole staff. Inspection and research continually reaffirm the importance of consistency in the way staff themselves behave and act in and around the school. This particularly helps boys to behave better and achieve more. (OFSTED, 2005, p.10)

As Daniels et al. (1999) and Daniels et al. (2003) found, this ‘ethos’ requires a ‘critical mass’ of staff committed to inclusive values, who seek to avoid the exclusion of children, seeing this as failure on the part of their school. Their beliefs and practice influence colleagues around them. Many influential teachers in the staffroom clearly demonstrate caring attitudes, share ideas and are willing to learn from colleagues. Teamwork is the norm and a collegiate approach, frequently talking to and listening to each other - as well as hearing the voice of the young people - are demonstrated on a regular basis (see also Munn, Lloyd and Cullen, 2000; Hatton, 2013). In such schools (see Daniels et al, 1999), as in the many successful PRUs identified for example in DCSF (2008c), there is clearly ‘shared purpose and direction’ (OFSTED, 2007, p.4).

5.2.3 Inclusive attitudes and values-driven practice are not sufficient of themselves. They need to be demonstrated within well-ordered, efficient communities. There must be well-thought out whole-school behaviour policies, covering all aspects of school life including as the Steer Reports (DFES, 2005, 2006) and OFSTED (2009) note, breaks and lunchtimes, when senior leaders should be visible, acting in support of well-trained supervisors. Schools should conduct regular audits of behaviour as recommended in Daniels and Williams (2000) and DFES (2007a) to identify strengths and weaknesses in relation to procedures at whole-school or class and individual pupil levels, possibly using tools provided by the National Strategies for this purpose. Many documents (e.g. DCSF, 2009c) also make the link between good and outstanding behaviour in the ‘vast majority’ of schools and their active promotion of social, emotional and behavioural skills (see below).

5.2.4 In such schools particular attention will be paid to keeping bullying to a minimum, following the guidance given in for example, Cowie and Jennifer (2008), Cowie et al. (2008) or Porter (2014). The modern and extensive challenges presented by cyber-bullying and appropriate responses to this are examined in Smith (2012).

5.2.5 Schools operating according to the values and practice outlined above should meet the Healthy Schools’ standards, linked in DFES/DoH (2004) to Maslow’s (1943) ‘Theory of Motivation’ (see the summary in Table 4 below). Solomon and Thomas (2013) see Maslow’s theory as having particular relevance to pupils in PRUs.

<table>
<thead>
<tr>
<th>RANGE OF NEEDS</th>
<th>DESIRABLE EXPERIENCES</th>
<th>IN SCHOOL THIS MIGHT LOOK LIKE</th>
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| Physiological or survival needs | • Warmth  
• Food  
• Shelter  
• Seeing, hearing and taking part in what’s going on  
• Safe physical exploration  
• Getting to know your own body and its strengths and limits | • Comfortable classroom with well-positioned equipment  
• Healthy meals and snacks; access to drinking water when needed  
• Breakfast club  
• Indoor and outdoor play areas  
• Sensory trails  
• Sport and challenge activities  
• Ponds and natural or wild areas |
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<th>RANGE OF NEEDS</th>
<th>DESIRABLE EXPERIENCES</th>
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| Safety needs   | • Having boundaries  
• Having basic needs met  
• Knowing you are in safe hands                                                                                                                                                                                                                                                        | • Secure, risk-assessed sites  
• Consistent, caring supervision  
• Simple, clearly explained rules  
• Clear policies and procedures for tackling and minimising bullying                                                                                                                                                                                                                   |
| Love, affection and belonging | • Feeling cared for  
• Having others look out for you when you can’t do it for yourself  
• Having responsibilities and opportunities to effect change  
• Recognising feeling states in yourself and others  
• Talking, listening, exploring and reflecting on experiences                                                                                                                                                                                                                   | Positive relationships and interactions with staff and peers  
• Diversity and difference is valued and celebrated  
• Pupil involvement in setting rules and expectations  
• Work displayed on the wall  
• Coat pegs with individual names on  
• Opportunities for group work  
• Peer support programmes                                                                                                                                                                                                                                                                   |
| Self-esteem    | • Being valued, accepted and celebrated  
• Being noticed and listened to  
• Influencing outcomes  
• Being supported to take responsibility for outcomes with increasing independence                                                                                                                                                                                                                                      | • ‘Star of the day’: events to be the focus of positive attention  
• Use of praise  
• Use of appropriate language to correct behaviour  
• Rewards and recognition systems  
• Opportunities to have special responsibilities                                                                                                                                                                                                                                               |
| Self-actualisation | • Exploring ideas and learning new things  
• Being creative  
• Developing talents and stretching yourself  
• Having an internal structure of values and principles  
• Recognising and using signs, symbols, image and metaphor  
• Being reflective  
• Developing shared meanings and a shared narrative (ways of talking about what happens)                                                                                                                                                                                                                       | • Lessons which provide stimulation, challenge and opportunities to use diverse talents  
• Values and rights education  
• Taught courses of SEBS, including thinking and problem-solving skills  
• Time for reflection  
• Use of storytelling, language, literature and metaphor in the curriculum  
• Drama, art, music and movement that communicates feelings, meanings, experiences  
• Positive modelling by all school staff                                                                                                                                                                                                                                                   |

5.2.6 Where ‘Healthy schools’ principles are embedded into an establishment’s daily life, such schools mirror the best institutions examined in Cole et al. (2001), OFSTED (2003, 2007, 2008b) and Daniels et al. (2003). In these settings the child with BESD at risk of exclusion was still seen as a wanted member of the community and, significantly, staff members were reluctant to attach any label to the pupil, referring and thinking of an individual with strengths and ‘needs’. The child’s misbehaviour was confronted but it was the ‘act’ which was condemned rather than the ‘actor’. Crucially staff maintained a capacity to forgive (Daniels et al. 1999; Daniels et al. 2003). Where a child had been excluded and admitted to a PRU or new school, as was often the case in Cole et al. (1998), Daniels et al. (2003) or in later OFSTED investigations, ‘staff conveyed to pupils that they were offering a ‘second chance’ or a fresh start’ (OFSTED, 2007, p.4). The titles of two of the Children’s commissioner’s exclusions reports ‘They never give up on you’ (OCC, 2012) and ‘They go the extra mile’ (OCC, 2013a) were also consistent with the findings of Daniels et al. (1999, 2003) and Parsons (2009). Pirrie et al (2011), having followed the careers of pupils excluded from PRUs were impressed (as Daniels et al., 2003, had been) that parents
and children often reported much improved social interactions, even friendship, between young person and their parents and the staff in a child’s new placement compared to the excluding school:

‘what made the difference was not whether or not a subsequent placement had been secured within six days, but the quality of personal relationships. It was the person who ‘held the story’, and for whom the young person was visible in their full humanity, that ultimately made the difference. The corollary of this is that it is simply not possible to legislate human kindness into existence.’ (Pirrie et al., p.536)

5.3. Class-wide approaches

5.3.1 It has long been recognised that classrooms in BESD schools containing groups of pupils who have been highly disruptive in and excluded from mainstream settings can be quiet, purposeful environments (Laslett 1977; Cole et al. 1998). Similarly, in mainstream settings, some children with BESD behave well for some teachers but are severely disruptive for others (Daniels et al., 1999; OFSTED, 2003, 2005). Disruptive behaviour is often ‘situation-specific’, relating in part to how practitioners in school settings operate and whether the way in which they interact with pupils is ‘deviance-provocative’ or ‘deviance-insulative’ (Jordan, 1974, cited in Smith and Laslett, 1993). This is often related to the micro-skills of teaching, such as educators’ communication skills, in particular how they speak to and make requests of pupils (Rogers, 2013). The paragraphs below identify classrooms where teachers show expertise which helps them manage disruptive behaviour while also promoting pupil well-being.

5.3.2 Cole et al.’s (1998) national study of schools for pupils with EBD found that teachers who work well with children with the most difficult behaviours do not need to be masters of psychoanalysis (though knowledge of child development helps) rather they should be well-organised, consistent, humorous, calm, enthusiastic, skilful in delivering their specialist subjects, set clear boundaries, flexible, understand ‘behaviour’ causation and empathetic. In special and mainstream schools, successful teachers can come to be seen as respected helpers by children with BESD particularly where form tutors embrace rather than resist their pastoral role as mentors and supporters of pupils at risk (Munn, Lloyd and Cullen, 2000). Daniels et al.(1999, 2003) and OFSTED (2005) found staff with a range of effective styles and classroom management techniques, reaching out successfully and engaging with some very challenging young people. Taylor (2012, p.4) in relation to PRUs noted that what their troubled clientele needed was ‘time, effort, commitment and expertise of dedicated professionals working in well-organised, well-resourced and responsive systems’.

5.3.3 OFSTED (2005) gave a succinct overview of classrooms in which the challenging behaviour of some pupils is well managed as well as social and emotional needs addressed:

- There is a positive classroom ethos with good relationships and strong teamwork between adults encourages good behaviour. Late starts to lessons, disorganised classrooms, low expectations and unsuitable tasks allow inappropriate behaviour to flourish.
- Learning is best when staff know pupils well and plan lessons which take account of the different abilities, interests and learning styles.
- Staff respect and have an interest in pupils showing challenging behaviour.

OFSTED (2005), repeating earlier studies (see Kounin, 1977; Cole et al., 1998), claimed that the ingredients of effective teaching for learners with the most difficult behaviour is similar in most respects to that which is most successful for all groups of learners. This stress on ‘getting the basics right’ agrees in many respects with the Behaviour Checklist and guidance on successful practice in alternative provision given by the CLD Coalition’s advisor, Charles Taylor (Taylor, 2011, 2012).

5.3.4 The components of effective teaching were also identified and listed in detail in the National Strategies’ ‘Quality First Teaching’ (QFT), ‘Wave 1’ (universal) class teaching (DCSF, 2007b). One aspect was the need to build on pupils’ prior learning. This is crucial for pupils
with mental health needs and at risk of exclusion. If there is a significant gap between their knowledge and skills and what the teacher thinks they can do, with inappropriate lesson planning resulting, then disruptive behaviour is likely to ensue and ‘within child’ anxieties increased. Attention has to be paid to the common lack of reading, writing, communication and maths skills in children with BESD (OFSTED, 1999, 2003, 2005 and 2007).

5.3.5 The National Strategies also stressed the need for:

- ‘Assessment for Learning’ ['AFL']: regular, accurate assessments of where these children are at, which approaches work best for them, what targets are realistic and how progress towards them should be monitored (DCSF, 2008d).
- Pupil participation - All pupils, but particularly those presenting difficult behaviour should be active participants in AFL. Beyond AFL there should be regular pupil involvement and engagement with their learning; high levels of interaction for all pupils; expecting pupils to accept responsibility for their own learning and to work independently - but providing sufficient support to children with BESD in pursuit of these aims. This advice mirrors the collaborative approach advocated by Cooper, Smith and Upton’s (1994) and Cole et al. (1998).
- Personalised learning approaches/ differentiation - QFT requires focused lesson design with sharp objectives. Yet flexibility must be built in to enable the teacher to try different routes to the desired end, finding the approach that best engages the individual child with BESD. Where the curriculum allows, a personalised approach, matching teaching to the pupil with BESD’s interests, preferred learning style, building on his or her strengths, will also help. Differentiating topics by task or expectation and accepting different levels of success is appropriate for teachers to use with pupils with BESD, particularly where they have learning difficulties other than ‘behaviour’ - but differentiation should not be an excuse for low expectations.
- regular and appropriate use of encouragement and praise to engage and motivate pupils (although ensuring that the praise reflects genuine child effort - see Dweck, 2006, 2009 on over-use of unearned praise).

5.3.6 The Labour government’s guidance on BESD reiterates key messages from the above. DCSF (2008a) recommended lesson content should be ‘balanced and broadly based’ but use the National Curriculum flexibly (particularly for secondary aged pupils). Curriculum:

- should be carefully sequenced to build on previous learning/experience.
- does not have to be taught in individual subjects (a themes and topic approach may be more appropriate way to deliver the national curriculum).

Teachers should:

- use highly interactive lessons.
- use groupwork to promote speaking and listening.
- use work-focused learning for 14-16 yr olds (see also OFSTED, 2007, on making learning seem relevant to pupils in KS4 PRUs).
- give opportunities to students to show responsibility/leadership.
- find time to work at conflict resolution/ building/keeping friendships.
- emphasise personal life skills and essential life skills.

5.3.7 Turning to approaches to avoid, OFSTED (2005), noted

- teachers can give too many instructions with the result that pupils become confused and respond with disruptive behaviour;
- unhelpful assessment of pupil work giving limited or unhelpful oral and written comments;
- staff (a small proportion) showing a lack of respect by shouting at pupils, making fun of them, making personal remarks or using sarcasm.

5.3.8 The many and various systems of peer review, peer mentoring and peer support are beginning to impact on school practice (e.g. Cowie et al., 2008) and Sellman (2009) probably to the benefit of pupils with challenging behaviour.
5.3.9 Classroom, corridor and playground routines can counter-balance the often chaotic home life associated by Taylor (2012) with children in PRUs. Children at risk of exclusion often respond with improved behaviour and learning when they know where they are, the staff they are with and what is going to happen next. Structure and routine provide emotional support (Cole et al. 1998; DCSF, 2010) fostering a sense of belonging and security. The organisation of the day around school and in the classroom should reflect this. In this respect the work of the Birmingham Framework for Intervention [FFI] team and its checklists for teachers to review and adjust the ‘behaviour environment’ (Williams and Daniels, 2000; Cole, Visser, Daniels, 2000a) is of relevance. This work was extended in Scottish ‘Staged Intervention’ materials (see also Scottish Government, 2012, and the relevance of FFI to preventing exclusions) and National Strategies behaviour audit materials. Each subject/class teacher should have a re-assuring routine for meeting and greeting children before they enter the classroom. There should be clear routines for basic procedures such as getting to seats; getting out materials; accessing equipment; getting work marked; asking questions; taking turns; leaving the room to go to the next lesson; going out into the playground or lunch areas; catching buses or going home on foot at the end of the school day. OFSTED (2005) similarly advises that seating plans, especially in secondary and special schools, help pupils with the most challenging behaviour to settle quickly at the start of lessons.

5.4. Promoting the social and emotional aspects of learning [SEAL]

5.4.1 The SEAL programme was launched in 2004 as part of the National Strategies (DCSF 2007a). In part, this was to meet a duty placed on schools to promote the general well-being of pupils under the terms of the Education and Inspections Act of 2006. The programme was influenced by evidence suggesting that the school environment was the largest determinant of the level of emotional and social competence and wellbeing in pupils and teachers (Weare and Gray, 2003; Wells, Barlow and Stewart-Brown, 2003; Cowie et al., 2004).

5.4.2 SEAL worked on the principle that to reach the most vulnerable groups in the least stigmatising way a backdrop of universal provision was ‘the best platform from which to provide more intensive help’ (DCSF, 2007a). DCSF (2009a) re-affirmed the rationale: social, emotional and behavioural skills [SEBS] underlie almost every aspect of school, home and community life, including effective learning and getting on with other people, therefore working at developing SEBS is:

‘fundamental to school improvement ... Where children have good skills in these areas, and are educated within an environment supportive to emotional health and well-being, they will be motivated and equipped to: be effective and successful learners; make and sustain friendships; deal with and resolve conflict effectively and fairly; solve problems with others or by themselves; manage strong feelings such as frustration, anger and anxiety; be able to promote calm and optimistic states that further the achievement of goals; recover from setbacks and persist in the face of difficulties; work and play cooperatively; compete fairly and win and lose with dignity and respect for competitors; recognise and stand up for their rights and the rights of others; understand and value the differences and commonalities between people, respecting the right of others to have beliefs and values different from their own.’ (DCSF, 2009a, p.2)

SEAL should sit alongside anti-bullying policies, promoting physical health and many other topics that tie in to the five outcomes and twenty five aims of the ‘Every Child Matters’ framework (DFES, 2003a).

5.4.3 The SEAL programme resources facilitate the pursuit of the above objectives. They provide ways through which teachers can help children:

- develop a vocabulary of feelings;
- use calming-down strategies;
- link thinking and feeling;
- counteract ‘emotional hijack’;
- understand ‘threat’, ‘fight’ and ‘flight’;


• manage anxiety, anger and fear;
• respond to loss and changed life circumstances.

In relation to conflict resolution SEAL resources draw on solution-focused thinking encouraging children to look at times when they have been successful; identify goals, ‘miracles’, dreams or preferred futures; set targets to help them to reach their goals or preferred future; use scaling to identify and support the process. Lendrum et al., (2009) make recommendations for the implementation of small group SEAL in primary schools, suggesting the method must be given sufficient time and space, integrated into intervention elsewhere in the school setting and should link to work with parents. Realistically the SEAL guidance recognises that some pupils with BESD may find it hard to acquire social and emotional skills within a group context and will require Wave 3 individual work (DCSF, 2007b).

5.4.4 After the launch of SEAL further research from America underlined the potential value of structured programmes for the teaching of SEBs. Durlak et al. ’s (2011) meta-analysis of 213 school-based universal programmes indicate that the teaching and promotion of social and emotional learning can produce measurable improvements in well-being in mainstream schools. Jones, Brown and Aber (2011) went a stage further, with their New York study indicating that it is possible to integrate the teaching of SEBS into general literacy lessons. Therefore the high hopes of the Labour government in championing the SEAL approach would not seem ill-founded. In England, Hallam (2009) reported a perceived positive impact, though causal connections could not be made. Humphrey et al.’s (2010) study of a sample of schools found that SEAL fell short of the ambitions set for it, noting the limited impact on children as measured by the SDQ (Goodman, 1997). These researchers attributed this to the construction of the varied adopted approaches, the vigour with which schools wanted to embrace SEAL and imperfect delivery because of stretched resources. The authors stress in their conclusion that their limited study does not undermine the concept of seeking to embed SEBS development into the fabric of school life and classroom experience but fidelity to pre-validated programmes was likely to be a better approach. Their findings are further discussed in Tew and Park (2013), who also draw attention to the positive findings of Bannerjee (2010) that SEAL does improve school ethos. Beecham et al. (2011) wanted more evidence but calculated that there would be ‘cumulative pay-offs per child’ resulting from programmes such as SEAL, which could save the public-sector long-term crime and NHS costs. Such research also received indirect endorsement in NICE (2008, 2009) who noted studies indicating the effectiveness of programmes promoting (in their term) ‘social and emotional well-being’ that were integrated into the regular curriculum and boosted through extra curricula activities.

5.4.5 Other approaches to promoting SEBS through structured programmes, were used in English schools before and after the advent of SEAL (e.g. Cole, Visser and Daniels, 2000b). One example was the ‘Promoting Alternative Thinking Skills’ reported in Honess and Hunter (2014). In Scotland the Australian ‘Bounce Back’ resilience building programme (McGrath and Noble 2010) is meeting with a positive response. Also to be noted is the importance that the Scottish Government attaches to such approaches as a means of lessening school exclusions. Scottish Government (2012) has an annex titled ‘Approaches to improving relationships and promoting positive behaviour’ which outlines a range of programmes adopted in Scotland.

5.5. Curriculum that engages children at risk of exclusion

5.5.1. Mention of other key content of curriculum is warranted here. It has been recognised for many decades that failure in basic skills can have a severe impact on a child’s mental health, with learning difficulties linking to rebellion in class (see the detailed national survey in the 1970s into ‘disturbed pupils’ by the Schools Council - Wilson and Evans, 1980). Twenty years later, OFSTED (1999) noted that in relation to pupils with BESD in special schools, their ‘prior learning in literacy and numeracy was often a history of repeated failure and a constant source of frustration’ (para.42, p.12). This report, after a long detailed investigation, went on:

‘Successful learning in these essential skills was often reflected in improved behaviour indicating how damaging to pupils’ self-esteem their lack of progress in learning to read and
Research in mainstream schools indicated the same phenomenon (e.g. Daniels et al. 1999; OFSTED 2003 and 2005) while OFSTED (2007) noted the learning difficulties of pupils in PRUs. The links between well-being, behaviour and speech, language and communication difficulties (SLCN) has started to be explored (Cross, 2004; Tommerdahl, 2009, 2013; Lindsay and Dockrell, 2011; Law and Stringer, 2014). As noted earlier, behaviour difficulties also co-exist with attentional/hyperkinetic difficulties (Green et al., 2005a) and sometimes unrecognised hearing or visual problems.

5.5.2 This is relevant to the debate in the 1990s (Cole et al., 1998; OFSTED, 1999) still ongoing in 2015, over how to improve school standards, as measured by access to a broad curriculum and success at GCSE, while keeping a large minority of pupils who find learning difficult, engaged, motivated and not disrupting the education of others. Expecting such children to follow a standard ‘academic’ path can emphasise their feelings of failure on a daily basis. DCSF (2008a) noted:

‘The National Curriculum may not be the most appropriate route to maximise some pupils’ learning and achievement, particularly those who have been disengaged by their experience of the NC at school and/or have specific learning or behavioural issues which need to be addressed before they can access a wider curriculum.’ (p.25)

To address the needs of such young people, flexibility in the curriculum is required, which plays more to these children’s potential strengths and help to build their self-confidence. This curriculum should seek to improve their basic skills, as OFSTED (2007) and DCSF (2008a) stressed but OFSTED (2008b, p.5), in its study of disaffected pupils, advised:

‘At Key Stage 4, a high-quality, flexible curriculum, involving a range of accredited training providers outside the school, was effective in engaging students more in their learning.’

This was also found by Daniels et al. (2003), OFSTED (2011b) and Hallam, Rogers and Rhamie (2010). Typically such curriculum should be practical and experiential, where staff (not necessarily qualified teachers) have time to talk informally and to listen to the young people involved. This element of personal adult-child interaction was key, and seen as being in contrast to the adolescent’s experience in their school setting.

5.6. Targeted approaches - Teaching Social Emotional and Behavioural Skills to Vulnerable Groups

5.6.1 As seen above, members of school staff regularly target the literacy, numeracy and IT abilities of vulnerable groups, thereby counteracting children’s feelings of inadequacy in relation to their peers. They also run or play a major part in the specific approaches to promoting SEBS outlined below.

5.6.2 ‘The Incredible Years: Dinosaur School’. A range of American and British research literature (see for example, NICE, 2013; NREPP, 2012) endorses the potential of ‘The Incredible Years’ programmes for parents, school staff and primary school children. ‘Dinosaur School’ (DS), a key part of this, is a classroom-based programme designed to promote emotional self-regulation and social competence in children who have been exposed to multiple, poverty-related risks (Webster-Stratton, Reid and Stoolmiller, 2008). DS consists of 18 weekly, two-hour sessions for groups of about six young primary school children featuring puppet characters including ‘Dina Dinosaur’. DS teaches social and problem solving skills, anger management, friendship and academic skills such as concentrating and checking. For homework, children talk to their parents about their progress. The delivery of such programmes can be shared between specially trained teachers and teaching assistants (Edgar, Molloy and Ducloz, 2012).

5.6.2 Circle time/Circle of Friends. Some government guidance (e.g. DFES/DoH, 2004) and inspectors’ studies (e.g. OFSTED, 2008, 2009) endorse ‘circle time’, including the model
developed by Mosley (1993). This is commonly used to promote social and emotional skills in children. A variant, although perhaps of more use to withdrawn, isolated or bullied children with BESD is 'Circle of Friends' (Farrell, 2006). The facilitator (usually a teacher) holds a preliminary discussion with a larger group of the peers of the ‘victim’ - the ‘focus child’. The focus child will usually not be present at this discussion but will have been approached before this happens. The facilitator finds out from the peer group the situations involving the focus child in which things go well and situations where they go badly. The peer group then consider their feelings when they have felt left out, teased or lacked friends. The facilitator asks for ideas to improve the situation, these might be suggestions such as sitting next to the focus child in a lesson or talking to him or her in the playground. Progress is reviewed at weekly meetings of the Circle. This kind of support can last for a term or sometimes longer (Farrell, 2006). A variety of this approach is the ‘Circle of Support’ described by Mosley and Niwano (2013).

5.6.3 Nurture Groups. Nurture groups, (recommended in DFES/DoH 2004, Hallam, Rogers and Castle, 2005b; DFES, 2005a; DCSF, 2008b and DFE,2014a) provide an extended and compensatory nurturing experience in schools to children, who usually have BESD and will often be at risk of exclusion. They are children with insecure and damaged attachments who have been subject to various risk factors (Bennathan and Boxall, 2000). Nurture groups should take the form of a small supportive class of up to 12 children, usually in a carefully planned nurture room in a mainstream primary school for a time-limited period, prior to the full re-inclusion of the child back into their mainstream class. Work supporting parents should accompany this school-based activity. Placement in the group should be determined on the basis of systematic assessment with the Boxall Profile (Boxall and Bennathan, 1998) recommended. Nurture groups seek to promote good mental health by

- helping these children to feel valued;
- building confidence and self-esteem;
- teaching children how to make good relationships with adults and with each other;
- developing communication skills;
- providing opportunities for social learning;
- facilitating learning through quality play experiences;
- improving school attendance and attainment.

5.6.5 Favourable accounts of the nurture group approach in Britain are given in Cooper and Tiknaz (2007), Reynolds, McKay and Kearney (2009), HMIE (2009), Seth-Smith et al., (2010); OFSTED (2011), Hughes and Schlosser (2014) and Cheney et al. (2014); and in other countries in Cefai (2008) and Couture (2013). Taylor and Gulliford (2011) see the need for a holistic approach, linking nurture group work in schools to interventions with parents. Nurture groups are also recommended as a means of:

- preventing exclusions (OFSTED, 2009a; Scottish Government, 2011);
- addressing the needs of children with BESD (DCSF, 2009);
- promoting TaMHS (DCSF 2008b and Wolpert et al.,2011).

This approach falls short of its potential when schools do not fully follow the precepts laid down for a ‘classic nurture group’ (Bennathan and Boxall, 2000; Cooper and Tiknaz, 2007).

5.6.6 There has also been experimentation with the nurture group approach in secondary schools. Hughes and Schlosser (2014) note the lack of research into these but encouraging initial findings appear in some small scale studies (Cooke, Yeomans and Park, 2008; Colley, 2009; Garner and Thomas, 2011; Kourmoulaki, 2013). On the other hand, Couture (2013) is concerned that it is not possible to adhere to the necessary core principles as laid out by Bennathan and Boxall (2000) in the large secondary school context.

5.7. Support from educational and other school-based support staff to individual pupils

5.7.1 The quality and regularity of helpful one-to-one relationships between staff members and child is clearly crucial to the mental health needs of those at risk of exclusion, as Daniels et al (1999, 2003) and Pirrie et al (2011) as well as various OFSTED investigations have noted. Such
relationships can develop and be re-inforced as part of the daily routine over a period of years between the ‘at risk’ child and classteacher, form tutor, head of year, SENCo, or with a caring and skilled teaching assistant specially assigned to support the child. In low excluding schools, the quality of these frequent social interactions reflects the values discussed earlier. The strength of the relationship, built on a history of gradually developing trust, will allow awkward issues such as bullying by the child and sensitive family issues to be addressed. There are suggestions that such relationships might be easier to develop in the less formalised settings of PRUs (Daniels et al., 2003; Hart, 2013; Michael and Frederickson, 2013).

5.7.2 When working one-to-one, school staff can draw on a range of evidence-based methods outlined in guides for practitioners such as Cowie et al.(2004), Cole and Knowles (2011) or Porter (2014). These include solution-focused brief therapy [SFBT] or other approaches based on cognitive behaviour therapy. Woods et al. (2011) note the enthusiastic application of SFBT across various settings, including schools. A limited range of studies point to its effectiveness in helping to reduce ‘externalising’ and ‘internalising’ behaviour difficulties, but more research is needed. Staff might also help children with anger management techniques, guided by CBT research, described in Faupel, Herrick and Sharp (2011) and recommended in OFSTED (2008b). The potential usefulness of CBT is recognised in NICE (2013) and Stallard (2013) sees its appropriateness where depression and anxiety co-exist with conduct disorders (although its value and cost effectiveness in relation to group work in schools has not been supported in a recent study by Anderson et al., 2014).

5.7.3 Mindfulness. Trained staff could try ‘mindfulness’, advocated by Mark Williams, until recently a professor at Oxford University (Williams et al., 2007; Crane, 2009), a technique tracing its origins to Eastern meditation and yoga but melding ancient knowledge with modern psychology and neuroscience. Children are encouraged to be ‘mindful’ of the present moment through focusing on their breathing and physical feelings in their body, thereby relaxing and harnessing the body’s natural defence systems against feelings of stress, anger and other negative emotions. Research into ‘mindfulness’ in school settings is in its infancy but it could be a promising intervention. Using these approaches in schools will involve much ‘talking and listening’ and shared experiences, the bed-rock of relationship building and informal counselling.

5.7.4 It is clear that the application of approaches mentioned in the paragraphs above cannot - and should not be - the exclusive reserve of CAMHS personnel. However, as Wood et al. (2011) warn in relation to SFBT, staff should be appropriately trained in and adhere faithfully to the prescribed programmes they use.

5.7.5 School-based counselling. Similarly CAMHS does not provide much of the extensive, easily-accessed and apparently effective counselling now provided in schools. DFE (2014a) recommends ‘school-based humanistic counselling’ seeing this as ‘effective in reducing psychological stress’ (p.21). This guidance refers to:

> ‘a family of psychological therapies that place particular emphasis on establishing a warm, understanding relationship with clients such that clients can come to uncover, and express, their true thoughts and feelings’ (p.21).

Cooper (2013), in an extensive survey funded by the Department of Health, found a resurgence in the use of school-based counselling (SBC), by trained counsellors often employed directly by educational establishments. In the early 1990s such practice was nearly extinct but Cooper reports a survey suggesting between 61 and 85% of secondary schools in England provide young people with access to counselling. This SBC is defined by the British Association for Counselling and Psychotherapy as ‘a professional activity delivered by qualified practitioners in schools. Counsellors offer troubled and/or distressed children and young people an opportunity to talk about their difficulties within a relationship of agreed confidentiality’ (Cooper, 2013, p.3).

5.7.6 The following key features are noted (although Cooper warns that figures should be viewed as indicative only):
72% of SBC is funded through schools’ own budgets;  
52% of referrals have a waiting time of one week; and 25% one month;  
The numbers attending SBC ‘may be approaching the number attending specialist CAMHS’;  
About 3% of those attending SBC are referred on to CAMHS;  
The SDQ (Goodman, 1997) is used as the usual assessment and monitoring tool;  
Most common problems discussed are family issues, followed by anger and behaviour in school;  
Young people receive on average, 3-6 sessions, with only a small minority receiving ten or more sessions;  
60% are girls and 40% boys;  
Young people see ‘counselling’ as less stigmatising than interventions prefixed by ‘psycho’ (p.11);  
Over two thirds of young people would rather receive counselling at school than at a location outside school;  
80% like one-to-one rather than group sessions;  
For maximum effect, SBC should be firmly embedded into a school’s normal operations.

School staff are strongly supportive of SBC, appreciating the speedy accessibility of trained professionals, with the time to give one-to-one sessions to children with a range of problems. Teachers appreciate that the counsellors are able to focus on wider mental health issues surrounding a child’s behavioural difficulties. School-based counsellors sometimes have good links to and work well with CAMHS but:

‘this is not always the case; and there is limited evidence of local protocols for ensuring integrated, seamless, and appropriately stepped pathways of care between school based counselling and other CAMHS’ (Cooper, 2013, p.16)

Cooper’s (2013) study offers persuasive support for SBC but he acknowledges the need for fuller assessment using RCTs.

5.7.5 The long-established charity Place2Be (2014) gives further evidence on the apparent value of one-to-one counselling (as well as small group approaches – see Lee, Tiley and White, 2009), which are said to assist in the promotion of good mental health in children ‘at risk’. Using the SDQ and the Clinical Outcomes in Routine Evaluation Outcome Measure, it conducts an annual assessment of its own work, which in 2014, took place in over 200 schools in disadvantaged areas. Over the last five years, they claim that teacher, parent and child ratings indicate the effectiveness of their counselling work helping children to ‘clinical recovery’. This work by a voluntary body, bought in by schools out of their own budgets, seems the type of enterprise encouraged by the CLD Coalition government, and which could be displacing services previously offered by local authorities (Rees and Anderson, 2012).

5.8. The ‘Targeted Mental Health in Schools’ Programme, 2008 - 2011

5.8.1 The ‘Targeted Mental Health in Schools’ Programme enabled a range of group and individual programmes in schools in many disadvantaged areas of the country. TaMHS was to complement and nest within SEAL. It aimed to help schools deliver timely interventions and approaches in response to local need to children with problems and others at risk of developing them.

5.8.2 Government guidance (DCSF, 2008b) to schools explained that despite talking of ‘emotional health and wellbeing’, already familiar to teachers under the Healthy Schools programme:

‘We felt it was important to use the term ‘mental health’ in this project, since a key aspect is to bring the expertise of mental health professionals into schools, so that schools are viewed as an access point for mental health services. However, we recognise that some practitioners from education and social care backgrounds can feel uncomfortable using what they see as ‘medicalised’ language.’ (p.8)
The aim is clear but did TaMHS bring ‘expertise into schools’ from mental health professionals that went beyond what educational practitioners already possessed or had access to in their local behaviour support and educational psychology services?

5.8.3 The national evaluation of TaMHS by Wolpert et al. (2011) involved a longitudinal sample and randomised control trial. This team of mainly medical researchers identified thirteen categories of mental health work in schools:

- Social and emotional development of pupils;
- Creative and physical activity for pupils;
- Information for pupils;
- Peer support for pupils;
- Behaviour for learning and structural support for pupils;
- Individual therapy for pupils;
- Group therapy for pupils;
- Information for parents;
- Training for parents;
- Counselling for parents;
- Consultation for staff;
- Counselling for staff;
- Training for staff.

This range would seem to cover the standard spectrum of approaches offered over many decades by behaviour support, educational psychology and counselling services, but these approaches were now given a mental health moniker. All schools qualifying for the scheme had to be promoting social and emotional development i.e. following the Healthy Schools/SEAL agenda already. More TaMHS interventions came under the ‘behaviour for learning’ category than under any other single category.

5.8.4 In terms of results Wolpert et al. (2011) found:

- some progress in the ‘relatively poor and limited’ (p.97) relations between schools and CAMHS (see similar finding in DCSF/DoH, 2008);
- ‘over time schools reported increasing amounts of specialist mental health input’ (p.10);
- the programme was well-received in schools and by TaMHS workers
- a ‘statistically significant decrease in problems’ in primary pupils who had behavioural problems at the outset (p9);
- no significant behavioural gains in secondary schools;
- ‘random allocation of evidence based mental health self-help booklets to pupils’ resulted in a statistically significant additional decline in behaviour problems (p9);
- ‘pupils reported high levels of contact with sources of mental health support in schools and those with the greatest difficulties reported the greatest contact’ (p.12).

In future, to increase effectiveness of interventions, schools should ‘be encouraged to consider using more manualised approaches with a clear evidence base as these have been found in the literature to have the greatest impact’ (Wolpert et al., 2011, p.14). The researchers had found a ‘striking absence of use’ (p.97) of such approaches. They do not discuss the practical challenges that would be faced by schools staff in transporting approaches, validated in clinical trials or different countries, to ‘real life’ situations in English schools.

5.8.5 Wolpert et al (2011) found an association between schools’ reporting of good links with specialist CAMHS and improvement in behavioural difficulties in secondary school pupils. They believed this suggested that:

‘access to specialist help may be particularly important for pupils in secondary school (as opposed to primary school) given the fact their behavioural problems may be more entrenched and may be less susceptible to in-school programmes of work than primary school pupils’ (p.100).
5.8.6 This evaluation hints at continuing obstacles in the way of effective multi-agency working. Wolpert et al. (2011) reported that TaMHS workers ‘highlighted challenges to finding a common language to use between mental health providers [sic] and schools’ (p.12). The wording of this statement could be interpreted as the researchers not recognising school staff as ‘mental health providers’ despite the Healthy Schools programme and SEAL? Also, the circumspection of the following seems strangely reluctant to admit the crucial part played by schools:

‘It may be important [sic] that schools should retain a role in being able to refer their pupils to CAMHS for appropriate help given the fact that parents identify them as the key point of contact and good advice for their concerns about their children’ (p.14).

Further, some schools (witnessed in Daniels et al., 1999 and DCSF/DoH, 2008) might argue that this referral role would be considerably enhanced were their local CAMHS to take such referrals more seriously and were CAMHS able to make a timely and appropriate response as envisaged under NSF Standard 9 (see 4.1.2 above).

5.8.7 Other findings indicate limits to the success of TaMHS, such as fears over whether project work could be sustained due to worries over long-term funding and whether mental health interventions could become embedded as a normal part of school life. A key intention, as noted above, was ‘to bring the expertise of mental health professionals into schools, so that schools are viewed as an access point for mental health services’ (DCSF, 2008b, p.8) Yet Wolpert et al. (2011) found:

• ‘Mental health support was reported to be provided principally by teachers rather than mental health professionals’ (p.9);
• ‘Schools indicated high use of educational psychology and other school-based resources for troubled pupils rather than direct referral to specialist CAMHS’ (p.11).
• Educational psychologists ‘appear to be a key group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS’ (p.14);
• ‘Parents tended to identify schools as the key point of contact for concerns about mental health issues. In particular they identified teachers as the key group they turned to if worried about their child’s mental health. Teachers were also regarded as the ones who provided the most help in these situations in comparison with other groups such as family doctor and family friends’ (p.12);
• ‘Pupils were not asked specifically about the TaMHS project but were generally aware and positive about support available from counsellors and peers mentors and others within the school.’ [such staff were unlikely to be CAMHS staff] (p.12).

5.8.8 The issue of ‘displacement’ and ‘substitution’, noted also by Parsonage, Khan, Saunders (2014) under the guise of ‘free-riding’, is a major concern. Wolpert et al (2011) comments in its conclusions:

‘A particular challenge identified by some TaMHS workers, school staff and parents was the danger of new TaMHS provision substituting rather than supplementing existing provision within schools.’ (p.13)

In relation to the future Wolpert et al. (2011) wondered:

‘When implementing interventions such as this one on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support and to how such support can be sustained, for example by not requiring that provision be “innovative” or “new” and rather allowing areas to draw on existing good practice.’

TaMHS was clearly popular and brought about much valued work, but might interventions made under TaMHS have happened anyway had the same funding been made available to educational professionals? It did at least serve the valuable role, identified in Vostanis et al.(2010), of bringing educationalists and mental health workers together in some joint ventures, thus providing
a vehicle for inter-disciplinary training and at times helping to build trust and understanding between health and education workers.

5.8.9 Finally, Wolpert et al. (2011) find that ‘Pupils with the greatest difficulties tended to rate their experience of support less positively than those with lower level of difficulties ‘(p.13). Did these pupils include many of the children most at risk of exclusion? And how willing and able were local specialist CAMHS to respond to the needs of this group? The call in the national evaluation of child mental health (DCSF/DoH, 2008) for far more attention to be paid by CAMHS to the needs of children with BESD and those in PRUs might suggest a reassuring reply to this second question is unlikely.

5.9. The professional groups providing targeted support
Support from school staff

5.9.1 Teaching Assistants/Learning Support Assistants. Hancock (2013) noted the rapid expansion in the numbers of TAs in this period and the fact that there are likely to be as many TAs as teachers in most educational settings. Their value has been endorsed in various documents associated with the Labour government’s National Strategies Behaviour and Attendance Strand. Some trained as Higher Level TAs or Lead Behaviour Professionals. TAs may not, as Blatchford et al (2009) found, contribute greatly to enhanced academic achievement for children with SENs, but TAs’ contribution to pastoral care is recognised by these authors as well as by Hancock (2013). Hancock (2013), prominent in training TAs over many years, comments:

‘It can be argued that for all children, and especially those experiencing emotional and behaviour difficulties, the personalized involvements that many teaching assistants regularly have with them are very important. Moreover, this provision of pastoral care does much to maintain the inclusion of children who are unhappy in classrooms—children who otherwise might find themselves in altercations with teachers and possibly excluded from schools.’ (p.299)

Effective TAs, Hancock reports:
- recognize very early on that there is a localized classroom problem brewing;
- quietly (because a teacher might still be talking to the class or, at least, talking to some children) move towards children in an unthreatening way;
- quickly read the situation and also the emotions of the children, appeal to their ‘better nature’ and elicit their co-operation;
- use friendliness, informality (and often humour) to help children engage with what they should be doing;
- help children to work productively together and help each other;
- stay with them as necessary to help engagement with the task;
- show respect, consideration and care for the children.

5.9.2 He gives a further instructive example of a teaching assistant, in this instance a volunteer, playing a language-learning board game with two young boys:

‘Whilst overseeing and participating in the game, the volunteer maintains the flow of the activity but is also prepared to have informal exchanges with the children which may or may not be directly related to the game. This social ‘leeway’ serves to help the children feel that they are personally important and this helps to keep them involved. She thus strikes a productive balance between nurture and progressing a planned learning activity, which lies, it could be argued, at the heart of a pedagogical approach that can be supportive of children with emotional and behaviour difficulties.’ (p.301)

Hancock argues that despite a growing research literature ‘there is reason to believe that this pastoral dimension and its impact on inclusion has not been sufficiently acknowledged’ (p.301). It seems reasonable to hypothesise that further research (added to past research indicating the
5.9.3 Many TAs have proved their worth in the classroom supporting children’s social, emotional and behavioural difficulties before moving into positions of greater responsibility, for example becoming Lead Behaviour Professionals (Hallam et al., 2005a and b) or managers of Learning Support Units. These TAs are likely to be working alongside teachers with a pastoral role, including Heads of Year (many of whose supportive work of children at risk of exclusion was observed by Daniels et al., 1999). In recent years, examples can be given of experienced TAs, as part of local authority behaviour support services, or outreach workers from PRUs and BESD schools running targeted group work in mainstream schools (see for example, Edgar, Molloy and Ducloz, 2012).

5.9.4 **Special Educational Needs Co-ordinators.** The role and status of SENCos would seem to vary from school to school. In 2009, it was made mandatory for SENCos to be qualified teachers (DCSF, 2009b), suggesting that the recommendation of DFES (2004a) for SENCos to be part of schools’ senior leadership teams had met with a limited response. Mackenzie (2007) and Rosen-Webb (2011) found a lack of consistency in interpretations of the Senco role, with variations in workload and position within school hierarchies. Oldham and Radford (2011) found a similar situation noting the Senco’s leadership role could conflict with their management of SENs provision. This role confusion is likely to affect the extent to which a Senco comes into contact with children who present challenging behaviour - particularly those not identified as having BESD. Daniels et al. (1999 and 2003) found schools where SENCos, some departmental heads and managers responsible for ‘behaviour’ act separately and the overlap between BESD and ‘disaffection’ is insufficiently recognised. Whatever the differing practices, the Senco is likely to be at the centre of planning and delivering support for children with BESD at risk of exclusion (Burton and Goodman, 2011). It is clearly a duty of the Senco to work closely with the subject teachers responsible for the child with BESD and to oversee support provided by TAs. The Senco is also required by DCSF (2008a), DFE (2011a) and DFE (2014a) to oversee the assessment of the SENs that often accompany behaviour difficulties such as communication or attentional difficulties.

5.9.5 Wedell (2014) reports the concerns of SENCos about changes introduced by the new SEND Code of Practice (DFE, 2014 b), in particular the abolition of the ‘School action’ and ‘School Action Plus’ stages. Further, government claims that too many children are identified as BESD (DFE, 2014c), could lead to reduced input from SENCos and possible unidentified special educational needs. This could result in a new rise in the numbers of children at risk of exclusion.

**Assistance from beyond the school - Behaviour Support Services**

5.9.6 In the years of the Labour Governments, the SENCo and school leaders with responsibility for pastoral care and behaviour management could seek help from local authority services, including behaviour support services (Cole, Daniels and Visser,1999; Barrow, 2002; DFES, 2003b; OFSTED, 2010). In the early 2000s, these might be part of multi-agency Behaviour and Education Support Teams (DFES 2004a; Hallam, Castle and Rogers, 2004). A decade later there is limited information on the extent to which these survive, although one senses many LA services are no longer funded and have to an extent been replaced by private enterprises or outreach services provided by PRUs or BESD schools, commissioned by individual or groups of schools (DFE, 2011b; Taylor, 2012; The Research Base, 2013). In the early years of this century, there would also exist local authority advisors whose main role was to provide support in matters relating to behaviour, beyond dealing with the practicalities of exclusions (Daniels et al., 2003). Many would be the Behaviour and Attendance Consultants, required by the Behaviour and Attendance Strategies (DFES, 2003b; Frost, 2009). A national network of Behaviour Support Staff would gather for an annual conference but it is claimed that this stopped when LA funding ceased (Gray, undated). New research is needed to establish the part played in 2015 by behaviour support services, sometimes in the form of outreach teachers from PRUs or BESD schools, in helping to minimise mental health difficulties and school exclusions.
Support from beyond the school: Educational Psychology Services

5.9.7 Leadbetter (2010, 2013) reported that educational psychologists were still in the main employed by local authorities and still managed to work at three levels - with schools, families and individual children. She thought however, that ‘as the work and employment bases for EP become more varied, it is likely that EPs will become more specialised in the types of work they undertake as they develop more specialist skills and knowledge’ (Leadbetter, 2013, p.139). However, at the moment, many EPs continue to assess children, help families but also offer CPD to school staff on child development (therefore mental health) issues. It is clear that at the start of the CLD Coalition government (see Wolpert et al., 2011) educational psychologists, when they could find time beyond meeting statutory SENs duties, were still seen as a major source of support for mental health promotion in schools. Leadbetter (2013) noted divisions within the profession over the extent to which psychometric testing, undoubtedly EPs’ speciality area, should dominate EPs’ workloads. Squires (2010), Pugh (2010) and Atkinson, Corban and Templeton (2011) wanted to go beyond this speciality, putting forward the case, in the light of their training and experience, to undertake a range of therapeutic work in schools including the delivery of CBT programmes.

5.10. Professional training, development and support

5.10.1 Wolpert et al.’s (2011) confirmation that it is mainly educational staff who address the mental health difficulties of children in school, adds to the argument for better initial training and continuing professional development for teachers, TAs and staff in behaviour support services. In addition to issues of ‘skill’ as Humphreys et al. (2010) remarked, there are also questions of ‘will’ (motivation, energy etc), both linking to time and resource considerations.

5.10.2 In relation to the initial training of teachers, Garner (2013) argues for a rolling back of the cruder training methods favoured after 2010 by the CLD Coalition and a return to the approaches adopted in the early years of this century when:

‘Greater understanding of child and adolescent development was placed at the heart of a ‘positive approach to pupil behaviour’, as opposed to a reactive “behaviour management” approach.’ (p.332)

Such training reflected the focus at that time on SEAL. The training sought to develop student teachers’ range of affective and inter-personal skills so that they could engage better with pupils with behaviour difficulties. Elliott (2009) also saw the importance of developing what he terms ‘soft skills’, for example, use of non-verbal communication, classroom ‘withitness’ (see Kounin, 1977) and the appropriate use of the spoken word (see Rogers, 2013).

5.10.3 NICE (2008) similarly wanted to ensure that teachers were trained and competent to integrate the teaching of social and emotional skills into their regular subject teaching. NICE (2009) went further in recommending that training and CPD for teachers should ensure they were conversant with the psychosocial issues that often lay beneath children’s behaviour difficulties. Teachers should also understand the importance of pastoral support within their schools and how and when to access specialist support services, including CAMHS.

5.10.4 With reference to specialist training, for instance, in addressing BESD, there were repeated calls in this period for improved practice with time and funding allocated for this purpose. Various OFSTED enquiries drew attention to the difficulties of recruiting and retaining staff in PRUs and special schools and the need to improve the skills of those who were in post (e.g. OFSTED, 1999, 2002, 2003, 2006; DFES, 2003c; DCSF, 2008c). The inspectorate’s investigations in 2003-2005 led to the following summary of necessary action:

‘Regular training, focused on classroom practice, combined with in-depth appreciation of child and adolescent development, is central to understanding and managing behaviour’ (OFSTED, 2005, p.10).
DCSF (2007a) recognised that training of staff was a crucial adjunct to the successful delivery of SEAL. Such concerns fed into the National Strategies Behaviour and Attendance strands (DFES, 2003b) and, for a brief period, the National Programme for Leaders in Behaviour Attendance programme (HMG, 2006) with its development of training materials and courses and also the Inclusion Development Programme web-based course on BESD (DCSF, 2010). Under the new government, the Green Paper (DFE, 2011a) did not acknowledge this work but showed awareness of the need, promising some funding for unspecified future specialist courses.

5.10.5 There has also been a growing awareness of the potential of schools to deliver their own staff development, the importance of which was recognised in OFSTED (2006):

‘In-school support, such as coaching, team teaching mentoring focused support and management interventions, was particularly effective in building the capacity to provide for pupils with BESD’ (p.11)

The mentoring and coaching approach had also been endorsed by the National Strategies (DFES, 2005b). Peer observation of teaching was encouraged both for inexperienced and experienced staff. The process might involve the videoing of lessons and later discussion of staff performance. For such approaches to have maximum impact, there needed to be a culture of openness and mutual support. In other words, the values and approaches stressed at the start of this Chapter needed to be present. The National Strategies’ mentoring and co-coaching approach is a variation of the Teacher Support Team method described in Creese, Daniels and Norwich (1997). These approaches, as Cole and Knowles (2011) stress, can also be of assistance in maintaining motivation and in monitoring staff well-being.

5.10.6 Other research (e.g. Hallam and Castle, 1999) suggested the worth of advisory teachers, at times taking the form of Behaviour and Attendance Consultants (Frost, 2009), perhaps working for the behaviour or educational psychology services, in developing staff skills in the classroom. The value of development days and longer, accredited courses organised by them could also inspire, motivate, re-assure and promote reflective practice which lessens staff stress.

5.10.7 In short, a variety of ways is likely to be used to develop staff skills. As the Underwood Report noted in 1955, experience, when mixed with the right qualities of character and personality, ‘is a good instructor’ (Ministry of Education, 1955) but continuing and frequent monitoring and development of skills is needed, particularly when it comes to addressing the needs of children at risk of exclusion.

5.11. Working with families and enhancing parenting skills

5.11.1 The benefits of schools working closely with the parents of children with BESD and others at risk of exclusion is widely recognised (e.g. DFES, 2003a; DFES/DoH 2004; OFSTED 2005, 2008b, 2009, 2011a; Porter, 2014). This task could be undertaken by home-school link workers, employed by either the local authority or directly by schools (see the Steer Reports: DFES, 2005, 2006) - or involve teaching staff as Cole et al. (1998) and Daniels et al. (2003) saw happening.

5.11.2 There was also a recognition, based on an increasing body of research in America, Europe and Britain, of the effectiveness of interventions to enhance families’ parenting skills, if delivered with fidelity to programme design (Moran, Ghatre, and Van der Merwe, 2004; SAMHSA, 2007; Lindsay et al., 2008; Lindsay and Cullen, 2011; NREPP, 2012; Murphy and Fonagy 2012; Brown, Khan Parsonage, 2012; Asmussen et al., 2012; Ogden, 2013; NICE, 2013; Luke et al., 2014). This influenced English Government’s policy and reached into school provision for children at risk of exclusion.

5.11.3 In the early years of this century, the Labour government was concerned about links between truancy, exclusions, youth crime and poor parenting. The government encouraged parenting programmes as a way of addressing this array of chronic challenges. In fact,
attendance on parenting courses could be required by the courts under the 2003 Anti-Social
Behaviour Act. Hallam, Rogers and Shaw (2004) found a fragile and uncoordinated use of a
range of programmes, with an eclectic choice of content, being provided by local authorities
and sometimes voluntary bodies. Funding was uncertain. Programmes would typically consist
of a weekly session for between 6 and 15 weeks. However, parents rated their experience
highly, saying it helped their practice with their children. Local authority behaviour support
and educational psychology services were often the lead facilitators, but at times there were
collections from CAMHS. Programmes would sometimes draw on , but not adhere with
fidelity, to the work of Webster-Stratton and colleagues (see below). Most programmes were run
in community centres but some highly rated schemes took place in schools. Hallam, Rogers and
Shaw (2004) write:

‘School based programmes were also reported to have very low drop out rates, perhaps
because there were no transport difficulties for attending parents. Parents seemed to be
more willing to engage with what their children were doing at school and programmes were
reported to have helped in improving home-school relations and contributed towards the
school being seen as a key part of the community. Many parents having attended parenting
programmes in school were reported to have the confidence to visit school more often.’
(p.49)

The programmes, particularly at primary level, were welcomed by parents and staff. Sometimes
parallel programmes in SEBS would be run with the children.

5.11.4 Lindsay et al.(2008) evaluated a new government scheme, the Parent Early Intervention
Pathfinder [PEIP], which followed the implementation of three selected parenting programmes
with parents of children aged 8-13 in 18 local authorities. Each of the three was said to have a
sound evidence base. PEIP increased the pool of trained facilitators, parental completion rate
was 73% and the training was very successful as measured by improvements in the parents’
mental well-being, parenting skills and the improved behaviour of their child. This encouraged
the government to roll out the scheme nationally, targeting disadvantaged families. Again the
results indicated a positive impact on children’s behaviour. Of interest were the following findings:

- Non-graduate lead facilitators with no parenting programme training or delivery
  experience prior to that gained on PEIP had significantly higher parent ratings for group
  leader style than any other facilitator category, including lead facilitators with higher
  qualifications with or without prior training/delivery.
- Outcomes also related to diversity of facilitator (age, gender, ethnicity, employment
  background, educational level, prior experience) and personal and inter-personal
  qualities (e.g. empathy, showing respect)

The three approved schemes included Sanders Triple P - Positive Parenting Programme2, now
being offered through Sure Start and Children’s Centres in various cities and areas of England
and Scotland and Webster-Stratton’s Incredible Years [IY] (see for example, Reid, Webster-
Stratton and Baydar , 2004; Reid, Webster-Stratton and Hammond, 2007), also widely in use
for parents of pre-school and primary-aged children. For adolescents, increasingly independent
of parental influence, multi-systemic therapy (MST), a family and community based approach is
recommended (e.g. Ogden, 2013; NICE, 2013; Fonagy et al., 2014; Haley et al, undated). This
approach could involve a school component.

5.11.5 The Incredible Years programme is possibly of the greatest relevance to this study, given
IY is often delivered to children and parents by educational and psychology service staff and
usually takes place in schools (although it is also designed for use elsewhere by therapists and
social workers). Webster-Stratton has alluded to the importance of making the location for
delivery of training easy, accessible, affordable and non-stigmatising, particularly for ‘hard-to-
reach’ families who would benefit most:

‘Clinical programs may be too far away from home, too expensive, insensitive, distant,
inflexible in terms of scheduling and content, foreign in terms of language (literally or
figuratively), blaming or critical of their lifestyle. A cost–benefit analysis would, in all likelihood, reveal that the costs to these clients of receiving treatment far outweigh the potential benefits) even though they do genuinely want to do what is best for their children.’ (Webster-Stratton 1998a, p.184, cited in University of Wales, 2006).

Some of this implied criticism could be unfair in the British context, but parenting programme delivery in schools (or community-based Family Centres) avoids many potential difficulties, if suitable accommodation is available. It helps to lessen the drop out rates (Brown et al, 2012) and to reduce the stigma associated with seeking mental health interventions, seen as a problem in DCSF/DoH(2008), Heflinger and Hinshaw (2010), Sainsbury CMH (2010) and Brown, Khan and Parsonage (2012).

5.11.6 One strand of IY, ‘Dinosaur School’ which develops social skills in groups of 3-8 year old children, has been described earlier. The second strand consists of three programmes for parents of babies, of preschoolers or of children aged 6-12. The programmes help to develop parent-child interactions and relationships, reduce harsh discipline and foster parents’ ability to promote children’s social emotional an language development. Parents are encouraged to work with teachers as partners and become involved in their children's school experiences to promote the children's academic, social skills and emotional self-regulation and to reduce conduct problems. An advanced course for parents whose children have severe difficulties is designed to be offered by professionals including special education teachers and psychologists (Incredible Years, undated). The third strand trains teachers to improve their classroom strategies, promote children's SEBS, to reduce children’s aggression and to work with parents.

5.11.7 The IY website describes the apparent success of this three-pronged (parent, teacher and child) programme:

‘Parent training is the single most effective strategy for preventing behavior problems and promoting children's social and emotional competence. Teacher training in classroom management strategies reduces aggression and increases children's social and emotional competence as well as academic success. Child social and emotional training improves children's relationships with peers and teachers at school and increases children’s emotional literacy, cooperation, school readiness and ability to problem solve. For highly aggressive children the research shows that a combination of parent and teacher/child training achieves better long-term results.’

This seems a reasonable summary. The IY programmes are recommended by NICE (2013) and other documents published in the CLD Coalition years.

5.11.8 But what of the role of fathers? This seems a question increasingly asked from a child mental health perspective. Ramchandani and Iles (2014) note the changing face of society with mothers returning to work and fathers in Western society potentially playing a huge part in their children’s daily care and upbringing:

‘Although differences exist globally within and between cultures, the impact of fathers on children's long-term social, emotional, behavioural and educational development is significant, multi-faceted, and indisputable.’ (Ramchandani and Iles, 2014, p.1213)

They note that parenting programmes are almost always only attended by mothers, also seen by Panter-Brick et al.(2014) in the USA, who call for a much more father-friendly approach, as authoritative co-parenting is the aim. Ramchandani and Iles (2014) ponder, ‘As clinicians, and as researchers, we should engage with the challenge: “Why is the offer that we make to families so often unappealing to fathers” ’ (p.1213). In the search for practical solutions, they make a suggestion not likely to prove popular with professionals, but one that might assist working fathers and indeed working mothers:
‘families are increasingly finding it difficult to attend services during a typical working week. Yet the extension of clinic working hours, which could be changed relatively easily with sufficient will and enthusiasm, is too rarely attempted.’ (p.1213)

5.12. Working with ‘looked after children’ and their carers

5.12.1 As has been outlined in Chapter 3, children taken into public care commonly face a range of risk factors, with multiplicative effects attached. However, some prove remarkably resilient and can prosper as Luke et al. (2014) point out. Whether they do cope in face of so much adversity often relates to how far their needs (see Chapter 2, 2.7 above) are addressed in a holistic, ecosystemic manner. If provided with lasting, high quality relationships both at school and with either foster carers or residential workers and often teachers in effective children’s homes or residential schools then, as Luke et al., (2014) point out, their mental health can be improved. Just as a child receiving the label of ‘BESD’ or indeed ‘ADHD’ (see for instance, Slee, 2013; Hjorne and Saljo, 2013) can be happenstance and will not instantly alter the young person’s personality, so children taken into care do not suddenly assume different personas with different needs because the ‘LACs’ label is attached. They remain individuals with the normal range of human requirements, albeit in more intense form in terms of their need for regular food, warmth, safety, security, attachments and ‘self-fulfilment’ (see Figure 1 in Chapter 3).

5.12.2 Luke et al. (2014) report a situation with regards to children looked-after that seems not to have moved on in a generation. Training for staff continues to lack impact - and should place more stress on social learning as well as attachment theory. Some residential approaches and multi-dimensional treatment foster-care can be prohibitively expensive and often ineffective - relating to the quality of staff involved. Luke et al.(2104) talk of the value of good ‘ordinary’ care, delivered day after day in stable, caring environments as having a lasting impact on ‘looked after’ children’s well-being. This message re-iterates the content of a key book from the 1970s called ‘Daily Experience in Residential Life’ (Berry, 1975). Luke et al., (2014) also bring to mind a quotation from Ward (1980, p.25):

‘It is what is going on between the people involved that determines the quality of residential care. What the work says and how he says it, what he does and how he does it, determines the nature of the worker/resident relationship, which in turn determines the basic mode of intervention. Every incident, however, seemingly unimportant, acts as a vehicle of communication: helping or hindering, caring or not caring, demonstrating authority over the resident, or setting the scene for self-responsibility and self-development.’

The micro-skills of care work in some key ways resemble the micro-skills of teaching (see Rogers, 2013) and teaching assistant work (see Hancock, 2013). Luke et al. (2014) stress again what should be unremarkable: mental health promotion in looked after children relates so much to the human qualities, capacities and motivation of the adults with whom they interact hour in, day out, as part of their regular lives. Specialist input from CAMHs or counsellors has a valuable part to play in some circumstances for some children, but these ‘add ons’ should complement not substitute for a child’s wellbeing-promoting daily experience. This issue was similarly discussed in Trieschman, Whittaker and Brendtro (1969) in relation to residential care and their key message was captured in the title of their book: it is what happens in ‘The Other Twenty Three Hours’ (‘milieux’ or ‘environmental’ therapy) rather than the hour long session with the mental health specialist that will often have the greatest beneficial impact (Cole et al., 1998).

5.12.3 It is important for schools to have in place mechanisms for working with foster carers and children’s home staff, as it is for schools to work with the parents and families of children not in care. This should help to realise the necessary co-ordinated holistic approach. In residential schools (some of which remain in demand and often care for children looked after), regular communication between teaching and residential social work staff as well as with carers and sometimes the families is essential.

5.12.4 From an educational perspective, school staff should be aware of other of Luke et al.’s (2014) ‘evidence-informed’ principles for good care:
• Many children in care do better if they remain ‘looked after’ and are not returned to family homes where chronic and acute difficulties exist;
• The positive aspects of good ‘ordinary’ care should not be under-estimated and predispose looked after children to benefit from targeted specialist interventions;
• The earlier children are placed in any kind of permanent placement, the more likely it is to succeed.

5.13. Promoting the inclusion of children with ADHD
5.13.1 The vulnerability to exclusion of children said to have ADHD has been noted earlier in this review. McGrath (2005) reports research showing pupils with this condition evoke negative reactions from peers and teachers because of their annoying, boisterous, intractable and irritating social behaviour. Their emotional volatility, aggression and non-compliant behaviour often create conflict and confrontations.

5.13.2 ADHD is seen as a mental health condition in DFE (2014a) and clearly within the domain of general practitioners and CAMHS, given it is usually treated with medication. Using drugs as the first response remains controversial (Visser and Jeanh, 2009). However, such an approach would seem to be the one most favoured in DFE (2014a). This CLD Coalition guidance says methylphenidate (e.g. ‘Ritalin’ or ‘Concerta’) has few side effects and is effective in 75% of cases. In an annex, this guidance does allow that ‘psychosocial treatments may…be considered by medical professionals’ (p.40). It can be assumed that this is a reference to highly specialised therapies. Yet strangely, DFE (2014a), although purportedly giving guidance on mental health in schools, has nothing to say about practical approaches in the classroom or playground.

5.13.3 Guidance for school staff is given in the Labour government advice (DFEE, 2001b) and in McGrath (2005). These recognise that, when working with children with ADHD, drugs do have a place, particularly as the evidence for psychosocial approaches working effectively and consistently is varied (see Colley, 2010). Indeed, some children might be extremely difficult to manage in classrooms without carefully administered psychostimulants (with dosages regularly checked and regular monitoring that pills are taken as prescribed). However, as Bilton and Cooper (2013) stress, a multi-modal approach should be used, applying educational, psychological and social interventions, given the clear social and sometimes situational factors that can exacerbate or lessen ADHD.

5.13.4 DFEE (2001b) sketches strategies that teachers and TAs can use to good effect:
• seating the child nearer to the teacher and away from distractions (e.g. the window);
• setting short, achievable targets and give immediate rewards when the child completes the task;
• using checklists for each subject, outlining the tasks to be completed, and individual homework assignment charts;
• using large type, and provide only one or two examples per page.
• avoiding illustrations that are not directly relevant to the task;
• encouraging the pupil to verbalise what needs to be done – first to the teacher, and then silently to themselves;
• using teacher attention and praise to reward positive behaviour; and give the pupil special responsibilities so that other children can see them in a positive light;
• keeping classroom rules clear and simple (DFEE, 2001b).

McGrath (2005) enlarges on this summary in a useful table (p.334) listing teacher approaches to promoting the child with ADHD’s social knowledge, personal values, social cognitions (i.e. recognising social cues, empathy, emotional regulation, goal selection, social problems solving and consequential thinking), performance and social skills and social self-reflection. Her table is, of course, also relevant to children with behaviour difficulties not seen as ADHD. The rest of her chapter then enlarges on each area in succinct and useful fashion.
5.14. How far can CAMHS provide support in school for children at risk of exclusion?

5.14.1 The national CAMHS review (DCSF/DoH, 2008) called for better integrated services which would tackle a chronic long-term barrier to improvement, namely the ‘difference in the professional cultures of health, education and social care, and also of some professional groups [e.g. educational and clinical psychologists]’ (p.61). In similar vein, Vostanis et al. (2012) note ‘there is still evidence of limited integration between CAMHS and education services, duplication of work, resistance to joint working at strategic and operational level, lack of information sharing, and differences in culture and use of “language” ’ (p.110). This is the context in which a discussion of the CAMHS role in school has to take place.

5.14.2 ‘School exclusion’ can be seen as a mental health issue but it will only rarely be mental health professionals working in the front-line in schools who regularly address the needs of most children at risk of exclusion. The mental health literature (e.g. DCSF/DoH, 2008; NICE, 2008, 2009, 2013) does envisage some individual interventions and occasional group work by CAMHS in schools, but CAMHS is seen mainly acting in an advisory or continuing professional development role, and in helping schools to better identify the children who should be referred on to specialist services This view reflects the past, present and, particularly in an age of continuing austerity (Beecham, 2014), likely future reality. In short, CAMHS too often lack the resources and time to act otherwise - and perhaps the will and skill to play a significant direct role in schools?

5.14.3 In the light of the above, it is unsurprising how little of the guidance on anti-social behaviour and conduct disorder for health and social care workers (NICE, 2013) is devoted to the practicalities of working with and through schools. There are, in the main, only general injunctions for health and social care managers and commissioners

- to collaborate with colleagues in educational settings to develop local care pathways that promote access to services for children with CD and their parents;
- to support the integrated delivery of services across all care settings [presumably including educational settings];
- to ensure clear criteria for entry to specialist mental health services;
- to ensure effective protocols and communication about the functioning of the local CAMHS pathways.

The sanctioning of targeted ‘selective prevention’ in schools, probably involving CAMHS facilitators working alongside teachers with ‘at risk’ groups, would seem of an insubstantial peripheral nature. In a brief allusion to this, NICE (2013) says that typically the programmes should consist of up to 30 classroom-based sessions over the course of one school year.

5.14.4 NICE’s earlier guidance (2008, 2009), issued under the Labour government in the ‘Every Child Matters’ and ‘SEAL’ period, was aimed at educationalists, witnessed by the absence of terms such as ‘conduct disorders’ and ODD. Both documents endorse ‘organisation-wide’ (i.e. ‘whole-school’) approaches to promotion of healthy schools standards (DfES/DoH, 2004) and social and emotional wellbeing [SEWB]. NICE (2009) asked for secondary schools to integrate into the general curriculum, and into extra-curricular activities, important aspects of SEWB including motivation, self-awareness, problem solving, conflict management and resolution, the understanding and management of feelings, collaborative working and working with parents. It asked for effective pastoral systems and effective support, especially for children with emotional and social behaviour problems. Teaching should promote positive behaviour, successful relationship formation and should help to reduce disruption and bullying. Teachers should also understand the role of CAMHS and how to access its help. It also called for teacher training to equip school staff in the above areas, for instance, in how to manage behaviours but also to understand underlying issues. The advice for primary schools covered similar issues (NICE, 2009). This again seemed to put definite limits on what CAMHS should do by way of direct work in schools. It recommends CPD delivered by appropriately qualified trainers drawn from educational psychologists, specialist behaviour support services as well as CAMHS Primary Mental Health Workers.
5.14.5 In 2008, the limited role for CAMHS extended to what they offered the most vulnerable groups. DCSF/DoH (2008) reported an unacceptable lack of support from CAMHS for pupils in many PRUs and for children with BESD in special schools - even allowing for some improvements in practice noted between 2004 and 2008:

‘It is our view that special schools, PRUs and other alternative education providers need further support with specialist training in order to improve the skills mix within their staff. They also need better access to and involvement of special mental health staff, given the complexity of the needs that they are working with and supporting.’ (p.55)

However, even in this instance, the support recommended is CAMHS offering CPD and being more easily reachable. It is not a general recommendation for CAMHS to increase the amount of direct work spent by mental health clinicians in PRUs and BESD special schools.

5.14.6 Wishing to break down the undoubted barriers between education and CAMHS, DCSF/DoH (2008) cited good practice examples of integrated service referral panels bringing together CAMHS, behaviour support and educational psychologists and specialist teachers who are part of CAMHS teams, and wanted to see more of this. It also encouraged the practice of link-workers such as Healthy Schools Coordinators (akin to the Mental Health Coordinators advocated in MHF, 1999; Cole et al., 2002 and Cowie et al., 2004) or Primary Mental Health Workers, providing liaison, consultation and training as well as joint clinical work with teachers and educational psychologists.

5.14.7 The specialist clinics focusing on behaviour problems or dedicated to supporting children with ADHD, run by child and community paediatricians were noted and praised by DCSF/DoH (2008). However, these were clinical services, and clinicians would control who should be admitted to such treatment (see Fonagy et al., 2014 for recent example of multi-systemic treatment offered on specialist CAMHS sites). It does not seem that these would involve teachers to a great degree.

5.14.8 CAMHS’ support to schools is also affected by geography. DCSF/DoH (2008) had referred to the lack of availability of CAMHS specialist staff in some parts of the country, a situation observed by the University of Birmingham EBD Research Team in the 1990s and early 2000s. Ford et al., (2008) referred to north-south variations with a shortage of child psychiatrists and longer waiting times in the North. This was new evidence of a historical trend, seen in Cole et al.(1998), for London and the south east to have more CAMHS (and training opportunities) than most other areas of England.

5.14.9 Further, the limits to the direct involvement of CAMHS in addressing acute social, emotional and behavioural difficulties in schools could also reflect clinician attitude and will. Ford et al. (2008) found that far fewer children with CD than those with hyperkinetic disorders are seen by ‘specialist services’ (and these are often specialist educational services). Coghill (2013) perhaps helps to explain this phenomenon in an editorial introducing various articles on conduct disorder:

‘It would seem that the high levels of academic research are not matched by levels of clinical activity within CAMHS. Whilst accepting that not everyone with ODD or CD requires specialist CAMHS, the historical, and in many areas current, assumption that children and young people presenting with disruptive behaviours are not really suitable for specialist CAMHS services does not seem to fit well with the evidence presented by the articles in this issue. If, as seems very likely, ODD and CD, whether child or adolescent in onset, are best conceptualised as neurodevelopmental disorders, with biological underpinnings and serious negative long-term outcomes, is there any clear reason why they should not be treated as seriously from a clinical perspective as other disorders such as autism and ADHD?’ (Coghill, 2013, p.922)

He claims ADHD and autism:
have had to battle for their place in the clinic, but have now been assimilated and accepted by clinicians in mainstream services as being appropriate for specialist CAMHS assessment and intervention. Those with ODD and CD, however, are often still rejected at the referral stage or at an initial screening assessment with the recommendation that they would be best managed by non-health services within the community. Why has this happened and why, despite growing evidence that these disorders are genuine neurodevelopmental disorders, is the situation taking so long to change? In part this is likely to be due to the age old prejudices that, despite appearing in both the DSM and ICD classification systems, CD and ODD are not ‘real’ psychiatric disorders.’ (Coghill, 2013, p.922)

5.14.10 Coghill ‘s editorial precedes Snell et al.’s (2013) article on the huge costs to public services associated with conduct disorder (not as much as those associated with hyperkinetic disorder but far more than those for emotional disorders). Looking back five years, they found that additional health, social care and education costs associated with child psychiatric disorders totalled £1.47bn in 2008 but that:

‘the lion’s share of the costs falls to frontline education and special education services. The findings illustrate stark differences in the distribution of resources provided to children and young people psychiatric disorder, and emphasise the large impact on the education sector’ (p.977).

These costs ‘are not restricted to delivery of specialist services targeting children and young people with mental health needs; there are also sizeable costs incurred within mainstream schools, including provision of additional teaching inputs and time spent meeting and discussing problems with parents ‘ (p.983-4).

5.14.11 This seems further evidence of a continuing preference among many CAMHS professionals to work with children who are anxious, depressed, or have ADHD or on the autistic spectrum. Such an interpretation is in accord with the glimpses seen in Cole et al. (1998), Daniels et al. (1999, 2003) of the same situation. Of course, this is a generalisation and there are many examples of highly valued work by CAMHS in a range of very challenging educational settings. Cole (2008) reported some examples. McCloughlin (2009, 2010), a psychotherapist employed by CAMHS, describes her work over many years, as a regular member of staff in a volatile and demanding London PRU. Vostanis et al. (2010) cites the role played by CAMHS in BEST and the ‘one-stop-shops’ set up by CAMHS in community schools focusing on ‘difficult’ children.

5.14.12 To help the disappointing general situation, Vostanis et al.(2010, 2012), recommend not only the training of school staff in the work of CAMHS but also the converse approach of training CAMHS workers, sometimes delivered by educationalists, in education policies, procedures and practice. Building on TaMHS, the authors called for more face-to-face liaisons involving school-visits and joint meetings. They also recommended more dual posts or services covering the interface between schooling and specialist CAMHS. These researchers report two respondents’ (both CAMHS workers) comments:

‘I wasn’t even sure what a whole school approach was, you know, and, um, there were lots of gaps in my knowledge . . . it [training] kind of really highlighted my gap.’ (p.118)

‘I hadn’t really thought about it in that way . . . that they have 30 children to deal with, and that a lot of it is about crowd control and all of those issues, and so it helps to kind of get into more the mindset of a teacher, and help to increase empathy a little bit as well.’ (p.117)

5.14.13 This last quotation possibly highlights a key reason why it should remain mainly teachers who provide large-group interventions (or at least be present in the class-room to provide back-up when a member of CAMHS leads a lesson). CAMHS specialists are trained for, and experienced in, working with small groups but most commonly with individual children. Borrowing a term used by Beedell (1970, p.158) in relation to social workers, CAMHS staff are
usually ‘dyadic interaction experts’ rather than school ‘systems experts’ that is, teachers used to controlling, working with and motivating groups of often challenging children. Pettitt (2003) made similar observations.

5.14.14 In conclusion, it seems a realistic and appropriate role for CAMHS in support of children at risk of exclusion from school would consist of:

- being easily accessible through widely known and easily followed pathways, so schools can make appropriate and timely referrals to specialist mental health services (as NSF Standard 9 envisaged - see 4.1.2 above);
- running time-limited courses in schools for ‘at risk’ groups, as NICE (2013) allows;
- bringing CAMHS expertise to bear in ‘treating’ individual children with severe mental health difficulties (beyond those who are anxious, depressed, have eating disorders, ASD or ADHD) sometimes in educational settings;
- giving far more support to children in PRUs and schools for children with BESD (as DCSF/DoH, 2008, recommends);
- offering expert advice and filling gaps in some schools staff’s knowledge of child development, risk and resilience factors.

This paragraph reflects some of the recommendations in Pettitt (2003) and much of the guidance given in DFE (2014a).

5.14.15 Key to the above - possibly happening already in many parts of the country - is having respected linkworkers, providing an effective interface between schools, PRUs and CAMHS, as DCSF/DoH (2008) recommended. Daniels et al. (1999, 2003) and Pettitt (2003) saw examples of this in practice, with quality of relationships between school staff and CAMHS linkworker being crucial. Vostanis et al. (2012) enlarge on this, also stressing the need for relationships and mutual trust: many participants in their study highlighted the need for:

‘an individual to act as a ‘go-between’, to represent both education and CAMHS, and function as a knowledge provider…The presence of a link person manages the need for knowledge and competency within the service, as opposed to full levels of knowledge within individuals. The suggestion here is that link people are useful resources to promote joint working, and serve as a benchmark of knowledge to address limitations of knowledge on an individual level.’ (p.115)

5.14.16 Resource, time, attitudes and particular professional skill-sets clearly impinge on what mental health specialists can offer in schools. Might the pressure put onto CAMHS for more input be reduced were the training and CPD for teachers and teaching assistants to follow the path outlined by Garner (2013 - see above)? Knowledge of child development, of mental health difficulties and responses to these could form a greater part of the normal repertoire of far more school staff - indeed this expertise has long been exhibited by some teachers and TAs working with pupils with BESD and others at risk of exclusion (Cooper et al. 1994; Cole et al., 1998; OFSTED, 2005, 2007, 2009).

5.14.17 Gaps in school staff’s knowledge over the last decades have also been filled by CPD offered by specialist behaviour support staff and, when other calls on their time have allowed, educational psychologists, who themselves in a past era, were practising teachers prior to training as EPs. Leadbetter (2013) indicates that EPs are equipped not only to assess children, but to provide expert CPD. Squires (2010) and Pugh (2010) agree, also stressing that EPs have the expertise to deliver empirically supported interventions in schools, such as cognitive behaviour therapy. Perhaps in the post-statementing era (DFE/DoH, 2014b) educational psychologists will be able to devote more of their time to such work?

2. Triple P, adopted by Glasgow Council, is now subject to a longitudinal research project, assessing its effectiveness (Glasgow University, undated).
Chapter 6: Conclusion - Making the Most of an Imperfect Future

6.1 This review has highlighted the intransigent social problems that intertwine with school exclusion, notably poverty, family breakdown, housing shortages and crime. In an era of acute financial stringency these issues could become worse. Government spending on social interventions is unlikely to match the levels of the early 2000s. Also, allowing for voters’ probable preference for prioritising the physical over the mental health needs of the nation, the inter-generational impact of poor parental well-being on their children is set to continue. There will likely be political initiatives of some benefit, perhaps more multi-systemic family work or more access to ‘talking therapies’ or slightly improved ‘benefits’ for low-income families - but there seems little prospect of dramatic change in policy and practice that would make a profound difference to the status quo. It is therefore hard to avoid a degree of pessimism when looking at the wider context in which schools, social care and CAMHS will continue to operate.

6.2 In more optimistic vein, it has long been shown that schools can make a positive difference in terms of both academic standards (Rutter et al., 1979; Mortimore et al., 1983) and in offering effective social and pastoral support in well-ordered communities to vulnerable children (e.g. DES, 1989; Cooper, Smith and Upton, 1994; Daniels et al., 1999; Munn et al., 2000). Children from the same social-economic areas can receive radically different types of schooling within their locality. Much research evidence presented in this review offers support for these statements.

6.3 The values, the skills and practice of ‘inclusive’ school staff have been outlined. These people at times draw on the particular expertise of educational psychologists, counsellors and CAMHS and work closely with children’s families, sometimes helping the latter to develop parenting skills. This review has described the factors needed:

- to create the safe, nurturing and compassionate environments, where positive adult-child relationships predominate;
- to address many pupils’ educational difficulties;
- to offer personalised curricula to build on pupils’ preferences and potential strengths;
- to allow children a voice, with their views heard respectfully;
- to target the particular mental health difficulties of vulnerable children in group and individual work.

In short the ethos of schools in which exclusion can be minimised and the well-being of children at risk of exclusion nurtured has been described. It is unsurprising that this is essentially the position reached over a decade ago in Daniels et al. (1999), Cole et al., (2002) and Daniels et al.(2003). Longitudinal random control trials are lacking in this area and on ethical, practical and financial grounds, it is difficult to see how such research could happen. However, from the wealth of historical, observational, case study and survey evidence cited in this review, there would appear to be a timelessness and universality to good practice in relation to helping children with mental health difficulties and behaviour problems to remain engaged and learning in educational settings (see also, Visser, 2002).

6.4 Exclusion is also far more than a child being given a formal fixed-term or permanent exclusion. Norwich (2014, p.409) correctly notes that inclusion (and exclusion) is:

‘multi-level in the sense that to be included is to be included in a specific setting and these settings are embedded within each other. So being included in one setting might also involve being excluded from another… being in a separate class or unit for behaviour difficulties can be seen as inclusion in an ordinary school (inclusion with reference to ordinary versus special schooling), but exclusion from an ordinary classroom (exclusion with reference to ordinary versus special class).’
This review has sought to outline the best ways of reducing the levels of exclusion that any child with mental health difficulties at risk of exclusion will experience. These pupils might need 'targeted' provision, which at times, takes them out of mainstream classes, for example, places them in a nurture group part-time for up to a year - or gives them specialist one-to-one tuition or counselling - or places a fifteen year old disaffected youngster in a work-placement. Research has been cited which indicates that a child can at times feel safer, more engaged and happier in a small special school or PRU, after unhappy and damaging experience of life in a mainstream school.

6.5 However, special schools for pupils with BESD and PRUs cater for a tiny minority, under 0.5%, of English school children. Most pupils with mental health difficulties and at risk of exclusion continue in so called ‘mainstream’ education. The total number of these children remains a matter for discussion, as was seen in Chapters 1, 2 and 3 above. Prevalence rates relate to acceptance or not of educational or clinical constructs and perceptions of the degree of accuracy achieved in measuring ‘BESD’ or ‘conduct disorder’ or ‘ADHD’ or other ‘disorders’. As described in Chapter 2, conduct disorders and BESD can come and go as environmental factors change. Nevertheless, it does seem feasible that in England, at any one time, there could be up to half a million children with mental health difficulties at risk of exclusion.

6.6 Finally, reflecting on the lead the English government should give, it would seem appropriate for it to re-emphasise the interconnectedness of children’s educational, social, emotional and family needs. A first step could be to revive ‘the Department for Children, Schools and Families’ in place of the misleading ‘DFE’ (Department for Education) title. A second step might be to create the Office for Standards in Education and Child Care (OFSTECC) in place of similarly mis-named Office for Standards in Education (OFSTED). Thirdly, the government could update and re-issue many of the helpful materials associated with SEAL and ‘Behaviour for Learning’ and re-launch the quest for closer inter-professional understanding and working attempted in the era of ‘Every Child Matters’. Finally, a reframing and expansion of some recent uneven government guidelines could show a greater understanding of the challenges faced - and contributions made - by educationalists. These actions could provide a more appropriate backdrop for a new and sustained campaign aimed at promoting the emotional well-being of children at risk of school exclusion.
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Appendix 1: Notes on Methodology

1. Parker and Ford’s (2013) call for carefully designed, large-scale, longitudinal RCT studies that seek causal relationships between mental health and school exclusions is to be supported. Such studies should satisfy the standards required by, for instance, NICE. At present, hardly any studies do, as Whear et al. (2013) discovered. Their initial screening identified 3712 abstracts of potential relevance but applying their criteria reduced this number to a mere five studies - and some of these, they acknowledged, contained methodological weaknesses.

2. Moran, Ghate and van der Merwe (2004) in their international review of effective parenting support, argue persuasively: ‘Many rigorous ‘systematic reviews’ set such scientifically stringent criteria for studies to be included for review that only a tiny proportion of the available literature is drawn upon’ (p.5). For many areas of research, they see a need to include both quantitative and qualitative evidence. Cartwright (2007) addresses the same theme in her article ‘Are RCTs the Gold Standard?’, She also notes the narrowness of scope of many random control trials. They might ‘have high internal validity but the formal methodology puts severe constraints on the assumptions a target population must meet to justify exporting a conclusion from the test population to the target’. Her conclusion is that ‘to draw causal inferences about a target population, which method is best depends case-by-case on what background knowledge we have or can come to obtain. There is no gold standard’ (p.11). Pugh (2010) similarly highlights the shortcomings of RCTs, arguing that such studies need to be only a part of wider approaches.

3. NICE (2013b, full guidance) rates the research quality of the studies they cite as ‘high, moderate, or low’ but even they stress that studies assessing behaviour in children are based on observation and that therefore the findings need to be treated with caution.

4. Also of relevance to the methodology adopted in this review is the lack of reliable data available on PRUs and other alternative forms of provision. The problems encountered by Cole, Daniels and Visser (1999) were mirrored by The Research Base (2013) in its review of alternative provision in London. Smith (2008) had similar difficulties with inaccurate data. However, she argued, as the present writer would, that inaccuracies do not necessarily make data unusable. All research methods have advantages and disadvantages. She concludes ‘Secondary data can provide a window to the social world, it can help identify trends and inequities which further enquiry often using in-depth research methods, can explore’ (p.99). This seems a valid standpoint to this writer, who encountered and confronted similar situations in some of his earlier studies (Cole, Daniels, Visser, 1999; Cole, Daniels and Visser, 2003; Daniels et al., 2003).

5. Moran, Ghate and van der Merwe (2004) also warn, in relation to research into parenting programmes, that ‘broader and more inclusive reviews exist but are often somewhat unscientific in their selection of material included.’ This comment is also pertinent to this study. Some of the documents (over 300 in total) examined for this review, could be viewed as unscientific - at least acknowledged as ‘non-academic’ e.g. by the Chair of the important National Review of CAMHS in relation to DCSF/DoH (2008). The documents studied are often based on ‘secondary data’, drawing on either a range of research of varying quality and relevance - or sometimes, as is the situation in relation to OFSTED investigations, the current perceptions and observations of experienced and skilled practitioners. In this study, views of relevance to mental health and school exclusions have had at times to be sifted from the political purpose of particular publications.

6. Dealing with such uncertainly is the stock-in-trade of so much research. The present writer is an historian and has also been involved for many years in social and educational research, looking into topics for which RCTs would not have been funded and probably could not have been designed. In short, the methodology adopted would seem the most appropriate way
to represent the current state of knowledge surrounding children’s mental health and links to school exclusion (see also Cole et al., 2013, on this issue).

7. In relation to academic articles accessed, the focus was on English journals known to take an interest in school inclusion, mental health and behaviour difficulties. These journals included ‘Emotional and Behavioural Difficulties’, ‘Support for Learning’, ‘British Journal of Special Education’ (hand searched). Web-based searches were conducted through the University of Oxford SOLO site to identify key recent articles in other journals, particularly relevant mental health journals. Given, as Whear et al. (2013) established, there are thousands of potentially relevant articles, there could only be a selective coverage of these materials.