**Title of article:** Riding the rollercoaster of school exclusion coupled with drug misuse: The lived experience of caregivers. Emotional and Behavioural Difficulties. DOI:10.1080/13632752.2020.1848985

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**Abstract**

The research aimed to investigate if drug misuse is an indicator and predictor of barriers to mainstream schooling and school exclusion. The objectives were to determine the extent of the barriers to mainstream schooling and to elicit and report the caregiver's experiences of their child’s drug misuse and the impact it has had on them, their child and their child’s siblings.

This research presents data drawn from face to face, semi-structured interviews with four caregivers of young people with multiple fixed-period and permanent exclusions from mainstream schools in England. The interviews were analysed using interpretative phenomenological analysis (IPA). IPA was chosen to understand how the homogenous sample made sense of their lived experiences (Smith 2004). The study brings to the fore the complexities of families being able to access prompt support from education and health care professionals for their children and themselves as caregivers. The research includes critical messages for education and health professionals and policymakers, including the need to provide timely identification, assessment and response to underlying disabilities and mental health needs. The research also highlights the importance of training for education professionals, so they can understand, identify and respond to the multifaceted behaviours children present to enable the creation of inclusive and accessible learning environments and curriculum.

**Keywords:** school exclusion, special educational needs, drug misuse, qualitative research, interpretative phenomenological analysis

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**Main Text Introduction**

The research utilises unreported data gathered during a two-year project investigating the impact of school exclusion on the mental health and wellbeing of children undertaken in the North East of England by Martin-Denham (2020a, 2020b, 2020c). The objective of the original research was to examine the barriers and enablers to mainstream schooling from the perspective of 174 participants, including 55 children, 41 caregivers and 78 education and health professionals. As part of the analysis the theme of drug misuse emerged in some of the interviews but was not explored in-depth. This article specifically focuses on four of the interviews with caregivers from the original study who had the commonality of their children consuming street and or prescription drugs, receiving multiple fixed-period and permanent school exclusions and having siblings living within the household (see Table 1). The findings presented in this article aimed to investigate, through phenomenological analysis if drug misuse is an indicator and predictor of barriers to mainstream schooling and school exclusion. The objectives were to determine the extent of the barriers to mainstream schooling and to elicit and report the caregiver's experiences of their child’s drug misuse and the impact it has had on them, their child and their child’s siblings.

In 1997, in England, the New Labour Government set out its strategy for securing parental involvement in its first white paper, 'Excellence in Schools' (Department for Education and Skills (DfEE 1997a). The plan included three elements: better information for parents; involving parents in their child's education “to put the years of division, conflict and short-term thinking behind us” (p.12) and giving parents a voice in the way schools were run through the election of parent governors. The subsequent green paper (DfEE 1997b) acknowledged the need for effective support for parents from multi-agency services, including those in the voluntary sector. Later, this view was reinforced within the fundamental principles of the DfES (2001) Special Educational Needs (SEN) Code of Practice declaring that “parents have a vital role to play in supporting their child's education” (p.12). This stance was endorsed by a Government-funded study (Desforges and Abouchaar 2003) which claimed parental involvement could significantly improve pupil achievement; a view shared in other studies (Higgins and Katsiparasis 2015; Castro et al. 2015). The importance of caregivers in influencing outcomes for children and young people was also reinforced in the National Institute of Clinical Excellence guidelines (Department of Health (DoH) 2009). More recently, the Children and Families Act (CAFA) (2014) strengthened the statutory requirement for caregivers to be involved in decisions that directly affect children with Special Educational Needs and Disabilities (SEND). In the press release at the time, DfE and Timpson (2014) announced “today is a landmark moment in improving the lives of children with SEND and their families. These reforms put children at the heart of the system”. The Driver Youth Trust (2015) in their commissioned review of the SEND policy landscape found that despite the reforms enhancing high-quality provision, there continued to exist a system of fragmented sharing of information and knowledge across agencies involved in the health, education and care of children with SEND. Parents telling their story once and co-ordinated support was a promise made to parents through the CAFA reforms, though the reality so far has been far from this (House of Commons 2019). The emphasis in the most recent statutory guidance the SEND Code of Practice (DfE and DoH 2015) increased the rhetoric of support for parents in terms of decision making, early identification, greater choice and control, the collaboration between agencies and high-quality provision. However, recent findings from an extensive local study on school exclusions found a distinct lack of support from some education and healthcare services for caregivers or their families Martin-Denham (2020a, 2020b, 2020c).

**Early identification**

The importance of early identification has been prevalent in several reviews, most notably: the Bercow Report (DCSF 2008); Lamb Inquiry (DCSF 2009); Salt Review, (DCSF 2010); Ofsted SEND Review (2010); and Timpson Review (DfE 2019a). Without early identification, it is suggested that young people's difficulties increase in complexity causing disrupted pathways as they move through education (Pirrie et al. 2011; Martin-Denham et al. 2017; Martin-Denham 2020a, 2020b, 2020cc). Horridge (2019, 2) supports the notion of early identification, as needs that are made visible are more likely to be addressed. She also reiterates the importance of "ensuring that each and every need of children and young people are accurately described using clearly understandable terms, documented and communicated to all who need to know". Pinney (2017) supports the need for consistency in terminology, raising the issue that health and education use different terms, for example, health-based medical diagnoses (learning disabilities) with schools focussing more generically on learning difficulties.

**School exclusions overview**

In the United Kingdom (UK), school exclusion refers to a "disciplinary sanction that prevents pupils from attending school for either a fixed-period or permanently" (Gazeley 2010, 451). Introduced through the Education Act (1986) "fixed-period" and "permanent" exclusions enabled the removal of a child from school when they were deemed to be persistently or severely deviating from the school's behaviour policy and where allowing them to remain would seriously harm the education or welfare of others (DfE 2017a). The decision to exclude a child must be lawful, rational, proportionate and fair (European Court of Human Rights 2010; Education Act 2002; Education Act 2011; School Discipline Regulations 2012). The reality is the emphasis on accountability for attainment in schools is a critical factor in unlawful off-rolling where children are removed from schools registers (House of Commons 2018; Hutchinson and Crenna-Jennings 2019; Ofsted 2019) and is particularly prevalent in the SEND population (Ambitious About Autism 2014; Paget et al. 2016). Earlier evidence of off-rolling was reported by Atkinson (2012) who found caregivers were persuaded to agree to a managed move (a move to a new school) as an alternative to a permanent school exclusion on their child's record and Gill, Quilter-Pinner and Swift (2017) who suggested schools coerce caregivers to home-school.

Between 1995-1996 and 2012-13 permanent exclusion was on a downward trend but has been rising since (DfE 2018). Furthermore, in 2017/18, the number of exclusions issued in England was higher than in recent years due, in part to the increase in the North East of England. The hikes have resulted in school exclusions receiving attention at a national level, with the recent report into alternative provision (House of Commons Education Committee 2018) prompting the Timpson Review (DfE 2019a). Findings by Martin-Denham (2020b) highlight that the prevalence of both fixed-period and permanent exclusions was more evident in years 5, 6, 9 and 10 in the lead up to national assessments; with these years also showing increased social, emotional and mental health difficulties Martin-Denham et al. (2017). Education Datalab (2018) illustrated spikes in pupil moves in year 10, in the year before GCSE examinations. These findings reflect national concerns regarding national assessments and the impact of these on schools retaining low attaining children (Gazeley 2010, House of Commons Education Committee 2018; Action for Children 2019).

**Barriers to mainstream schooling**

In the UK and internationally there is a growing body of evidence that suggests that young people excluded from school have an increased risk of poor educational outcomes (Social Exclusion Unit 1998; McDonald and Thomas 2003; Daniels et al. 2003; Cole, Daniels and Visser 2013; Martin-Denham (2020c). How to support children with diverse abilities to enable them to remain in a mainstream school context is an ongoing international debate (Blatchford and Webster 2018; Martin-Denham 2020, 2020b, 2020c). The authors suggested that there are many variables in school can affect children's ability to learn, including the dynamics and number of children in the class and the availability of support staff. Ofsted (2010) found that access to relevant expertise in education was often reliant on a diagnosis from health services rather than when an educational professional identified a child had a learning difficulty. Children relying on their school to have support needs met is of ongoing concern, particularly "when for whatever reason, a school fails to provide high-quality SEN support, the child is failed" (House of Commons 2019, 6). This view is shared by DfE (2017b) and Johnson, Carroll, and Bradley (2017), who suggest that barriers to providing adequate support were resource issues, the availability of teaching assistants and external professionals. Oetting and Donermeyer (1998); Smith (2009) and Dong and Krohn (2020) signified that time away from school during an exclusion is also a barrier to learning as they miss work and may find catching up difficult resulting in lower achievement levels. The longer they are excluded, the greater the difficulty catching up and decreasing the likelihood of reintegration into mainstream education (Duncan and McCrystal 2002; Martin-Denham 2020c) increasing the possibility of being unemployed as adults and anti-social behaviour and drug misuse (Kaplan and McArdle 2004).

**School exclusion and drug misuse**

Historically in the UK, school exclusion has been recognised as a predictor of the onset of drug misuse and anti-social behaviour (Newcomb, Maddahian and Bentler 1986; DfEE 1997a; Lloyd 1998; Stationery Office 1998; Miller and Plant 1999; Ball and Connolly 2000; Home Office 2004) with an increased likelihood of becoming involved in the criminal justice system (Gray et al. 1996). This view was supported by McCrystal, Percy and Higgins (2007) who reinforced that not only are excluded young people at increased risk of drug use but also later marginalisation from society as adults. Unlike in the United States in the UK, few studies have examined the impact of school exclusion on later negative behaviours, including crime and drug use (Dong and Krohn 2020).

However, in 1996, the Audit Commission reported that three-quarters of young people excluded from school offended compared with one-third of those without exclusions. Renshaw (2003, 2) employed by the Commission at the time reported that young people in custody "have a history of professionals failing to listen, assessments not being followed by action and nobody taking charge".

**Teacher-student relationships**

To date, several studies have explored the relationship between positive teacher-student relationships and positive academic-related outcomes (Sellman 2009; Furrer, Skinner, and Pitzer 2014; Nind, Boorman and Clarke 2012; Jalali and Morgan 2018). Ruzek et al. (2016) propose that emotionally supportive teachers in classrooms give the children increased autonomy in improving their outcomes. Meehan, Hughes and Cavell (2003); Martin and Dowson (2009) and Martin-Denham (2020a), agree that positive teacher-pupil relationships are a protective factor enabling children to manage in school despite their challenges contributing to more positive school experience. However, several studies show that children feel negatively perceived by teachers due to their past behaviours within a school (O'Connor et al. 2011; Nind, Boorman and Clarke 2012; Michael and Fredrickson 2013; Sheffield and Morgan 2017; Cosma and Soni 2019; Martin-Denham (2020a, 2020b, 2020c). The relationship between negatively labelling young people and resulting entrenched behaviours from children and reactions of staff is noted in research (Lopes et al. 2012).

**Impact on siblings**

There are no existing UK studies that specifically examine the impact of school exclusion and drug use on siblings within the household. What is known is that mental health disorders are associated with reduced quality of life and increased psychological strain (Steinhausen 2010; House of Commons 2019) and that aggressive and hostile behaviours within sibling relationships can lead to behaviour difficulties (Volling and Blandon 2005; Buist et al. 2013). Strong sibling bonds have been shown to provide protection and emotional support during adversity (Buist et al. 2013; Davies et al. 2019) and the development of social skills and strategies for emotional regulation (Lohaus, Vierhaus and Maass 2010). Bojanowski et al. (2020, 8) recently examined sibling relationships of adolescents with mental health conditions. They found "children and adolescents with mental disorders perceive their sibling relationship as warm and close, more so than healthy children and adolescents". They suggested further studies were needed with larger cohort samples.

**Challenges in securing support from health professionals**

Numerous studies have shown that children who are excluded from school are among the most at risk of poor outcomes (Parsons 1999; 2008; 2009; Office of the Children's Commissioner 2017; Gill, Quilter-Pinner, and Swift 2017) and are likely to have special educational needs Martin-Denham (2020a). The Timpson Review of school exclusion (DfE 2019a, 39) said that where there are concerns with behaviour, there should be an assessment of causal factors such as "undiagnosed learning difficulties, difficulties with communication or mental health issues". However, studies have shown there is a multitude of barriers to prompt assessment and identification of underlying needs within both health and education Martin-Denham (2020c), despite the consensus that children with disabilities need multi-disciplinary support (Williams and Salmon 2002; Ofsted 2010; House of Commons 2019). Indeed, the Future in Mind report (Department of Health and NHS England 2015a, 57), recommended a "whole system" approach and "coordination of assessment and planning around the individual child, involving all relevant services, facilitated by information sharing and a lead professional or key worker". Though the reality is, there is a lack of cohesion in service provision (Department of Health and NHS England (2015b) and increasing demand for specialist input for children with social, emotional, and mental health difficulties (Chief Medical Officer 2012; Horridge 2019; Martin-Denham 2020b).

Boyd et al. (2011) and McCann and Lubman (2012) all suggest there is a lack of information available to service users; not knowing where a service is, the pathways or how to make an appointment for seeking mental health support. This view has recently been expressed by Iskra et al. (2015), whose research indicated that not knowing where to go for support is a barrier to seeking help for their children. Anderson et al. (2017) believe this is not an uncommon issue and is due, in part, to services not being well publicised. The result of this being that caregivers must seek out themselves where to find and request support; a particular issue for those with language barriers (Williams and Rheingold 2013). A further problem is caregivers having their child's request for help rejected (Crenna-Jennings and Hutchinson 2018). They shared that over the last five years, the number of referrals to Child and Adolescent Mental Health Services has increased by 26%, but 55,800 children were not considered right for support.

Complex administration systems and processes are believed to be a further barrier to ensuring children attend appointments with caregivers needing to make many phone calls to find a clinician, to explain why their child needs to be seen and to explain the treatment history (Cohen et al., 2012; Radovic et al., 2014). Glascoe (1999); Tervo (2009); Woolfenden et al. (2014) and Ireland and Horridge (2016) highlighted that caregiver concerns have accurately predicted the presence of both developmental issues and disabling conditions in their children.

Long wait times are the most cited barrier to engagement with mental health services from service users (Golding 2010; Vohra et al. 2014; Iskra et al. 2015; Anderson et al. 2017). With some adolescents being made to feel they are not considered to be severe enough to be seen, deterring them from persevering with gaining an appointment (McCann and Lubman 2012). Further frustration for caregivers is believed to be when they make multiple referrals to many services, only to be then referred to another service and subsequent waiting list (Iskra et al. 2015). Gallucci, Swartz, and Hackerman (2005) and Westin, Barksdale and Stephan (2014) summarise that the evidence indicates that long waiting lists can harm family engagement with services for mental health support. They suggest this is due to delays in appointments being scheduled, the length of time between referral and appointment and the likelihood of the service user attending the first consultation.

**Materials and methods**

Interpretative Phenomenological Analysis (IPA) was employed as a qualitative research perspective which aligns itself to the assumption that phenomena have multiple, subjective interpretations (Guba and Lincoln 1994; Lewis and Staehler 2010). The method of IPA is based on the premise that humans interpret and understand their world by formulating biographical stories in a way that makes sense to them (Brocki and Wearden 2014; King et al. 2019) in each context, at a given moment in time (Cuthbertson, Robb, and Blair 2020). It is believed the strength of IPA is the level of rich detail in individual accounts which allows for in-depth analysis (Smith et al. 2009). Therefore, IPA enabled the researcher to gain a comprehensive understanding of the four caregivers' lived experiences of having children who had experienced multiple school exclusions, and drug misuse during a time with siblings living in the household (Smith and Osborn 2008; Smith et al. 2009; Flick 2018) providing insight into topics where little is known (Tompkins and Eatough 2012). The approach for IPA was ideal as it is acknowledged as being valuable when “examining topics which are complex, ambiguous and emotionally laden” (Smith and Osborn, 2015, 1). The method of analysis allowed the researcher to investigate if drug misuse is an indicator and predictor of barriers to mainstream schooling and school exclusion, to determine the extent of the barriers to mainstream schooling and to elicit and report the caregiver's experiences of their child’s drug misuse and the impact it has had on them, their child and their child’s siblings.

The researcher had an active role, through a two-stage process or double hermeneutic where the participant makes sense of their world, and the researcher tries to make sense of their perceptions of their experiences (Smith and Eatough 2007; Smith and Osborn 2008) by examining the complexity of their attitudes and emotions (Harding 2019). By synthesising collective lived experiences of participants, the researcher sought to represent their emotional, psychological, and transformative journeys (Colaizzi 1978; Giorgi 1985; van Manen 2014) and was concerned with understanding personal experience (King et al. 2019). Qualitative data collection methods were used to capture participant views, as is typical in interpretive research (Silverman 2000; Willis 2007; Nind, Boorman and Clarke 2012).

**Aims and objectives**

The research aimed to investigate if drug misuse is an indicator and predictor of barriers to mainstream schooling and school exclusion. The objectives were to determine the extent of the barriers to mainstream schooling and to elicit and report the caregiver's experiences of their child’s drug misuse and the impact it has had on them, their child and their child’s siblings.

**The sample**

Adhering to the approach of IPA, a small purposive sample was chosen (Collins and Nicholson 2002; Smith 2004). Through gatekeepers, the participants were selected for their lived experiences (Spiers and Riley 2019) in that they all had children who were excluded from school, who had misused drugs and had siblings living in the household (Smith et al. 2009). The caregivers who took part in the 1:1 interview was a mixed-gender sample of three mothers and one father (Kate, Maz, Zita and Jacob) with male secondary school age sons from 14-16 years of age. Three households had caregivers employed on a full-time basis with one currently unemployed. One was married to her son's father, two were in new relationships, and one was a single parent. Siblings were living in all households (see Table 1).

Twenty-one caregivers consented to take part in the original study; of these, four met the criteria for the IPA analysis.

* They had a child who had received both fixed-period and permanent exclusions
* They had a child who was involved in the misuse of street and/or prescription drugs
* They had siblings living within the household during their child's school exclusion

Table 1: Household profiles.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Caregiver name | Employed | Name/age  of child | Number of/reason Exclusions and Managed Moves | Diagnosed SEND | Disclosed drug use | Siblings |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Mother Kate,    Father Will | Yes | Ryan 14 | FeX (multiple) Persistent disruptive behaviour  PeX (2) Drug related/Persistent disruptive behaviour  One unsuccessful MM | No formal diagnosis | Xanax | One younger sister |
| Father Jacob | No | Tom 16 | FeX (multiple) Persistent disruptive behaviour/Drug related  PeX (1) Racist abuse | Epilepsies | \*Green, Tramadol, acid, ecstasy, other drugs unknown | One younger sister |
| Mother Maz, Father Rick | Yes (father only) | Huey 16 | FeX (multiple) Persistent disruptive behaviour/Drug related  PeX (1) Verbal abuse/threatening behaviour against an adult | No formal diagnosis | Green,  ecstacy | One younger sister, one older brother and two adult siblings |
| Mother- Zita  Father Karim | Yes | Mo 15 | FeX (multiple) Persistent disruptive behaviour/ Physical assault against a pupil  PeX (1) Verbal abuse/threatening behaviour against a pupil  Three unsuccessful MM | No formal diagnosis | Green | Two adult sisters |

Note. All names are fictitious. Fixed-period (FeX), Permanent Exclusion (PeX), Managed Move (MM)

\*’Green’ local name for cannabis

**Participant recruitment**

For the main study purposive sampling was used to recruit a homogenous sample of caregivers to ensure the participants were experienced and knowledgeable on the research subject (Palinkas et al. 2015; Embeita 2019). They were recruited through schools who provided placements for children with permanent school exclusions. The use of this sampling sufficed as it ensured the participants would have experienced the phenomenon being explored (Smith and Eatough 2007; Flick 2018). All caregivers were sent a letter outlining the research project, and this was followed up with a phone call from a member of the school staff who also shared the contact details for the researcher Martin-Denham (2020a, 2020b, 2020c). The sample for this journal article were retrospectively chosen for as they met the criteria for inclusion in the analysis.

**Data collection methods**

As advocated by Smith and Osborn (2003) data collection methods used for this research were individual 1:1 face to face semi-structured interviews, ranging from 30-90 minutes in length between September 2018 and June 2019. Open-ended questions supported the natural flow of conversation where respondents were able to express feelings while allowing the researchers to explore salient points relating to the research aims (O'Leary 2004). This approach is advocated by the phenomenological method as it focuses on the meaning's participants make from their experiences with the researcher taking a neutral, non-directive stance (Seidman 2012) with the participants as the primary expert (Alexander and Clare 2004). An inductive approach was taken whereby the participant (the expert) was asked to share their experiences and thoughts on school exclusion rather than using a priori hypothesis (Smith, Flowers and Larkin, 2009). Through this approach they could talk about what was important to them using their own terms.

During the interviews, it became apparent that the caregivers wanted to share broader issues that they felt contributed to their child's fixed-period and permanent school exclusions. As supported by (Griffiths, 2009) during the interviews there was drifting from the interview focus to allow the exploration of related but unanticipated topics, namely drug use, school exclusion and living with siblings. Smith, Flowers and Larkin (2009) advocate the researcher modifying questions considering the responses given and to enquire about interesting areas that arise in discussions. Using phenomenological interviews allowed the researcher to secure detailed descriptions of their experiences, feelings, perceptions and understandings of the caregivers' experience of requesting support for their child (Vagle 2014). All interviews were recorded using a Dictaphone and transcribed verbatim with the omission of personally identifiable information.

**Generalisability**

IPA has the overarching aim of determining the 'essence' of the human experience of a particular phenomenon (Lewis and Staehler, 2010). By describing typical characteristics of human experience, it is explained that phenomenology strives for empirical generalisation as the experience is deemed to be universal and a case in point (Flick, 2018). Smith, Flowers and Larkin (2009) share that as the idiographic approach of IPA studies is that they are conducted on small purposively selected samples the immediate claims made are bounded by the group studied. In acknowledgement of this view, Noon (2018, 81) suggests that the objective “should not be to uncover what occurs in *all* settings, but rather the perceptions and understandings of a particular group withing *their* setting”. A further issue is that no two analysts would interpret the data the same way, raising questions of validity and reliability (Golsworthy and Coyle 2001). The limitation of small sample sizes can result in IPA studies being difficult to publish due to concerns of representativeness and transferability (Charlick et al., 2016).

**Ethical conduct**

The original study gained ethical approval from the University of Sunderland's Ethics Committee (Martin-Denham, 2020a, 2020b, 2020c). The study was conducted under the British Educational Research Association guidelines (BERA 2018) obtaining voluntary, informed consent before any research was undertaken. Gatekeepers permission was sought and gained from the pupil referral unit or alternative provision where the caregivers children attended, every caregiver was invited to take part. From the initial interest only two declined on the day of the interview, so 41 took part, 4 with children in key stage 1, 16 from key stage 2/3 and 20 caregivers with children in key stage 4.

Following the Information Commissioner's Office (2019) participants were provided with information sheets and consent forms that included the procedure for processing their data, retention periods for the data and who it will be shared with, known as privacy information (Information Commissioner's Office 2019). Their right to withdraw, including time frames, were made explicit as suggested in the BERA (2018) guidelines. It was essential the caregivers were given explicit information on their anonymity as they were being invited to share intensely personal experiences where it was likely they would experience awkwardness, shame and anger (Noon, 2018). To overcome any harm to the participants they were invited to bring a safe adult to the interview with them, Kate, Maz, Zita and Jacob all elected to attend alone. I pre-arranged with the school where the interview would be held, ensuring we were given a comfortable and informal room where we would not be interrupted. During the interview I carefully monitored the body language of the participants, offering reassurance, comfort and time to take breaks if needed. I told all participants they could stop at any time, but despite being visibly upset they all wanted to tell their story to help and support other families who would inevitably going through similar experiences.

**Data analysis**

The approach to the analysis of the four interviews was based on the ideas of Husserl (1927) that phenomenology requires the careful examination of the essence of human experience focussing and reflecting systematically on lived experiences as they were experienced (Smith, Flowers and Larkin 2009).

Participants' names and other identifying information were changed to protect anonymity. Following the principles of IPA (Smith and Osborn 2003) the data were analysed in four broad stages:

* Detailed readings of the transcripts to obtain a holistic perspective and to document initial thoughts in note form
* Initial emergent themes from each interview were identified and organised into clusters
* Refining and condensing data to create superordinate themes and examining for connections and similarities across emergent themes
* Creating a narrative account of the interplay between the interpretations of the researcher and the participant's experiences in their own words

The transcriptions were coded using NVIVO 12 using open coding in the first instance. The original audio recordings were listened to, to ensure accuracy in the transcription, coding and arising themes. The transcripts were read multiple times to ensure the interpretation was part of the original account rather than the researcher's interpretation (Smith and Osborn 2003). The researcher read participants words identifying themes "patterns of description that recur repetitively as primary aspects of participants' description of their experiences" (Emaliana and Lailiyah, 128) and making notes (Smith et al. 2009). The themes were then carefully labelled once the overall name was determined. The researcher later revisited the themed transcripts to check accurate capture and to identify any misconceptions. The themes were quality assured by a third party for review and comment. The NVIVO 12 themes and phrases were then transferred to Excel for checking and interpreting.

**Limitations**

A limitation of the research is that the findings were the interpretation of the participant's views (Smith et al. 1999) meaning the analytical account produced was the joint reflection of both participant and researcher (Osborn and Smith 1998; Smith, Flowers and Osborn 1997). The results were the based on the experiences of the four caregivers which could have been interpreted differently by another analyst, raising questions of validity and reliability (Golsworthy and Coyle 2001). However, the research has uncovered the perceptions and understandings of the caregivers who experienced this specific phenomenon, as advocated by (Noon 2018).

**Results**

The following superordinate themes were derived from the data and were pertinent to the research aim and objectives:

* Barriers to mainstream schooling
* The drivers and implications for drug misuse on the household
* The impact of school exclusion on siblings
* Barriers to timely access to health services

**Barriers to mainstream schooling**

**First noticing difficulties**

All caregivers identified that their child had difficulties many years before their first school exclusion. They believed that there were indicators that challenges with their child's behaviour lay ahead, often, in the early years. Zita described that her son was born early in the second trimester and was advised by his then paediatric team that he may have difficulties physically and cognitively. "One [consultant] said in his early life up to adolescence; there are hurdles we might encounter, he might be without speech, he might be deaf or brain-damaged". She described how there were no issues during nursery school but recognised he had an exuberant personality and that he was quite mischievous. Zita recalled his year one teacher calling her over at the end of the school day to say "We have had a lot of silliness today". Similarly, when her son was in year one, Kate was informed by the class teacher "You know your child is a bit lively. He doesn't want to sit down in class". The impression given by both these caregivers was that the teachers weren't overly concerned about their behaviour but that it was seen as typical ‘boy’ behaviour.

The majority of caregivers cited key transition phases in school as significant in behaviour changes, finding it difficult to articulate why their behaviour changed to such an extent during this stage. "Infants was fine. Then he went in with one teacher he didn't gel with. From then, he started to fall behind in junior school. He was a little naughty more mischievous" (Maz). "I started to work with the school closely because his world fell apart in Year 7. Emotionally, his wellbeing, his psychological wellbeing. The fact that there was a lot of changing expectation in the Year 7 setting. Because he was used to primary, and you have to conform quickly to Year 7 expectations" (Kate). "In nursery and primary, he was great, right up until the last year of Primary. He started acting up, went into the Comp and throughout the Comp, he just couldn't handle it, in his words. He would lash out and shout. More anger than anything else, and the school just didn't seem to be able to cope with him" (Jacob).

**Mainstream school not supporting children with special educational needs and disabilities**

All the caregivers intimated that requests for meetings to get referrals for support were not positively responded to "no one seemed to take any responsibility, in the end, we shouted so loud we got someone to the house" (Zita). There was a familiar pattern across all four interviews that keeping their child in mainstream education was an ongoing battle. The main commonality across all caregivers was the intense portrayal that schools faced both internal and external barriers to providing timely mental health and educational support for their children. Their frustrations at their lack of control over getting support for their child from school was apparent in all the interviews, none of the children were on the SEN register despite their challenging behaviours in school. They all felt that the lack of schools listening to their concerns or forthcoming support from school were compounding factors that led to their child's difficulties with accessing mainstream school. They felt that critical to providing support was understanding the impact and range of adversity and learning challenges experienced by their children.

Zita expressed frustration and despair at schools' focus on attainment at the cost of mental health support "They didn't give a shit [after mum informed him of his best friend's death]. Maybe he didn't disclose it. But I did. No one cared; they were all too busy. No time. Why can't they scrap all the targets? And scrap all the pressure from the Head". The lack of mental health support was also of concern to another caregiver "there needs to be more support, the support is there, but the school 'um and er' because they have to pay for it. They shouldn't have to pay for mental health support for children. It shouldn't be" (Maz). There was a view that interventions were unhelpful when the mental health needs of the children were not identified or prioritised in school. This was described with varying degrees of intensity depending on their personal experiences and relationships with the school "the interventions I found weren't helpful, this is just my opinion, but I don't think they were much good for him, because his health and wellbeing wasn't looked after in the same process" (Kate). Zita recalled her anger at having to repeatedly ask for a referral for support, to gain access to a counsellor for her son "We even said 'Can we have a meeting? There is obviously something wrong with him.' We realise there is something wrong with behaviour now. I wanted them to have doctors involved, referrals. I referred him to everywhere I could, but no one seemed to take any responsibility. In the end, we shouted so loud that we got someone to the house". Maz did secure someone to support her son's anti-social behaviour which she felt was effective, but they were not able to work with him over a long enough period of time to make a long-term difference.

Three of the caregivers' accounts described how their children encountered difficulty with learning and accessing the teaching in class, causing their behaviour to worsen. They all agreed that the focus of schools is on academic accomplishment and that for their children, this was a key factor in the demise of their behaviours. "As time went on, my son's behaviour worsened. He isn't academic. He fell behind a lot. I think because he couldn't catch up. He wasn't understanding. His behaviour started. It was a cycle" (Maz)

*"He said that a lot of it was because he couldn't do the work. He said he told them that the work was too hard and that he needed to go into a different group or something like that. But the school said it was because he wanted to be with his friends. Possibly it was partly that. But that's what he put it down too. That he couldn't do the work. So he would sit there and do nothing because he didn't know what he was doing?*" (Jacob)

*"He was quite open with saying that he couldn't keep up with everyone else. Therefore his heart wasn't in the right place when he walked in the door. He knew from when the bell went he wouldn't be able to keep up with the work, he won't be able to ask for a teacher for fear of getting on their nerves"* (Kate)

**Unrealistic behaviour expectations**

The caregivers agreed that strict and unrealistic behaviour expectations were placed on their children which directly affected their ability to cope in mainstream school. It was made clear that they felt the processes and systems of discipline in schools did not improve behaviour but made it worse. This was due to an expectation of consistent conforming to school rules with a zero-tolerance approach to what the schools perceived to be negative behaviours. Zita stated that "you did something wrong and you were tarred, that reputation stuck". She talked about how processes and systems of discipline do not work; her son had 310 recorded incidents of negative behaviour over three years with sanctions such as detention and lines that did not affect or improve their behaviour. Kate also felt that these systems were not realistic for her son "The expectations of, not behaviour, but of conforming readily. All of the time. Sit. Speak. Work". The implications of their children not conforming to schools' standards of behaviour were frequent requests for the caregivers to come into school. There was a strong sense that the school held control and made decisions about whether the child would be able to remain in school.

*"Every time he did something at school we got called in. We were having weekly meetings, putting him on this plan to do this. They were saying at one point, if he comes in Monday and does four days, he can have a day off to do whatever he wants"* (Jacob).

The inflexibility of behaviour points was that where children had difficulties with learning and mental health needs, it was not possible for them to adhere to zero tolerance compliance. This was a particular difficulty for Zita’s son when he was on a managed move. There was the expectation that he would follow the same sanction system as everyone else despite his difficulties with learning and compliance.

"Apparently he shouted out in class and on a managed move you can't. I said ‘*Mind; he has been expelled, he has come from a PRU, you are saying if he gets more than three behaviour points, then you will kick him out? How can you expect him to go from that to being an angel? Surely, there will be allowances. I was thinking please; someone listen, we are setting him up to fail"*.

**The drivers and implications of drug misuse**

All of the caregivers talked about how their children became addicted to drugs to the extent that two continue to have drugs tests to check they are clean. As outlined in Table 1, the young people consumed a range of drugs, including Xanax, Green, Tramadol, Acid, Ecstasy, Pills and other unknown drugs during the time they were in mainstream education and beyond this period. The reasons the caregivers gave for their children taking drugs were varied. Kate explained why her son takes Xanax, that he acquires from drug dealers "it helps him relax, he feels he has always been a single person in the middle of the crowded circle around him but when he takes that he feels a part of that circle. That's the way he describes it, it is not to feel good, he took drugs, so he didn't even know where he was". The other caregivers talked about their children being "hooked" and the ease in which drugs are accessible in the local area "He was taking anything he could get his hands on. He says you can walk down the street and you have walked past a dozen dealers without knowing" (Jacob). He added that his son began smoking green when he was 12 or 13 years of age during mainstream education, before moving onto "heavier stuff". Similarly, Maz described how her son would take anything he could get his hands-on including pills. For her son, his drug misuse lessened following the death of his best friend from the use of street drugs. Zita also explained that her son "was hooked at this point [during mainstream school] as well (to green). He has admitted later that he was addicted to it. When he was getting pocket money that it was all going on that" (Zita). Kate, Jacob and Zita discussed the physical effects of drug-taking on their children, including consequences of ongoing addiction. Kate shared physical effects "I had to feed him, dress him, sit up with them all night make sure that he was still alive the next day because he was taking them so much". Jacob shared that following an accidental overdose their son now has epileptic seizures, these are ongoing and will affect him for the rest of his life.

**The psychological impact of drug misuse on caregivers**

The strain on caregivers of having to deal with the psychological impact of drug misuse was palpable in the interviews. They all shared the detrimental effect on their mental health due to having a child dependent on drugs. Kate used terms such as "exhausted" and "I can't do it anymore, go on for much longer" when reflecting on the impact on her psychological difficulties. She described how she loses her train of thought, is forgetful alongside feeling "frustrated and snappy". Similarly, Maz explained that she felt like she was going to have a breakdown, saying she could not cope anymore. She felt powerless to help her son, she had wanted to keep him in the house forcibly but thought she would end up in trouble with social services. Zita also described feeling like she was "on her knees" sharing that she considered getting on a one-way train and not returning. Her son had punched her once, and she was "exhausted, I have been very sad for years". Jacob was undergoing treatment for cancer during the peak of his son's drug misuse, and like Zita shared there were times "I was in tears in the house, I didn't want him there". He perceived that his son did not care, so he involved police and social services, signing the papers to place him in residential care. Still, no one was prepared to take him due to the extent of his difficulties being presented in the paperwork.

**The psychological impact of drug misuse on a young person**

All the caregivers described the detrimental impact of drug misuse on their child's mental health. Jacob explained how under the influence of drugs his son believed he had inappropriately touched his sister; this resulted in the son having to move households. Zita referred to her child "feeling down," saying he alluded to the fact he was suicidal. She described the enormity of the change in their child "his personality changed. He became horrible. We knew this; we knew the signs and symptoms. He became a different boy. It all went tits up". Maz also shared concerns of ongoing mental health issues experienced by her son saying, "he does get low, he gets depressed". This view is shared by Kate, who described ongoing issues with her child as his wellbeing is "completely shattered" due to a lack of support during this time.

**The long-term impact of drug misuse on the child**

During the time, her son was under the influence of drugs; Kate would have to feed him, dress him, and sit up with him all night. She described how the volume of drugs he was consuming meant she was not sure he would be alive the next day. These concerns were shared by Jacob as his son unintentionally overdosed on Tramadol and ended up in the hospital and as a result, has epilepsy "he still has seizures, he came home a couple of days ago and had a fit in the bedroom, he bit his tongue and cheek, I said that's something you will have to live with for the rest of your life".

Two of the young people became involved in criminal activity when under the influence of drugs. Jacob shared his son was carrying weapons, "knives, bars, anything he could get his hands on. He was hallucinating and was caught stealing and got arrested. The hallucinations caused him to steal and threaten his dad and to say he was going to decapitate his sister". Zita explained that her son now has a criminal record for stealing and taking drugs at school "irreparable damage has been done, he has lost an education, he has paid the price, the ultimate sacrifice he was permanently excluded".

**The impact of school exclusion on siblings**

The analysis of the comments from the caregivers raised essential points. Firstly, that siblings are often overlooked by services and the focus is on the child consuming drugs and encountering difficulties in school "they are just forgotten, there are no meetings about how it is affecting the other children" (Kate). She felt there needed to be support for the children remaining in the school so that their mental health needs are protected. Kate reported that her younger daughter struggles with what her brother has evolved into and says she is worried that the school is judging her waiting for her to become like him. Maz agreed with Kate saying that "how it has affected the other children is wrong". Her youngest son is replicating her son's behaviours but not to such an extreme level. She has concerns that her two adult children have had to intervene by restraining him to prevent him attacking his younger sibling "he will pull at me to get to him, he would just get a mist and lash out". Jacob has a much younger daughter with his new partner, and because of social services involvement, his son can never be alone with her, so he hardly ever sees her. Zita also recalls her eldest daughter having to restrain her son, though she feels they are very close "she is the only person that my son would listen to until recently, she is the only one who can control him. He has never fought against her even if she went to restrain him". Zita reflected that her daughters seemed to fade into the background at home to the focus of attention on the son.

**Barriers to timely access to health services**

Three caregivers agreed that there are challenges in securing assessments for underlying disabilities from health professionals. Kate recalled waiting for years for a diagnostic evaluation to understand better the underlying reasons for his difficulties with behaviour and learning. She talked about feeling "let down" as any diagnostic assessments she suggested to the General Practitioner (GP) were met with a response of "work with the school." Similarly, Zita said she wanted to have doctors involved "I referred him to everywhere I could, but no one took any responsibility". Maz felt that there was a reluctance to diagnose any underlying disabilities, appointments were cancelled and when he was seen by mental health services they said he did not have mental health problems despite the caregiver sharing he seemed depressed following his best friend's death. In this case, the GP referred him, but the health practitioner said, "I'm not here to diagnose him, I'm here to listen to him". Two of the caregivers felt strongly that family grief could have been a contributing factor that led to changes in their child's behaviour and their need for specialist support from schools and external agencies. However, despite requests, this was not forthcoming. It is important to acknowledge that Jacob did not raise access to health professionals as an issue. This may be because of the extent of his drug misuse that social services, police, and health services were involved with the family from the age of 12.

**Discussion**

The research aimed to investigate if drug misuse is an indicator and predictor of barriers to mainstream schooling and school exclusion. The objectives were to determine the extent of the barriers to mainstream schooling and to elicit and report the caregiver's experiences of their child’s drug misuse and the impact it has had on them, their child and their child’s siblings.

This research has provided an insight into the perceptions and lived experiences of four caregivers in the North East of England. The data from interviews suggests that there are wide-ranging and co-existing factors that contribute to a child's exclusion from school and subsequent drugs misuse. Based on the results of the research several conclusions can be drawn under the four broad themes namely, barriers to mainstream schooling, the drivers, and implications of drug misuse on the household, the impact of school exclusion on siblings and barriers to prompt access to health services.

Using interpretative phenomenological analysis, the study has highlighted the necessity to provide prompt intervention and support to children and households as soon as behavioural changes and concerns are reported by caregivers. The Children and Families Act (CAFA) (2014) strengthened the statutory requirement for caregivers to be involved in decisions that affect children with special educational needs and disabilities (SEND). Of concern, is that during their mainstream schooling none of the children were on the SEN register, despite multiple behaviour sanctions, official school exclusions, they were not recognised or protected by the CAFA. They were placed on the SEN register following their final school exclusion by their alternative provision provider and referred for assessment of SEND. All the caregivers suspected their children had underlying disabilities many years before their first school exclusion, but they encountered barriers to having their child referred for assessment and identification from both schools and health services. This concern has been raised historically by Boyd et al. (2011); McCann and Lubman (2012) and Iskra et al. (2015), the solution is to publicise services and for schools to signpost to services at the first point of concern. It will only be through training for education professionals and revised health pathways that understanding can be gained of what lies beneath the range of behaviours that children present with so that caregivers can be supported in navigating referral pathways to support.

The importance of prompt and supportive multi-agency referrals is paramount to ensure timely identification and assessment from a non-fragmented system (Driver Youth Trust 2015) that identifies and captures each and every need children present with so they can be addressed (Horridge 2019). These factors coupled with a lack of transition support between school years and key stages compounded barriers to learning leading to disaffection and increasing mental health needs. As recognised by (Martin-Denham 2020a, 2020b, 2020c) it is clear from the data analysis that a key barrier to mainstream schooling was unachievable behaviour expectations placed on children by schools. It seems that systems and processes to ‘manage’ behaviour in school are, instead compounding behaviour and marginalising children who cannot be compliant all the time. Until the pressures for academic achievement are removed and the myriad of special educational needs and disabilities are identified, addressed, recorded and shared across agencies that these children will continue to be subject to unrealistic curriculum, unachievable progress targets, and unobtainable behaviour expectations. There can be no doubt that until children have their social, emotional and mental health needs met they will not be able to participate and learn in school.

The collateral damage caused by barriers to mainstream schooling, coupled with a lack of evaluation of underlying needs led to dire consequences for these children. The caregivers shared that their children consumed illegal drugs during their time in mainstream school. The reasons the children began to consume drugs included to cope with grief and to cope in social situations, it has become a form of self-medication, to relax and not be aware of the world around them. The evidence suggests that drug use is a predictor of both barriers to mainstream schooling, a predictor of school exclusion and in some cases lifelong physical disabling conditions. For all the children taking one street drug led to further drug use and a more extensive range of drugs being taken, this led to addiction in all cases. As McCrystal, Percy and Higgins (2007) raised the issue of children excluded from school being at increased risk of drug use but also marginalisation from society of adults. Had these children not had access to a high-quality alternative provision they may not have had such positive outcomes.

The strain of having a child in a household consuming illegal drugs was widely shared by all four caregivers. Having children reliant on drugs affects the whole household, including the siblings who are often overlooked in terms of both support and empathy. It was clear that supporting a child through both school exclusion and drug use had a deleterious effect on the caregiver's mental health to such an extent that, for many, they felt exhausted. The impact of drug misuse compounded challenges in accessing education but more importantly, their ability to lead a healthy life and for some led to a criminal record. The long-lasting impact of drugs for one of these children is lifelong epilepsy. This research is original in that it has exposed the effects of drug misuse as a predictor of barriers to mainstream schooling and a factor in school exclusion. It has also raised concerns that need to be addressed on the impact on siblings living within the household. They too need support and empathy as they are at the epicentre of the experience often without an understanding of how the situation is affecting their mental health.

The study also highlights the extreme impact on the caregivers' mental health, which in these instances suffered detrimental effects. School exclusion and drug misuse affect the whole family and training is needed for schools and local communities to understand the detriment it can cause. This is seemingly due to not having their concerns responded to and a distinct lack of service availability. There is a clear need to provide holistic support to the whole household to enable them to support their children.

**End remarks**

The research aimed to investigate if drug misuse is an indicator and predictor of barriers to mainstream schooling and school exclusion. The objectives were to determine the extent of the barriers to mainstream schooling and to elicit and report the caregiver's experiences of their child’s drug misuse and the impact it has had on them, their child and their child’s siblings.

There needs to be national resources to tackle supporting young people on the edge of school exclusion through reintegration back into education. An in-depth qualitative study would provide greater insight into the lived experiences of this group; we need to understand the drivers for drug misuse and work with children to find alternative coping mechanism. A further study would also provide insight into the nature of drug misuse, access to drugs and the factors that lead to young people being drawn to taking them. This would allow multi-disciplinary professionals to better support children, caregivers and siblings to prevent the short and long-term adverse effects of drug misuse.

It is hoped this study provides insight into the factors that contributed to fixed period and permanent school exclusions. It also provides solutions and identifies the importance of collaboration with families and multi-agency approaches.

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