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Publication 4: Martin-Denham, S. (2020c) A review of school exclusion on the mental health, well-being of children and young people in the City of Sunderland. Sunderland: University of Sunderland.

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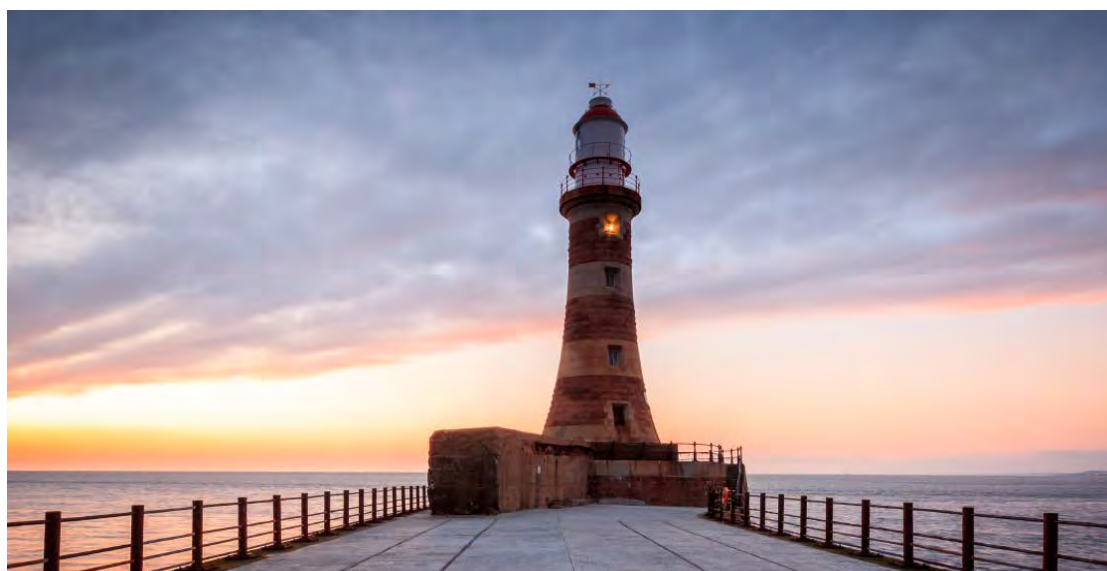


**University of  
Sunderland**

  
**Sunderland**  
City Council

The prevalence of Special Educational Needs and Disabilities (SEND)  
identified in young people, aged 3-16, across the City of Sunderland:  
University of Sunderland, School of Education

**May 2017**





## 1 Abstract

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This paper presents the findings of a mixed methods investigation into the prevalence of Special Educational Needs and/or Disabilities (SEND), identified in children and young people aged 3-16 years, across the City of Sunderland. This study was commissioned by Sunderland City Council, with the aim of informing their 5-year strategy for SEND provision. In providing a backdrop for this investigation, three inter-connected literature bases are explored; firstly, the demographics of the City of Sunderland and the current legislation surrounding SEND; secondly, the literature surrounding the specific primary need of Autism is analysed; and thirdly, literature highlighting alternative forms of education is presented and discussed. Analysis of data gathered through both qualitative and quantitative research methods has highlighted a range of foci for the Council, in formulating their 5-year SEND strategy. The data has indicated that there is a particularly high prevalence of children identified with Social, Emotional and Mental Health difficulties, as well as Autism and Moderate Learning Difficulties in Sunderland compared to national averages. Conversely, there is a lower than expected prevalence of children identified with Specific Learning Difficulties. The recommendations from this study focus on providing quality Continued Professional Development (CPD) opportunities in relation to meeting the varying needs of the SEND population, particularly for Special Educational Needs Co-ordinators (SENCOs); clarifying the role of the Designated Medical Officer (DMO); exploring opportunities for data sharing and ensuring that developing opportunities for effective multi-agency working are a priority for the Council.

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### **3 Executive summary**

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The University of Sunderland, School of Education were commissioned by Sunderland City Council to undertake this piece of research. The aims of the research were as follows:

- To carry out analysis of existing data sets from the Council to gain insight into extent and nature of special educational needs and disability requirements for 3-16 year olds in Sunderland.
- To carry out qualitative research with key stakeholders from the National Health Service (NHS) and Clinical Commissioning Group (CCG).
- To produce a report with supporting evidence on findings to inform Sunderland City Councils 5-year strategy.

The research methods employed in this study included the examination of Pupil Level Annual School Census (PLASC), Early Years Foundation Stage (EYFS) and Department for Education (DfE) data to examine the prevalence of SEND in Sunderland, with comparison to national statistics. Qualitative, semi-structured interviews were undertaken with two Stakeholders from the CCG and the NHS in Sunderland. We also carried out geographical mapping of children and young people with a diagnosis of Autism Spectrum Disorders (ASD) in Sunderland to inform the five year plan for provision. In addition there was analysis of High Needs Funding, Children missing from education and the primary need of children and young people in Pupil Referral Units (PRU).

To enable effective data analysis ten themes were agreed:

- Theme 1:** Analysis of the prevalence trends based on identified primary need: children and young people 5-16 years in Sunderland (2013-2017).
- Theme 2:** Analysis of the prevalence of identified primary need: children and young people 5-16 years based on school year and key stage in Sunderland (2017).
- Theme 3:** Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support in Sunderland (2017).
- Theme 4:** Analysis of national data compared to Sunderland City Council data based on primary type of need identified in children and young people 5-16 years (2016).
- Theme 5:** Analysis of Early Years data (reception year) by primary type of need and Good Level of Development in Sunderland (2014 – 2017).
- Theme 6:** Analysis of interviews with the NHS and CCG.
- Theme 7:** Analysis of the prevalence of Autism Spectrum Disorder in the City of Sunderland (3-16 years) (2017).
- Theme 8:** Analysis of high needs funding.
- Theme 9:** Analysis of the primary need of children missing from education in Sunderland.
- Theme 10:** Analysis of the primary need of children and young people in Pupil Referral Units (PRU).

### **3.1 Main findings: Primary need PLASC data**

The most prevalent primary needs in Sunderland are:

- **Moderate Learning Difficulties (MLD)**, though the data shows that the number of children and young people identified with MLD have fallen since 2013.
- **Social, Emotional and Mental Health (SEMH)**
- **Speech, Language and Communication Needs (SLCN)**
- **Autism Spectrum Disorders (ASD)**, this has seen an increase year on year since 2013

**Recommendation:** For the Council to examine with SENCos their knowledge and understanding of Moderate Learning Difficulties and to use this information to plan CPD to support educational contexts in accurate identification to meet the needs of children and young people with MLD.

**Recommendation:** Due to increase in prevalence of SEMH between 2016 and 2017, it is recommended that the Council support a focus on early identification of SEMH and ensure that all educational settings in Sunderland are equipped to support children and young people with this primary need.

When considering year group and key stage, the PLASC data identified:

- There is a notable rise in children identified with SEMH from Year 5 to Year 6, in Year 9 and in Year 11.
- In the primary age phase, there is a notable increase in MLD identification from 2.68% of all children in Year 1 to 5.55% in Year 6. The number of young people with MLD peaks between the Key Stage Two and Key Stage Three transition point.
- The number of children identified with SLCN in Sunderland peaks in year 1 at 6.14%. Then there is a dramatic reduction in rate of identification between Year 1 and Year 6. This indicates that the early years and early primary age phases are effectively supporting children in developing age-appropriate speech, language and communication skills.
- The numbers of children identified with ASD as a primary need in Sunderland remains relatively constant across year groups. However, there are notable peaks in prevalence following Key Stage transition points.
- The numbers of children identified with Specific Learning Difficulties (SpLD) in Sunderland are exceptionally low, as a proportion of all children identified with SEND.

**Recommendation:** For the Council to review existing models for effective multi-agency working and explore means by which greater collaboration between clinical teams, educational psychologists, SENCos and CAMHS can work together to support early intervention in educational contexts, by identifying geographical and age related hotspots for SEMH difficulties (DfE, 2015a; Eames and Shippen, 2017).

### **3.2 Main findings: Primary Need by classification (SEN Support, Statement of SEN and Education Health and Care plan)**

- 322 children and young people in Sunderland currently have a Statement of SEN, with 481 children currently in receipt of an EHC plan. This equates to 40% of children who need to be transferred from a Statement of SEN to an EHC plan by April 2018.
- The most prevalent primary needs for those identified as **SEN Support** in Sunderland are:
  - **MLD** (30.56%)
  - **SEMH** (22.94%)
  - **SLCN** (19.60%)
- The most prevalent primary needs for those who have a **Statement of SEN** in Sunderland are:
  - **ASD** (30.12%)
  - **SEMH** (18.32%)
  - **SLCN** (16.77%)
- The most prevalent primary needs for those who have an **EHC plan** in Sunderland are:
  - **ASD** (34.30%)
  - **SEMH** (24.53%)
  - **SLCN** (17.67%)

**Recommendation:** For the Council ensure the timely transfer of all 322 children currently in receipt of a Statement of SEN to an ECH plan, prior to April 2018.

### 3.3 Main findings: National and Sunderland City Council PLASC data

There is higher prevalence of children on Statements/EHC plan, compared to national data, with the following primary needs:

- **Social Emotional Mental Health:** National prevalence = 12.3%; Sunderland = 26.3%.  
This represents an increase in prevalence of **+14.03%** in Sunderland.
- **Autism Spectrum Disorders:** National prevalence = 25.9%; Sunderland = 31.03%.  
This represents an increase in prevalence of **+5.13%** in Sunderland.
- **Physical Disability:** National prevalence = 5.8%; Sunderland = 10.14%. This represents an increase in prevalence of **+4.34%** in Sunderland.

With regard to SEN Support, compared to national data, Sunderland has a higher prevalence of children with **Moderate Learning Difficulties**, at **32.72%**. This is **5.92%** higher than the national average.

**Recommendation:** For the Council to use the National Data to monitor the prevalence rates of SEMH in Sunderland to inform future service planning and CPD needs of educational contexts. There needs to be further analysis carried out as to why SEMH is 14.03% above the national average.

There is lower prevalence of children on Statements/EHC, compared to national data, with the following primary needs:

- **Moderate Learning Difficulty:** National prevalence = 13.4%; Sunderland = 5.93%. This represents a decrease in prevalence of **-7.47%** in Sunderland.
- **Severe Learning Difficulty:** National prevalence = 13.1%; Sunderland = 7.29%. This represents a decrease in prevalence of **-5.81%** in Sunderland.
- **Specific Learning Difficulty:** National prevalence = 4%; Sunderland = 0.37%. This represents a decrease in prevalence of **-3.63%** in Sunderland.

**Recommendation:** For the Council to respond to the under identification of SpLD by evaluating the effectiveness or impact of arrangements for identifying and assessing the needs of specific groups of children and young people with SpLD across provision in the City. This will require the Council to provide school based training on neurodiversity.

### 3.4 Main findings: Early Years

- The main primary need is SLCN within Early Years in the current academic year with 55.61% of all children with identified need.
- The second highest primary need is SEMH is 11.48% of the SEND population.
- ASD is the third most prevalent primary need of 10.97% of the SEND population.

**Recommendation:** To explore providing an accredited SLCN programme for early years practitioners, either level 2 (GCSE) level 3 (A level equivalent) or Undergraduate credits (Level 4, 5, 6) or MA credits (level 7).

### 3.5 Main Findings: Interviews

- **Multi-agency working**

- Collaboration between Education and Health was deemed to be effective. This was cited as being due to open and honest communication between stakeholders.
- The participant from the NHS considered working closely with Social Care to be more challenging due to higher thresholds for working with families in light of demands on the service provision and staff changes in Child and Adolescent Mental Health Services (CAMHS).

**Recommendation:** For the Council, in collaboration with stakeholders to examine ways of consistently engaging social care to promote effective multi agency working across the stakeholders.

- **Increase in prevalence of specific needs**

- It was suggested by interviewed participants that there has been a significant and visible increase in the number of children and young people identified with ASD, Diabetes, Child Obesity and Child Mental Health Difficulties in Sunderland over recent years.

- **Relationships with parents**

- Good practice was identified with regard to the building of effective relationships with parents and carers. Multiple examples of engagement opportunities were highlighted particularly within the NHS
- There was a suggestion that some parents were reluctant to liaise with social care due to possible underlying stigma related to social services.
- Good practice was evident in terms of supporting parents when a child is born prematurely; clear pathways of support exist within the NHS.



- **Supporting SENCos**

- There is currently no standardised exemplar EHC plan used by educational settings which can result in setbacks when there is incomplete or inconsistent evidence at SEN panel meetings. This is resulting in some children and young people encountering delays in acceptance of EHC plans and frustration for those involved in the process.

**Recommendation:** For the Council to devise and distribute an exemplar Education, Health and Care Plan and accompanying evidence to support SENCos. This will have the added benefit of improving the efficiency of the SEN panel meetings.

- **Data sharing**

- One respondent identified challenges in meeting the needs of children and young people who have been educated in multiple settings, often due to inadequate data sharing across settings. This was believed to be particularly widespread when children have attended Pupil Referral Units (PRUs) and/or young offender's institutions.
- Both respondents interviewed identified that there are opportunities for improvements in data sharing across the services.

**Recommendation:** To formally assess children and young people in a PRU context on entry, to ensure that their range of needs are identified early and that EHC plan can be either created or updated to reflect their current needs. This assessment must involve multi-agencies, as it is highly likely that the child will require support from CAMHS as well as from the educational setting itself.

**Recommendation:** Review current data sharing policies to enable sharing of data, where appropriate, between CCG, NHS Digital, LA and DMO to inform better identification of needs and local decision-making around SEND.

- **Role of Designated Medical Officer (DMO)**
  - Both respondents interviewed in this study highlighted that the responsibilities associated with the DMO role require clarification as it is currently a shared position.

**Recommendation:** For the Council to devise role descriptions, clearly delegating specific responsibilities to the two parties sharing the DMO role. These should focus on supporting joined up working across Education, Health and Care.

### **3.6 Main findings: Prevalence of Autism Spectrum Disorders (ASD)**

- The Autism Outreach Team (AOT) have reported that there are 6 new diagnoses of ASD per week in Sunderland, which is reflected in the very high prevalence rate of ASD across all Key Stages, when compared to national figures, and particularly in Key Stage 2. This could be due to the broadening of diagnostic criteria in recent years and/or increased awareness of Autism.
- There are areas where prevalence rates are higher, such as Washington North and Shiney Row. However, the reasons for this are unknown and could be due to population rates.

**Recommendation:** For the Council to conduct additional analysis into where there needs to be additional provision particularly in terms of nursery and school placements and where the children and young people reside, this should inform capacity building within the Autism Outreach Team. The local offer needs to be reviewed to ensure it effectively signposts families to support and services.

### 3.7 Main findings: High needs funding

It is evident from discussions with the stakeholders that Sunderland City Council has a robust banding system in place that is transparent and related to costed provision planning.

Following discussions with stakeholders it is clear the Council operate a robust, costed four point banding system for allocation of funding on a per pupil basis. This has been in place and will remain in position during the academic year 2017-2018. A second phase of consultation by the DfE (2016a) on the new National Funding Formula (including a consultation on funding for High Needs which ran concurrently) closed on 22<sup>nd</sup> March 2017. Due to the date of the closure and the time of submitting the completed research to Sunderland City Council it was not feasible to future forecast beyond the current financial year.

Until the government release their findings from this consultation and legislate for the new funding formula, it is not appropriate to make predictions although there is a guarantee that in 2018-2019 no school will receive more than 1.5% reduction per-pupil funding and a 3% overall cut for this financial year. It would be wise to assume that this would be based on pupil data from 2017-2018, as has happened historically, although this is not specifically highlighted. Further to this per-pupil gains in funding are capped at 3% for 2018-2019 and 2.5% in 2019-2020.

Using these discussions and the limited amount of information available, Sunderland City Council should consider the following recommendations:

**Recommendation:** For the Council to develop a strategic SEND Provision map for the next five years in line with guidance (DfE, 2016a). This map will support optimal allocation of funding, resources and provision for SEND across Sunderland. The data contained in this report will support this process.

### **3.8 Main finding: Children missing from education**

- Unfortunately current data was not available. The following recommendation is therefore made:

**Recommendation:** For the City Council to appoint a senior officer responsible for obtaining and collating data on children missing from education to ensure they are meeting their statutory obligations.

### **3.9 Main finding: Primary needs of children and young people in a Pupil Referral Unit (PRU)**

- 86% of children and young people are identified as SEMH as their primary need with 101 children on SEN Support and 1 with an EHC Plan (also for SEMH).

**Recommendation:** For the Council to commission further research into effective alternative provision models that support children and young people in achieving good outcomes in terms of education and to examine good practice approaches in meeting social, emotional and mental health needs.

#### 4 University of Sunderland: Researchers and Authors

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The planning for this research began in January 2017, following full ethical approval from the University of Sunderland Ethics Committee, with data collection beginning in February 2017. This research was conducted in accordance with University of Sunderland ethical protocols and the BERA (2011) Guidelines for Educational Research.

##### **Project Director, Lead Researcher and Author: Sarah Martin-Denham**

Sarah is a Senior Lecturer at the University of Sunderland and the Lead for Special Educational Needs and Disability in the School of Education. She has extensive knowledge of teaching in the North East of England in a variety of settings from Early Years to Post 16, where she has developed a particular interest and expertise in meeting the needs of children and young people with Special Educational Needs and Disabilities. Sarah is the Programme Leader for the Post Graduate Certificate National Award for Special Educational Needs Co-ordination, and she leads and teaches on the MA Special Educational Needs, Disability and Inclusion. In addition, Sarah teaches on the Initial Teacher Education programmes to extend trainees knowledge and understanding of meeting the needs of children with diverse learning and care needs. Sarah's research interests include how we can better meet the needs of excluded children and young people through effective professional learning and collaboration with families. She is also interested in how the Special Educational Needs Co-ordinator (SENCo) can be enabled to effectively lead improvements in provision and practice for children and young people in partnership with parents and carers. Her recent publications include Martin-Denham, S. (Eds.) (2015) *Teaching Children with Special Educational Needs and Disabilities 0-25 years*. London: Sage and a collaboration with Stewart, C. (2017) SENCO magazine: 'Ports in a Storm'. Teach Primary.

**Head of the School of Education: Dr Lynne McKenna**

Lynne is Head of the School of Education and Head of Research in the Faculty of Education and Society at the University of Sunderland. Prior to this, Lynne was Director of Initial Teacher Education in the Faculty of Health and Life Sciences at Northumbria University. Lynne has a wealth of experience as a practitioner, a senior education manager and a researcher in teacher education, family learning and parental engagement. Prior to joining the University, Lynne designed and delivered one of the fourteen national pilot Family Numeracy Programmes. She was involved in the evaluation of the pilot project and contributed to the Basic Skills Agency/NFER (1999) final report Family Numeracy Adds Up. As Family Numeracy co-ordinator for South Tyneside Local Authority, Lynne was responsible for the roll out of this programme. She has conducted a number of evaluations of Sure Start programmes. More recently Lynne led a social impact research which examined the impact of the Foundation of Light's Wider Family Learning programmes (2012). Lynne was a member of the research reference group for the National Inquiry into Family Learning which published its final report in October 2013. Lynne is also an invited member of the Early Intervention Foundation Evidence Panel.

**Professor of Vocational Education: Professor Maggie Gregson**

Maggie is Professor of Vocational Education, Director of the University of Sunderland's Centre for Excellence in Teacher Training (SUNCETT) and Research Lead for the School of Education. From 2003- 2005 she was a Principal Investigator, in an Evaluation of a Thinking Skills in Schools in Northumberland Project and Lead Author in the final report Raising Achievement and Aspirations in Northumberland. Maggie was invited to present advisory evidence to the National Commission for Adult and Vocational Teaching and Learning (CAVTL) in 2013. She is a member of the National Expert Panel Member the ETF Professional Standards for teachers and the Panel for Higher Level Technical Education. Her research interests include the initial and continuing professional development teachers and the collaborative approaches to educational evaluation and improvement.

Her recent publications include, Gregson, M and Hillier, Y. (eds.) (2015) *Reflective Teaching in Further, Adult and Vocational Education*. London: Bloomsbury Press and Gregson, M. , Nixon, L. Spedding, P., (eds.) (2015) *Readings for Reflective Teaching in Further, Adult and Vocational Education*. London: Bloomsbury Press. She is currently Principal Investigator for the ETF National Research Development Fellowship and Exploratory Research Programmes which support practitioner-researchers in the Further Adult and Vocational Education in the improvement of their practice.

#### **Researcher and Author: Dr Helen Saddler**

Helen undertook a BA (Hons) Primary QTS at the University of Sunderland between 2007 and 2011 and won the Langham award for outstanding academic contribution with her thesis. She completed an MPhil with Distinction from the University of Cambridge in 2012 and went on to receive full ESRC funding for her PhD in Education, completed through the University of York in 2015. Helen has worked in central and local government, as a Youth Policy Advisor at the Cabinet Office, and for the Mayor of London's Education and Youth Team at Greater London Authority. Helen is the Founder and Director of Inclusive Classrooms, a social enterprise organisation providing training and professional development opportunities for Teaching Assistants in mainstream primary schools. Helen has published a range of papers on her research into the role of TAs, has been the sole author of the Mayor of London's London Curriculum programme for primary schools since 2015 and has authored a range of professional development materials for Teaching Assistants through her work with Inclusive Classrooms. Helen's research interests include the process of social inclusion for children identified with Special Educational Needs and the influence of Teaching Assistants on academic and social outcomes of children identified with Special Educational Needs.

**Researcher and Author: Simon Ripley**

Simon has 15 years of classroom and leadership experience. Early in his career he began developing his skills and those of others in relation to the education of children and young people with Special Educational Needs and/or Disabilities including the support for those now termed 'disadvantaged' and in receipt of pupil premium. Simon was an Assistant Head Teacher and then Head Teacher of an all-age Specialist School for pupils with complex needs. During this time he represented pupils with additional needs on several regional and national forums and working groups including the strategic development of multi-disciplinary provisions. He currently works as an Associate Tutor for the School of Education at the Sunderland University. He is an Academic Tutor on the NASENCo qualification, the MA in Special Educational Needs, Disability and Inclusion, Initial Teacher Education Mentor and is also a mentor for a large cohort of trainees studying for the International PGCE qualification. Simon's research interests include improvement of the outcomes for children and young people with Special Educational Needs and/or Disabilities, contextual factors that influence and inform provision planning, Leadership, pedagogy and how technology can support and improve learning.

**Research Analyst: Jacob Donaghue**

Jacob graduated in 2015 with a Distinction in MSc Psychological Research Methods and in 2014, with BSc in Psychology. Jacob has worked on projects for the Schools of Psychology and Social Science. Recent projects include The Wolf and the Lion: Conceptualising Dyslexia and Social Class and the Athena Swan Award for the Faculty of Education and Society. Jacob's current research interests include how Assistive Technologies and Inclusive User Experience benefit individuals with specific learning difficulties - namely Dyslexia.

The research team would like to thank Jacqui Cassidy, Senior Lecturer at the University of Sunderland, for her contribution to the project.



## 5 Glossary of acronyms

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|          |                                                           |
|----------|-----------------------------------------------------------|
| ADD      | Attention Deficit Disorder                                |
| ADHD     | Attention Deficit Hyperactivity Disorder                  |
| ASD      | Autism Spectrum Disorders                                 |
| BERA     | British Educational Research Association                  |
| CAMHS    | Child and Adolescent Mental Health Services               |
| CAVTL    | Commission for Adult and Vocational Teaching and Learning |
| CCG      | Clinical Commissioning Groups                             |
| CMOOE    | Children Missing Out of Education                         |
| CoS      | City of Sunderland                                        |
| CPD      | Continuing Professional Development                       |
| CSF      | Cerebrospinal Fluid                                       |
| CYPS     | Children and Young People Services                        |
| DfE      | Department for Education                                  |
| DMO      | Designated Medical Officer                                |
| DO       | Designated Officer                                        |
| DoH      | Department of Health                                      |
| EFA      | Education Funding Agency                                  |
| EHC plan | Education, Health and Care plan                           |
| EYFS     | Early Years Foundation Stage                              |
| EYFSP    | Early Years Foundation Stage Profile                      |
| FE       | Further Education                                         |
| FSM      | Free School Meals                                         |
| GLD      | Good Level of Development                                 |
| GP       | General Practitioner                                      |
| HI       | Hearing Impairment                                        |
| IMD      | Index of Multiple Deprivation                             |

|        |                                              |
|--------|----------------------------------------------|
| ITE    | Initial Teacher Education                    |
| JSNA   | Joint Strategic Needs Assessment             |
| LA     | Local Authority                              |
| LSOA   | Lower Layer Super Output Layer               |
| MLD    | Moderate Learning Difficulty                 |
| MSI    | Multi-Sensory Impairment                     |
| NCTL   | National College for Teaching and Leadership |
| NHS    | National Health Service                      |
| NSA    | No Specialist Assessment                     |
| Ofsted | Office for Standards in Education            |
| OH     | Occupational Health                          |
| ONS    | Office for National Statistics               |
| PCHI   | Permanent Childhood Hearing Impairment       |
| PD     | Physical Difficulty                          |
| PLASC  | Pupil Level Annual School Census             |
| PMLD   | Profound and Multiple Learning Difficulties  |
| PRU    | Pupil Referral Unit                          |
| SEMH   | Social, Emotional and Mental Health          |
| SEN    | Special Educational Needs                    |
| SENCo  | Special Educational Needs Co-ordinator       |
| SEND   | Special Educational Needs and/or Disability  |
| SIO    | School Improvement Officers                  |
| SLCN   | Speech, Language and Communication Needs     |
| SLD    | Severe Learning Difficulty                   |
| SOC    | Standard Occupational Classification         |
| SPARK  | Simons Foundation Autism Research Initiative |
| SpLD   | Specific Learning Difficulty                 |
| SPSS   | Statistical Package for the Social Sciences  |
| TA     | Teaching Assistant                           |
| TaMHS  | Targeted Mental Health in Schools            |
| VI     | Visual Impairment                            |
| YOT    | Youth Offending Team                         |

## 6 Glossary of terms

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(Definitions taken from DfE, 2014a; DfE 2015a; NICE, 2017).

**Alternative Provision (AP):** These are education settings for children unable to attend a mainstream school. Local Authority maintained establishments providing alternative provision are often referred to as pupil referral units. There are also an increasing number of alternative provision academies and free schools.

**Annual review:** The review of an EHC plan which the Local Authority must make as a minimum every 12 months.

**Care pathway:** The route a person takes through healthcare services. For example, a care pathway might show the order in which various tests are done to diagnose an illness, which treatments should be tried, and when care moves from primary to secondary care, or from hospital back into community care.

**Child and Adolescent Mental Health Services (CAMHS):** These services assess and treat children and young people with emotional, behavioural or mental health difficulties. They range from basic pastoral care, such as identifying mental health problems, to specialist 'Tier 4' CAMHS, which provide in-patient care for those who are severely mentally ill.

**Classification of Primary Need:** When children and young people are entered onto the Special Educational Needs register they are entered for their primary need (these classifications can be found on p.43-44).

**Clinical Commissioning Group Outcomes Indicator Set:** Support to enable Clinical Commissioning Groups (CCGs) and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs.

**Clinical Commissioning Groups (CCGs):** Groups that co-operate with the Local Authority in jointly commissioning services, ensuring there is sufficient capacity contracted to deliver necessary services, drawing the attention of the LA to groups and individual children and young people with SEND, supporting diagnosis and assessment, delivering interventions and reviewing support regularly.

**Commissioning:** The process used by health services and local authorities to: identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated.

**Compulsory school age:** A child is of compulsory school age from the beginning of the term following their 5th birthday until the last Friday of June in the year in which they become 16, provided that their 16th birthday falls before the start of the next school year.

**Data set:** A collection of data, usually presented in a table. Each column represents a particular variable. For example, the dataset from a survey of school children could be organised so that the data could easily be compared by the age and gender of respondents. The tables might then be summarised so that you could compare behaviour or illnesses experienced by these characteristics.

**Deprived areas:** Geographic regions or areas that have significantly higher levels of unemployment and lower rates of income per head than the national average.

**Designated Medical Officer (DMO):** The DMO supports the CCG in meeting statutory responsibilities for children and young people with SEND, primarily as a point of contact for local partners, when notifying parents and LAs about children and young people they believe may have SEN or a disability, and when seeking advice on SEND.

**Diagnosis:** The process of identifying a disease or condition by carrying out tests or by studying the symptoms.

**Early Years Foundation Stage (EYFS):** The EYFS sets standards for the learning, development and care of children from birth to five years.

**Early Years Provider:** A provider of early education places for children under five years of age. This can include state-funded and private nurseries as well as child minders.

**Education Funding Agency (EFA):** A Government agency who manage £54 billion of funding a year to support all state-provided education for 8 million children age 3-16 years, and 1.6 million young people aged 16-19 years.

**Education Health and Care Plan (EHC plan):** An EHC plan details the education, health and social care support that is to be provided to a child or young person who has SEN or a Disability. It is drawn up by the Local Authority after an EHC needs assessment of the child or young person has determined that an EHC plan is necessary, and after consultation with relevant partner agencies.

**Effect Size:** The observed association between interventions and outcomes, or a statistic to summarise the strength of the observed association.

**Extent Rank:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 30% in the country.

**Good Level of Development (GLA):** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.

**Graduated Approach:** A model of action and intervention in early education settings, schools and colleges to help children and young people who have special educational needs. The approach recognises that there is a continuum of special educational needs and that, where necessary, increasing specialist expertise should be brought to bear on the difficulties that a child or young person may be experiencing.

**Health and Wellbeing Board:** A Health and Wellbeing Boards acts as a forum where local commissioners across the NHS, social care and public health care work together to improve the health and wellbeing of their local population and reduce health inequalities. The boards are intended to increase democratic input into strategic decisions about health and wellbeing services, strengthen working relationships between health and social care and encourage integrated commissioning of health and social care services.

**Healthy Child Programme:** The Healthy Child Programme covers pregnancy and the first five years of a child's life, focussing on universal preventative service that provides families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

**Index of Multiple Deprivation (IMD):** The official measure of relative deprivation for small areas or neighbourhoods in England.

**Joint Strategic Needs Assessment:** Information, Advice and Support Services provide advice and information to children with SEN or disabilities, their parents, and young people with SEN or disabilities. They provide neutral and factual support on the special educational needs system to help the children, their parents and young people to play an active and informed role in their education and care. Although funded by local authorities, Information, Advice and Support Services are run either at arm's length from the Local

Authority or by a voluntary organization to ensure children, their parents and young people have confidence in them.

**Listwise Deletion:** This is a method of handling missing data where a record is removed from the analysis if a single value is not present.

**Local Authority (LA):** Leading integration arrangements for children and young people with SEND

**Local Concentration:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 10% within a Local Authority, compared to those in other areas.

**Local Offer:** Local Authorities in England are required to set out in their Local Offer information about provision they expect to be available across education, health and social care for children and young people in their area who have SEN or are disabled, including those who do not have Education, Health and Care (EHC) plans. Local authorities must consult locally on what provision the Local Offer should contain.

**Lower Layer Super Output Areas (LSOA):** These are small areas designed to be of a similar population size with an average of approximately 1,500 residents of 650 households. For ease of communication LSOA are sometimes referred to as neighbourhoods or small areas.

**Maintained School:** Schools who are maintained by a Local Authority any community, foundation or voluntary school, community special or foundation special school.

**Methodology:** Describes how research is carried out, including how information is collected and analysed, and why a particular method or methods have been chosen.

**National Curriculum:** This sets out a clear, full and statutory entitlement to learning for all pupils, determining what should be taught and setting attainment targets for learning. It also determines how performance will be assessed and reported.

**NHS England:** NHS England is an independent body, at arm's length to the government and held account through the NHS Mandate. Its main role is to improve health outcomes for people in England by providing national leadership for improving outcomes and driving up the quality of care; overseeing the operation of clinical commissioning groups; allocating resources to clinical commissioning groups, and commissioning primary care and specialist services.

**NHS Foundation Trust:** NHS foundation trusts are not-for-profit corporations that provide NHS hospitals, mental health and ambulance services. NHS foundation trusts are not directed by the Government, but are accountable to their local communities and governors, to their commissioners through contracts and to Parliament through their annual report and accounts. Foundation trusts are registered with and inspected by the Care Quality Commission.

**Ofsted:** Office for Standards in Education, a non-Ministerial government department established under section 342 of the Education Act 1996 to take responsibility for the inspection of all schools in England. Her Majesty's Inspectors (HMI) form its professional arm.

**Parent:** Under section 576 of the Education Act 1996, the term 'parent' includes any person who is not a parent of the child, but has parental responsibility (see below) or who cares for him or her.

**Population:** A group of people with a common link, such as the same medical condition, living in the same area or sharing the same characteristics.

**Prevalence:** How common a disease or condition is within a population, either at a point in time or over a given period of time (it includes new and existing cases). It is different from incidence.



**Primary Care:** Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians. It includes community clinics, health centres and walk-in centres.

**Public Health England (PHE):** An executive agency that delivers services to protect the public's health through a nationwide integrated health protection service, provides information and intelligence to support local public health services, and supports the public in making healthier choices.

**Pupil Referral Unit (PRU):** Any school established and maintained by a Local Authority under section 19 (2) of the Education Act 1996 which is specially organised to provide education for pupils who would otherwise not receive suitable education because of illness, exclusion or any other reason.

**Reliability:** The ability to get the same or similar result each time a study is repeated with a different population or group.

**Research Recommendations:** Recommendations for future research, covering questions relating to an uncertainty or lack of evidence that has been identified.

**Review of the Literature:** A summary of the evidence in a number of different individual studies, with conclusions about their findings.

**SEN Support:** Extra or different support that is provided in addition to the school's usual curriculum. The class teacher and SEN co-ordinator (SENCo) may receive advice or support from outside specialists.

**Social care:** Social care generally refers to all forms of personal care and other practical assistance for children, young people and adults who need extra support. This includes:

- Vulnerable children and young people (those who are at risk of, or who are already experiencing social and emotional problems).
- Children, young people and adults with learning or physical disabilities or mental health problems.

**Special Educational Needs (SEN):** A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she has a significantly greater difficulty in learning than the majority or others of the same age, or has a disability which prevents or hinders him or her from making use of educational facilities of a kind generally provided for others of the same age in mainstream or mainstream post-16 provisions.

**Special Educational Needs Co-ordinator (SENCo):** A qualified teacher in a school or maintained nursery school who has responsibility for co-ordinating SEN provision. In a small school, the head teacher or deputy may take on this role. In larger schools there may be a team of SENCos. Other early years settings in group provision arrangements are expected to identify an individual to perform the role of SENCo and childminders are encouraged to do so, possibly sharing the role between them where they are registered with an agency.

**Special Educational Provision:** Special educational provision is provision that is different from or additional to that normally available to pupils or students of the same age, which is designed to help children and young people with Special Educational Needs or Disabilities to access the National Curriculum at school or to study at college.

**Special School:** A school which is specifically organised to make special educational provision for pupils with special educational needs. Specialist schools maintained by the comprise community specialist schools and foundation specialist schools, and non-maintained (independent) specialist schools that are approved by the Secretary of State under Section 342 of the Education Act 1996.

**Stakeholder:** An organisation/individual with an interest in a topic, including public sector providers and commissioners of care or services.

**Standard Occupational Classification Hierarchy:** This hierarchy is used by the Office for National Statistics to classify a range of occupations.

**Statement of Special Educational Needs:** A pupil has a statement of SEN when a formal assessment has been made. It is a document that sets out the child's need and the extra help they should receive, all Statements of SEN should be converted to an Educational Health and Care plan by April 2018.

**Triangulation:** The use of two or more different research methods in combination; principally used as a check of validity. Generally, greater similarity of results produced by different methods indicates greater validity of the findings.

**Validity:** Whether a test or study actually measures what it aims to measure.

**Young person:** A person over compulsory school age (the end of the academic year in which they turn 16). From this point the right to make decisions about matters covered by the Children and Families Act 2014 applies to the young person directly, rather than to their parents.

## 7 Introduction

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Sunderland City Council commissioned the School of Education at the University of Sunderland to examine the prevalence of Special Educational Needs and Disabilities (SEND) identified in young people, aged 3-16, across the City of Sunderland. This research was requested to inform the strategic requirements in enabling effective provision for Sunderland's children and young people with SEND over the next five years.

With the recent changes in SEND policy, it is vital that Councils forward plan their SEND delivery strategies and funding arrangements, to better support schools and other education providers in navigating the challenges and opportunities posed by these changes (Children and Families Act 2014, DfE, 2015a). It is intended that this research will better place the City of Sunderland Council to challenge the DfE and EFA over funding arrangements for Sunderland, as it identifies specific potential pressures on the high needs block in the region. The Department for Education (DfE, 2016a) indicate the purpose of high needs funding is to provide the most appropriate support package for an individual with special educational needs (SEN) in a range of settings, taking account of parental and student choice. It is also intended to support good quality alternative provision for pupils who cannot receive their education in schools (ibid).

This research is taking place in a climate of ever-changing and extremely challenging financial pressures. This climate necessitates a targeted approach to delivery which maximises efficiency, effectiveness and innovative delivery routes to inform long term commissioning priorities.

## **8 Research methodology**

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BERA (2011) suggest that 'educational researchers aim to extend knowledge and understanding in all areas of educational activity and from all perspectives including learners, educators, policymakers and the public' (p.4).

### **8.1 The focus of the research**

The initial interview between the research team and Sunderland City Council identified the following foci for this research:

- To carry out analysis of existing data sets to gain insight into extent and nature of special educational needs and disability requirements for 3-16 year olds in Sunderland.
- To carry out qualitative research with key stakeholders from the National Health Service (NHS) and Clinical Commissioning Group (CCG).
- To produce a report with supporting evidence on findings to inform Sunderland City Councils 5-year strategy.

Following meetings with City of Sunderland Council the researcher team devised key themes to meet the research brief.

## **8.2 Key research themes**

- Theme 1:** Analysis of the prevalence trends based on identified primary need: children and young people 5-16 years in Sunderland (2013-2017).
- Theme 2:** Analysis of the prevalence of identified primary need: children and young people 5-16 years based on school year and Key Stage in Sunderland (2017).
- Theme 3:** Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support in Sunderland (2017).
- Theme 4:** Analysis of national data compared to Sunderland City Council data based on primary type of need identified in children and young people 5-16 years (2016).
- Theme 5:** Analysis of Early Years data (reception year) by primary type of need and Good Level of Development in Sunderland (2014 – 2017).
- Theme 6:** Analysis of interviews with the NHS and CCG.
- Theme 7:** Analysis of the prevalence of Autism Spectrum Disorder in the City of Sunderland (3-16 years) (2017).
- Theme 8:** Analysis of high needs funding.
- Theme 9:** Analysis of the primary need of children missing from education in Sunderland.
- Theme 10:** Analysis of the primary need of children and young people in a Pupil Referral Unit (PRU).

## **8.3 The research approach**

The research team approached this study from a social constructivist viewpoint. This approach centres on the idea that people play an active part in their own meaning-making and in the co-construction of knowledge in social interaction through dialogue (Vygotsky, 1978). This process of meaning making and knowledge construction is strongly influenced by social context – the situation in which a person finds themselves.

In this study, the qualitative data collected from participants is influenced by the social culture of the organisations in which they work (Fosnot, 2005). This also results in the researchers approaching this study from an interpretivist paradigm. The interpretivist approach emphasises the importance of social interaction as the basis of knowledge-building. From this perspective the individual and society are regarded as inseparable entities (O'Donoghue, 2007).

#### **8.4 Research methods**

The researcher team employed a mixed-method approach, involving both quantitative, qualitative data collection and analysis. Detailed descriptions of the methods undertaken in this study are given in the remainder of this section. Basit (2010) argues that the researcher should choose between qualitative or quantitative methods; however, Thomas (2013) draws attention to the need for a researcher to decide how the specific form of inquiry lends itself to the research question. As Higbee, Arendale and Lundell, 2005, p. 12 stated 'Qualitative research complements the more generalizable data that are gained through quantitative measures.' With the requirements of the Council in consideration this research project included both quantitative and qualitative methods.

#### **8.5 Qualitative methods**

Semi-structured interviews were undertaken by one member of the research team, with two purposively sampled participants in this study. Denscombe (2010) defines purposive sampling as: 'the researcher deliberately selects particular cases because they are seen as instances that are likely to produce the most valuable data' (p.17). Consequently, both participants were sampled for involvement in this study because it was deemed by the researchers and the Council that these participants would yield the most relevant data for analysis in meeting the aims of this research. One participant was an employee of the National Health Service (NHS) in Sunderland, employed as a Consultant Paediatrician; the other participant was an employee of the Clinical Commissioning Group (CCG) as a Joint Commissioning Officer.

Cohen et al. (2013) described interviews as a move from seeing humans as data to more of a social situation where an interchange of views can occur. Thomas (2013) agrees and adds that interviews enable the researcher to have face-to-face contact with the participants which will inevitably make them react in a different way to, for example, a questionnaire. Semi-structured interviews were undertaken due to the need to investigate the values, beliefs and motives behind individuals' experiences, in fully exploring the research questions of this study (Foddy, 1993). All interviews were undertaken inside the offices of the two participants. This was deemed to be conducive to effective data collection as, 'people talk more freely on their own ground' (Gillham, 2000, p.9). Exact locations of the individual interviews were chosen based on the availability of rooms at the time of the interview.

Wengraf (2001) argues that the greatest advantage of semi-structured interviewing as a research method is the flexibility. The relatively unstructured interview protocol enables both the researcher and the participant to exert control over the direction of the interview. Not only does this encourage interviewees to follow their interests within the parameters of the issues explored, but it also urges the participants to share their stories and extend their answers, due to the supportive culture that flexibility provides (Keats, 2000).

When conducting interviews, the researcher undertakes the role of the research instrument. Therefore, the researcher's 'biases, angers, fears and enthusiasms influence questioning style and how what is heard is interpreted' (Rubin and Rubin, 2004, p.12). This is recognised as a limitation of the research undertaken, however, the lead researcher who conducted these interviews did exercise self-reflexivity during data collection and data analysis, to reduce the bias that her personal values and beliefs may have presented.

Whilst it is widely accepted that interviewing produces rich data (Gillham, 2000; Siedman, 1998; Wengraf, 2001), the time consuming nature should not be ignored. Semi-structured interviews allow little scope for follow up (Basit, 2010 and Thomas, 2013). In order to afford effective data analysis, interviews require transcription. For this reason, it was decided that two interviews with key stakeholders were appropriate for the scope of this study.



Additionally, a transcriber was employed to undertake the transcription of the interviews. This also prevented any researcher bias during the transcription process.

The questions were designed to gather information about the intended outcomes across four themes, as agreed by the researchers and Sunderland City Council:

- Criteria and pathways - diagnosis
- Effectiveness of multi-agency involvement
- Joint commissioning provision
- Data sharing protocols to inform strategic decision across the local area
- The possibility of joint data base to inform decision making

Costa (1994) advocates the use of open-ended questions that require a recall of thinking and hypothesising. 'Would/if kinds of questions cause the brain to dream, visualize, evaluate, speculate, and imagine. Those two little words carry great power.' (p. 111). In light of this the interview questions were designed to be open-ended (appendix 1 and 2). Arksey and Knight (1999), McNiff (2013) and Thomas (2013) suggest that semi-structured interviews adopt a more open ended approach which allows researchers to follow up responses thus gaining greater insight into the topic being discussed. There were opportunities given in both interviews to elaborate on answers and to give additional clarification.

Prior to the interviews commencing the questions were discussed and approved, no modifications were required as it was agreed the questions were straightforward. As Fulcher and Scott (1999) suggested, 'unless the question is carefully worded, there will be scope for ambiguity and misunderstanding on the part of the respondents. As a result the answers that they give may be difficult to interpret' (p.77). The interviewer ensured that the questions were clear and that the participants felt at ease answering them. The justification for qualitative data was that it would examine the judgements or feelings of people key to multi agency working within Sunderland City Council (Verma, 1999).

## 8.6 Quantitative methods

This research utilised the data made available from Sunderland City Council to meet the aims of the study. The data was used to examine the primary need of children and young people with special educational needs and disabilities from 3-16 years. This included children who have a Statement of SEN, Education, Health and Care plans (EHC plans), and those who were identified as needing SEN Support from 3-16 years. This data was analysed to provide the Council with a detailed overview of the number of children and young people who have a primary need within the broad areas:

- Communication and Interaction
- Cognition and Learning
- Social, Emotional and Mental Health Difficulties
- Sensory and or Physical Needs

(DfE, 2015a).

To organise the data and to examine the prevalence of SEND across the City of Sunderland the following classifications and categories were used (DfE, 2015a; DfE 2016b)

- Statement of SEN
- Education, Health and Care plan
- SEN Support

**SpLD** Specific Learning Difficulty

**MLD** Moderate Learning Difficulty

**SLD** Severe Learning Difficulty

**PMLD** Profound and Multiple Learning Difficulty

**SEMH** Social, Emotional and Mental Health

**SLCN** Speech, language and communication needs

**HI** Hearing Impairment

**VI** Visual Impairment

|            |                             |
|------------|-----------------------------|
| <b>MSI</b> | Multi-Sensory Impairment    |
| <b>PD</b>  | Physical Disability         |
| <b>ASD</b> | Autism Spectrum Disorder    |
| <b>OTH</b> | Other Difficulty/Disability |
| <b>NSA</b> | No Specialist Assessment    |

## **8.7 Exploratory Geographical Analysis**

Bakian et al. (2015) recommend the use of mapping tools to identify any localised regions of heightened risk of ASD, this allows for the development of hypotheses based on findings in relation to factors such as familial risk or socio-economic status. For example in her study, using geographical mapping ASD hotspots were identified in four out of five birth cohorts. Exploratory geographical analysis was chosen as a method of data analysis to identify if there were any areas of Sunderland where there was a higher than average prevalence rate compared to other areas within the city. The maps produced were based on the children and young people aged 3-16 years with a diagnosis of ASD, identifying where they attend nursery/school and where they live in Sunderland or neighbouring area and whether they had a Statement of SEN/EHC plan or were identified as needing SEN Support. A ward map of Sunderland can be viewed in appendix 4.

To comply with the Data Protection Act 1998 legal guidance was sought on mitigating the chance of identifying an individual child or young person. The initial brief was to map where the children with Autism live by their home postcode.

To address the issue of inadvertently identifying children, the research and data protection team decided to map the children in multiple year groups:

- Map 1: All children with a diagnosis of Autism
- Map 2: Nursery and Reception children with a diagnosis of Autism
- Map 3: Key Stage One children with a diagnosis of Autism
- Map 4: Key Stage Two children with a diagnosis of Autism
- Map 5: Key Stage Three children with a diagnosis of Autism
- Map 6: Key Stage Four children with a diagnosis of Autism.

Furthermore, the research team would advise Sunderland City Council to refrain from making this document available to the public due to the aforementioned reasons.

## **8.8 The data collection schedule**

The data collection for this research began in January 2017 through initial conversations with one of the key stakeholders. The quantitative and qualitative data was received following ethical approval from February- April 2017.

## **8.9 Ethical considerations**

The principal researcher for this research project sought and gained ethical consent from the University of Sunderland Ethics Committee. Following this approval, voluntary and informed consent was sought for the interviews for Theme 6. As BERA (2011) advocate, researchers must take the steps necessary to ensure that all participants in the research understand the process in which they are to be engaged, including why their participation is necessary, how it will be used and how and to whom it will be reported. Cohen et al. (2013) acknowledge that an inevitable tension exists, between ensuring that research is ethical and ensuring that the data gathered is of optimum quality. Approval by the University of

Sunderland Ethics Committee was deemed by the researchers to effectively strike a balance in mitigating this tension.

The securing of participants' voluntary informed consent, before research gets underway, is considered the norm for the conduct of research, this was the process followed prior to the interviews taking place (Cohen et al., 2013). Ethical consent also ensured that participants were aware of their right to withdraw from this research at any time, if requested (McNiff, 2013). In accordance with ethics, information sheets and consent forms were circulated to the interview participants prior to the interviews taking place and the researcher clarified the purpose of the research. The participant information sheet distributed also adhered to both BERA (2011) Ethical Guidelines and met the expectations of the University of Sunderland Ethics Committee.

### **8.10 Reliability**

Reliability is defined by Kirk and Miller (1986) as, 'the degree to which the findings of a study are independent of accidental circumstances of their production' (p.26). Therefore, the reliability of a study deals with its replicability. Cohen, Manion and Morrison, (2007) clarify that the meaning of reliability varies in quantitative and qualitative research. Reliability in relation to quantitative research focuses on similar data from similar respondents over a period of time. In relation to this study reliability would occur if the interviews were carried out and repeated in a similar time frame then similar results would be obtained from similar respondents.

'Reliability is the extent to which a repetition of the research would result in the same data and conclusions – in other words, if the research were to be repeated, by you or another researcher, the same results would be achieved, assuming nothing has changed'

(Payne and Whittaker, 2006, p. 192).

Seidman (1998) argues that, 'to work most reliably with the words of participants, the researcher has to transform those spoken words into a written text to study' (p.97). However, in doing so, participants' responses may have been affected (Rubin and Rubin, 2004). The researcher team elected to employ an independent transcriber to avoid researcher bias during the transcription process.

### **8.11 Validity**

Validity is defined by Hammersley (1990) as, 'the extent to which an account accurately represents the social phenomena to which it refers' (p.57). Consequently, this research is regarded as valid if it accurately represents the extent and nature of SEND requirements of 3-16 year olds in Sunderland. Validity refers to the extent to which researchers are measuring what we set out to measure, if not the research is meaningless (Muijs, 2011). Consequently, research is valid when the research methods measure what they are intended to measure, with the result being the same if an alternative method of measurement was used (Cohen, Manion and Morrison, 2007). The data collected in this study is deemed to be valid, as the researcher team and the commissioners of the research worked together to identify the key data sets to be analysed. These data sets are routinely used by Sunderland City Council, therefore are highly relevant to the phenomena explored in this study (Higbee, Arendale and Lundell, 2005). In determining the validity of this research holistically, it is important to consider the internal and external validity of the methods employed.

Internal validity refers to the extent to which the data generated by the research relates to the aims, within a singular piece of research (Cohen, Manion and Morrison, 2007). Lincoln and Guba (1985) argue that triangulation of research methods promotes internal validity in qualitative research. Whilst it cannot be claimed that triangulation alone ensures internal validity, the multi-method nature of this research design does promote validity of this study. Yet, the small number of participants involved in the qualitative data collection process limits internal validity, to some extent.

In determining the external validity of a research project, the generalisability of the conclusions drawn to other contexts must be considered (Cresswell and Miller, 2000). It is important to address external validity, as the results of this study may not be representative of the wider learner population (Cohen, Manion and Morrison, 2007). The data for this piece of research are representative of Sunderland City Council with comparisons made where relevant to national data. Therefore, this research is predominantly valid only to Sunderland, with limited external validity on a national scale.

### **8.12 Analysis of data**

Smit (2002) defines data analysis as, 'a process of resolving data in its constituent components, to reveal its characteristic elements and structure' (p.66). Data gathered through qualitative methods were analysed separately, and using different data analysis techniques, to the data gathered through quantitative methods. Analysis of qualitative data is typically an iterative process; a framework of specific codes to be imposed on the data is not devised. Instead, codes and concepts arise from the data as they are continually analysed (Srivastara and Hopwood, 2009). Thus, the constant comparative method of analysis was deemed most appropriate for qualitative data.

### **8.13 Constant comparative method of data analysis**

This method required repeated comparison and contrast of new codes, categories and concepts as they arose (Denscombe, 2010). The process began with semi-structured interview one, drawing out codes from the interview transcripts to compare with interview two (see appendix 3). This comparison continued until both interviews had been fully analysed and definite themes running through the data had been identified. Two researchers were involved in the analysis of interview transcripts, thus the researchers were able to cross-check identified codes to ensure inter-rater reliability and that saturation of analysis had occurred.

## 8.14 Quantitative data analysis

IBM Statistical Package for the Social Sciences 23 (SPSS) was the main analytical tool used to analyse quantitative data and create a series of contingency tables for this research. As Muijs (2011) suggests it is probably the most common statistical data analysis software package used in educational research and it is widely used in Higher Education. Microsoft Excel 2016 and a 3D mapping add-on were used to create a series of maps for Theme 7. Sunderland City Council supplied all local (Sunderland specific) data for the research, whilst national or regional data was attained by the research team. The theme specific datasets that were analysed are given below:

- Themes 1-3 Pupil Level Annual School Census (PLASC)
- Theme 4 PLASC and SEND Local Authority Tables (DfE, 2016c)
- Theme 5 School Census data and PLASC
- Theme 6 NHS and CCG Interviews (No quantitative data analysis required)
- Theme 7 School Census data originally provided by Sunderland Autism Outreach Team
- Theme 8 High Needs Funding (No quantitative data analysis required)
- Theme 9 Children Missing out of Education (No data provided)
- Theme 10 Pupil Referral Unit and Alternative Provision census data.



## **9 Literature review: Part one**

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The following review of the literature supports exploration of the ten themes identified in the methodology chapter of this research. The review is split into three distinct sections: the first explores the legislation and policy surrounding Special Educational Needs and/or Disability (SEND) provision, with specific reference to Sunderland; the second examines Autism Spectrum Disorder; and, the third discusses Alternative Provision including Pupil Referral Units (PRUs) and Children Missing from Education.

### **9.1 Setting the scene: The City of Sunderland**

The City of Sunderland, lies on the North East coast of England and has a long and illustrious history of shipbuilding, heavy engineering and glass-making (Short and Fundinsland-Tetlow, 2012). Dodds (2011) writes that Sunderland lies at the mouth of the River Wear and is one of the principal water ways, and it is the regions second largest city. She adds that the south of the river is the most populated area of Sunderland. Sunderland grew from being a small trading port into a large industrial city due to rural-urban migration within the region, high birth rates and historic immigration from Ireland and Scotland (Cookson, 2015). Although the industrial greatness in now in the past, it did achieve city status in 1992 and it is now identified as a major conurbation in the North East of England (Meikle and Newman, 2007). City of Sunderland Council (2017) report that over the past five years, there have been around 200 strategic projects, creating more than 8,800 jobs and bringing about £1.3 billion of investment. BAE Systems is the latest world class manufacturing company to move into the City of Sunderland. BAE's new purpose built plant will house a forge, machining centre, and heat and surface treatment plants as it manufactures casing for Ministry of Defence ammunition orders.

See it do it Sunderland (2017) describes Sunderland as a welcoming, bustling city set right on the coast and at the mouth of the River Wear. It recommends visiting the wide sandy beaches and acres of relaxing and invigorating green spaces. Culturally Sunderland has a range of attractions, while its underground music scene is considered one of the most vibrant in the UK. Sunderland has recently bid to be the UK City of Culture (2021) which is supported by a host of key figures. Gareth Pugh, Fashion Designer quoted Sunderland as “representing a singular and compelling combination of post-industrial grit and charisma. It is home to a history of story-telling and a veritable cast of larger than life characters.” (Sunderland City of Culture bid, 2017).

The resident population of Sunderland in 2015 was 277,200 with 135,000 males and 142,200 females. From October 2015 to September 2016 the number of people 16-64 years who were economically active was 74.1% which is 0.9% lower than the regional average and 3.7% below the national average (Nomis, 2017). In Sunderland there are 45,900 people not in employment (25.9% of the population). From January to December 2015 in terms of workless households, Sunderland had (23.6%) compared to the regional average of (21.3%) and a national average of (15.3%) (ibid). According to employment by occupation data, in Sunderland there are a greater proportion of working age people 16+ employed in lower paid jobs such as plant and machinery work, caring, leisure and sales compared to the regional and national average. An example of this is in the Standard Occupational Classification group 6-7; lower paid roles in Sunderland equate to 23.9% compared to the regional at 19.8% and the national at 16.8% (see Table 1).

Table 1

*Employment across Sunderland, the North East and Britain by occupation (October 2015 - September 2016).*

| Standard Occupational Classification Group      | Sunderland    |             | North East  | Britain     |
|-------------------------------------------------|---------------|-------------|-------------|-------------|
|                                                 | <i>N</i>      | %           | %           | %           |
| <b>SOC Group 1-3</b>                            | <b>37,200</b> | <b>29.8</b> | <b>38.7</b> | <b>45.1</b> |
| 1 Managers, directors and senior officials      | 8,200         | 6.6         | 8           | 10.5        |
| 2 Professional occupations                      | 15,900        | 12.6        | 18.2        | 20.2        |
| 3 Associate professional & technical            | 13,100        | 10.5        | 12.3        | 14.3        |
| <b>SOC Group 4-5</b>                            | <b>32,700</b> | <b>26.1</b> | <b>21.9</b> | <b>20.9</b> |
| 4 Administrative & secretarial                  | 15,600        | 12.4        | 10.3        | 10.4        |
| 5 Skilled trades occupations                    | 17,100        | 13.6        | 11.4        | 10.4        |
| <b>SOC Group 6-7</b>                            | <b>29,900</b> | <b>23.9</b> | <b>19.8</b> | <b>16.8</b> |
| 6 Caring, leisure and Other Service occupations | 12,300        | 9.8         | 10.4        | 9.1         |
| 7 Sales and customer service occs               | 17,600        | 14          | 9.3         | 7.6         |
| <b>SOC Group 8-9</b>                            | <b>25,200</b> | <b>20.2</b> | <b>19.7</b> | <b>17.2</b> |
| 8 Process plant & machine operatives            | 9,500         | 7.5         | 7.4         | 6.4         |
| 9 Elementary occupations                        | 15,800        | 12.6        | 12.2        | 10.7        |

*Note.* SOC refers to Standard Occupational Classification. Data includes individuals aged 16 and over (Office for National Statistics, 2016).

*Source: ONS annual population survey*

Sunderland City Council (2017) have announced current and future plans including a £100 million civil engineering project a new river Wear cable-stayed bridge and approach roads, due for completion by early 2018. Sunderland is also hosting the Tall Ships Race in July 2018 as well as bidding for the City of Culture.

## 9.2 The Index of Multiple Deprivation: Sunderland

The English Index of Multiple Deprivation (IMD) is the official relative measure of deprivation for neighbourhoods or Lower-layer Super Output Areas (LSOAs) in England and is based on 37 indicators from 7 domain indices (DfCLG, 2015a).

These indices are weighted and combined to produce the IMD for each LSOAs, they are:

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

(DfCLG, 2015a).

There are 32, 844 Lower-layer Super Output Areas (LSOAs) across England and are designed to have an average of 1,500 residents or 650 households living in them. The LSOAs are ranked where 1st is the most deprived and 32, 844th is the least deprived (DfCLG, 2015a). The individual LSOAs for Sunderland Local Authority for 2015 are given in Figure 1 overleaf. It can be seen from the figure below that the most deprived areas of Sunderland are within the wards: Redhill, Southwick, Pallion, St Annes, Sandhill, Hetton and Copt Hill, small areas within Washington North and Central.

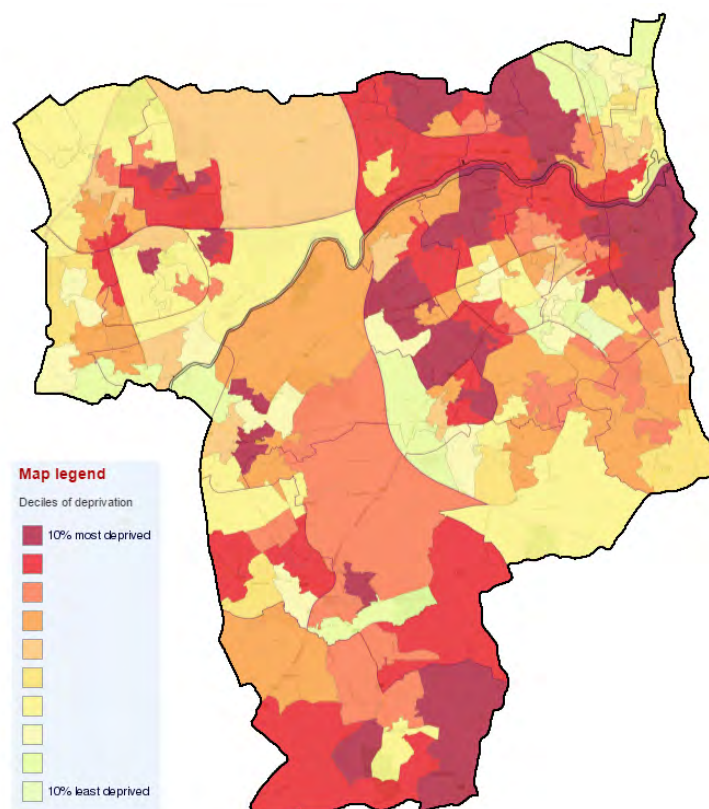


Figure 1: The Index of Multiple Deprivation rank for each LSOA in Sunderland (2015) (Open Data Communities, 2017).

The individual IMD ranks can be combined to produce an overall IMD rank for Local Authority districts. Out of 326 Local Authorities in England, Sunderland is ranked as 38th overall (DfCLG, 2015b). There is no single measure of deprivation that is the most suitable when comparing higher-level areas such as Local Authorities due to the spread of deprivation, size, population and geographical differences. Instead several deprivation measures should be used to present a fuller account. In light of this, the IMD rank, extent rank and local concentration measures have been used, and are given in Table 2 overleaf.

Table 2

*The Index of Multiple Deprivation (IMD) by Local Authority area in Tyne and Wear.*

| Local Authority     | IMD Rank | Extent Rank | Local Concentration |
|---------------------|----------|-------------|---------------------|
| Sunderland          | 38       | 37          | 46                  |
| Gateshead           | 80       | 73          | 67                  |
| Newcastle upon Tyne | 92       | 45          | 13                  |
| North Tyneside      | 138      | 106         | 112                 |
| South Tyneside      | 31       | 23          | 71                  |

*Note . IMD Rank, Extent Rank and Local Concentration are ranked where 1 is the most deprived (DfLG, 2015b).*

**\*Extent Rank:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 30% in the country.

**\*Local Concentration:** This is a weighted measure and summary of the local population proportion that live in neighbourhoods classified as among the most deprived 10% within a Local Authority, compared to those in other local authorities.

### 9.3 Deprivation versus educational outcomes in Sunderland

Social inequalities and their influence on the educational experiences of young people have been highlighted by many researchers, both historically and in recent years. The challenge is often characterised by a lack of physical resources for families to afford quality educational experiences for their children, but it can also include indirect inequality, stemming from parental attitudes to education (Morris, Dorling and Davy Smith, 2016). Research by Crawford, Macmillan and Vignoles (2014) into social inequalities in education highlighted that socially disadvantaged children are far less likely to experience high academic attainment, across a range of academic phases. Additionally, this research indicated that high-attaining socio-economically disadvantaged children are often overtaken by their average-attaining, more economically advantaged peers. Therefore, the effects of social inequality on the educational experiences of young people are likely to be enduring, requiring longitudinal intervention.

The Department of Health (2013) acknowledge that social disadvantage and adversity increase the risk of developing mental health problems. Furthermore, children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes.

#### **9.4 Academic attainment nationally and in Sunderland**

The Office for National Statistics (2017) show that pupils in Sunderland achieving 5+ A\* -C GCSEs, or equivalent, including English and Mathematics between September 2013 and August 2014 was 50.9%. This is 3.7% lower than the regional average for the North East and 5.7% less than the national average.

Wilshaw (2017) stressed that not a single child on free school meals from the North East and Yorkshire and Humber regions had gone to Oxbridge University after leaving school in 2010. Amanda Brown, Assistant General Secretary at the National Union of Teachers added in the report that 'cuts to Local Authority budgets, which had been at their most severe in areas with the highest levels of child poverty, had reduced the funding available to sustain and develop vital child and family services.'

Table 3 below shows the proportion of children with SEND eligible for free school meals (FSM) nationally for each primary need and SEND provision. It highlights that most of the children and young people on SEN Support are categorised as having a Moderate Learning Difficulty (MLD) as their primary need. Social Emotional and Mental Health Difficulties (SEMH) are identified as the second most prevalent need for children on SEN Support. In terms of those children and young people with a Statement of SEN or on Education, Health and Care plans the predominant need is Autism Spectrum Disorder (ASD) followed by SEMH. This analysis relates to children eligible for free school meals.

Table 3

*Prevalence of pupils with identified Primary Needs and Free School Meal (FSM) eligibility (2016).*

| Primary Need                              | Pupils on SEN support   |              | Pupils with SEN with statements or EHC plan |              |
|-------------------------------------------|-------------------------|--------------|---------------------------------------------|--------------|
|                                           | <i>Total Population</i> | <i>% FSM</i> | <i>Total Population</i>                     | <i>% FSM</i> |
| Specific Learning Difficulty              | 26,561                  | 18.7         | 2,196                                       | 24.6         |
| Moderate Learning Difficulty              | 71,358                  | 29.2         | 10,915                                      | 36.8         |
| Severe Learning Difficulty                | 934                     | 28.3         | 10,088                                      | 34.8         |
| Profound & Multiple Learning Difficulty   | 215                     | 22.4         | 2,811                                       | 28.2         |
| Social, Emotional and Mental Health       | 51,988                  | 33.0         | 11,592                                      | 42.5         |
| Speech, Language and Communications Needs | 48,020                  | 25.2         | 8,873                                       | 28.7         |
| Hearing Impairment                        | 2,744                   | 18.8         | 1,579                                       | 26.6         |
| Visual Impairment                         | 1,795                   | 21.7         | 848                                         | 25.5         |
| Multi- Sensory Impairment                 | 300                     | 18.0         | 156                                         | 24.7         |
| Physical Disability                       | 4,564                   | 22.8         | 3,474                                       | 27.0         |
| Autistic Spectrum Disorder                | 9,117                   | 21.3         | 15,635                                      | 27.3         |
| Other Difficulty/Disability               | 11,842                  | 23.7         | 1,398                                       | 26.7         |
| SEN Support but No Specialist Assessment  | 9,044                   | 25.3         | 70                                          | 26.1         |
| Total                                     | 238,482                 |              | 69,635                                      |              |

*Note.* Excludes pupil referral units, general hospital schools and independent schools.  
Percentages are rounded to the nearest 0.1 (DfE, 2016d).

*Source: School Census*

In 2010, Ofsted acknowledged that pupils identified as having SEN were disproportionately from disadvantaged backgrounds. They were also far more likely to be absent or excluded from school and achieve, academically, at a lower rate than expected compared with more affluent peers, both in terms of their attainment at any given age and in terms of their progress over time. Additionally, it is recognised that pupils identified with special educational needs and/or disabilities have fewer friends, are less popular and are more likely to be the victims of bullying than their peers not diagnosed with a special educational needs (Frostad and Pijl, 2007; McLaughlin, Byers and Peppin-Vaughan, 2010; Nowicki, 2012).



## **9.5 What are Special Educational Needs and/or Disabilities (SEND)?**

The legislative document which presents the current definition of SEND is the 'Special Educational Needs and Disability Code of Practice: 0 to 25 years' (DfE, 2015a). This document also provides statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities.

The current definition of SEND in the 2015 Code of Practice (DfE, 2015a) arose from changes in legislation enshrined in the Children and Families Act 2014. This legislation replaces previous legislation including the Special Educational Needs and Disability Act 2001, the new legislation has far reaching implications for children and young people, families and other agencies working alongside them (Ko, 2015). The reforms will be explored in detail in the following section. The SEND code of practice (DfE, 2015a) defines Special Educational Needs and Disabilities as when:

- A child or young person has a learning difficulty or disability which calls for special educational provision to be made for him or her.
- A child of compulsory school age or a young person has a learning difficulty or disability if he or she:
  - has a significantly greater difficulty in learning than the majority of others of the same age, or
  - has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions

The SEND Code of Practice (DfE, 2015a) also offers a definition of disability, which draws upon the Equality Act (2010). This Act explains that children have a disability if they present with ‘... a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities’ (p135).

This definition provides a relatively low threshold for disability and includes more children than many realise: ‘long-term’ is defined as ‘a year or more’ and ‘substantial’ is defined as ‘more than minor or trivial’. This definition includes Sensory Impairments such as those affecting sight or hearing, and long-term health conditions such as Asthma, Diabetes, Epilepsy, and Cancer (DfE, 2015a).

Cheminais (2015, p. 15) stresses the importance of teachers being aware of the diversity of children and young people who, under the Equality Act (2010) are considered to have a disability. These include:

- Sensory Impairments, e.g. Visual Impairment (VI), Hearing Impairment (HI) and Multi-Sensory Impairments (MSI)
- Physical impairments or illness that affects mobility, dexterity or control of movement e.g. Arthritis, Multiple Sclerosis and Stroke
- Developmental conditions, e.g. Dyslexia, Dyspraxia, Autism Spectrum Disorders
- Progressive diseases, e.g. Motor Neurone Disease, Muscular Dystrophy, Dementia and Lupus
- Illnesses with impairments with fluctuating or recurring effects, e.g. Myalgic Encephalitis (ME), Chronic Fatigue Syndrome (CFS), Epilepsy, Diabetes
- Mental health conditions and mental illnesses, e.g. Depression, Eating Disorders, Obsessive Compulsive Disorder (OCD), Schizophrenia, Bipolar Affective Disorders and Self-Harm
- HIV infection
- Cancer
- Facial disfigurements.

The SEND code of practice (DfE, 2015a) indicates that many children identified with SEN may also be identified as having a disability. It explains that there is a significant overlap between children with disabilities and young people and those with SEN. Where a child with a disability or young person requires special educational provision they will also be covered by the SEN definition. Ko (2015) stresses that where a health body identifies a child under school age has an SEN or disability they must inform the child's parents and inform the Local Authority where appropriate.

## **9.6 Special Educational Needs and Disability Policy**

Edward Timpson MP launched the Children and Families Act in March 2014; it was billed by the Department for Education as the biggest education reform in a generation for children and young people identified with SEND (DfE, 2014a; Martin-Denham, 2015). Many of the reforms to SEND provisions, contained in the Children and Families Act, were introduced on 1 September 2014. These reforms stipulated a range of changes to the classification and categorisation systems, with respect to the needs presented by children identified with SEND. These changes are discussed later in this chapter.

The rationale for the Children and Families Act (2014) was to bring together disparate strands of legislation and embed the principles of inclusivity, agency and equality into policy aimed at meeting the needs of children identified with SEND. The rationale was to ensure relevant public bodies provided all children and young people with SEND access to integrated, multi-agency provision through new Education, Health and Care Plans (EHC plans).

The reforms also strongly advocated for the voices of young people and their parents to be better taken account of in choosing and funding the provision that best meets their needs. The principles of the Children and Families Act (2014) shaped the SEND Code of Practice (DfE, 2015a), as they set out the legal framework governing SEND and provided practical advice to organisations and bodies (such as Local Authorities, schools and colleges) in meeting their statutory obligations as set out in the Act.

The Driver Youth Trust released a report in 2015, highlighting the recent challenges and opportunities associated with the SEND reforms, from the authors' professional experiences of running charities focused on supporting children identified with SEND. The report presented many examples of high quality practice, emerging from the reforms. However, it argued that the system was still fragmented, with high quality practice appearing in 'pockets,' rather than across the system as a whole. This has led to difficulties in sharing information and knowledge. The report also indicated that one of the key causes of fragmentation was the lack of communication and support available to Local Authorities in navigating the changes to their role. Specifically, support for Local Authorities in developing their 'Local Offer' to children identified with SEN and their families was lacking. Additionally, the authors suggested that a disparate funding system was also exacerbating the difficulties associated with fragmentation in the system. The current funding models associated with SEND are explored later in this chapter.

The remainder of this chapter gives information on specific and relevant reforms to SEND policy, stemming from the Children and Families Act of 2014, as well as presents national data on the prevalence of SEND and explores current funding models associated with support for children identified with SEND.

## **9.7 National data overview**

Figure 2 overleaf highlights the national picture in terms of the primary need of pupils and their SEN classifications. It can be seen that Moderate Learning Difficulties are the most prevalent primary need for those identified as SEN support. In terms of Statement of SEN or EHC plan ASD is the most common need at 25.9% of this group.

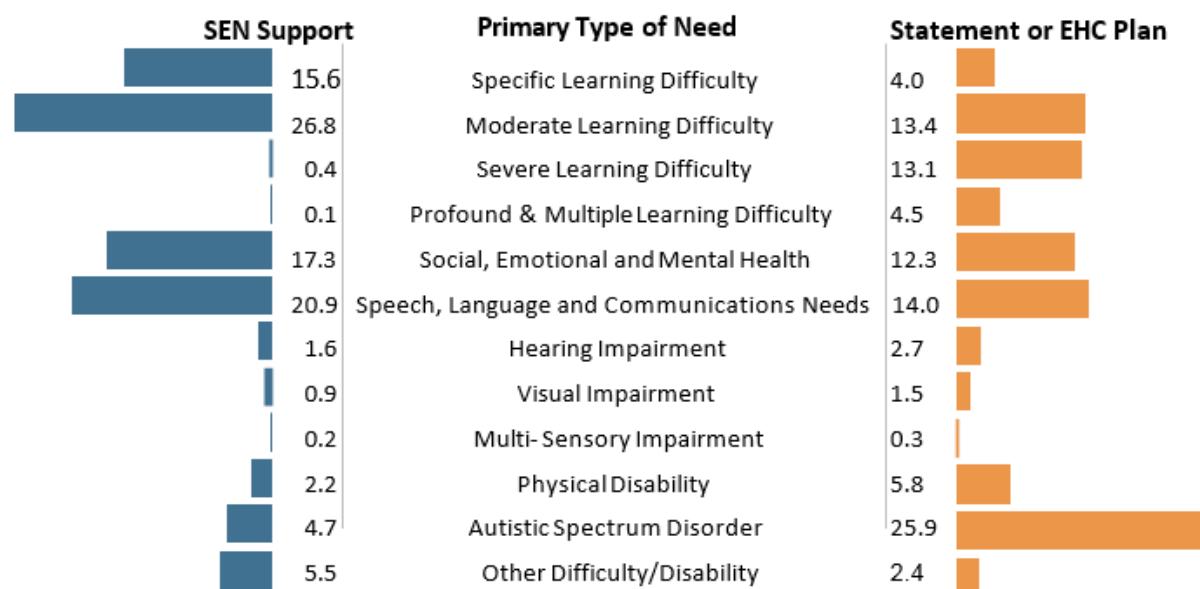


Figure 2: Percentages of pupils with identified Primary Needs and SEN classifications in the United Kingdom (DfE, 2016b). Pupils with SEND in state funded primary, secondary and specialist schools.

The DfE (2016b) presents that the number and proportion of pupils classified with SEN has been in decline since 2010. It clarifies that there are now 1.23 million pupils with SEN in schools in England. This represents 14.4 % of all pupils. Of these, 237,000 have a statement of SEN or EHC plan (2.8% of all pupils) and 992,000 have SEN Support (11.6% of all pupils). Ofsted (2016a) report that the proportion of pupils who have special educational needs and/or disabilities is at the lowest level since 2007. This decline is due to a fall in the proportion of pupils identified as having special educational needs without a statement or EHC plan (those in receipt of SEN Support). In 2016, this group declined to 11.6% of all pupils. This is the lowest on record and down 6.7 percentage points from its peak in 2010. Almost half of the reduction in the proportions of pupils identified as requiring special educational needs support has occurred since 2014, a 3.5 percentage point fall, when the revised SEND Code of Practice (DfE, 2015a) and Children and Families Act 2014 came into force. The proportion of the total pupil population with a statement or EHC plan has remained constant, at 2.8%, since 2007 (DfE, 2016b).

## **9.8 Statements to Education, Health and Care plans**

The previous SEND Code of Practice (DfES, 2001) advised that children whose SEND needs required specialist input from various professionals should to be issued with a Statement of SEN. This was intended to detail the specific support offered for an individual, usually with associated funding. One of the most radical changes initiated by the Children and Families Act 2014 was that the Statement of SEN was to be replaced by Educational Health and Care plans (EHC plans) by April 2018. These EHC plans are to focus, not only on education provision for children identified with SEND (previously covered in Statements of SEN), but also on health and social care needs (DfE, 2015a). Ko (2015) adds that the EHC is a statutory process with parents, a young person over the age of 16 but under the age of 25 or a person acting on behalf of the school or post 16 institution being able to request an EHC assessment.

The Education, Health and Care plan (EHC plan) was introduced with the principle of a person-centred approach to supporting children and their families (Martin-Denham, 2015). The rationale behind the change was to stimulate more joined up multi-agency working between public services working with individuals and their families. The SEND code of practice (DfE, 2015a) details that a pupil may be given an EHC plan once a formal assessment of a child's needs has been made. If a child is successful in applying for an EHC plan, the resultant document produced sets out the child's need(s) and the additional support they should receive; thus, better enabling families to hold public agencies to account in meeting their child's needs (DfE, 2016d). All children must have transferred from a Statement to an EHC plan by the 1st April 2018 (ibid).

Ofsted (2016a) stated that the proportion of boys (4%) who have an EHC plan or statement is more than twice that of girls (1.5%). Thirty per cent of boys who have a statement or EHC plan have Autism Spectrum Disorder identified as their primary need, compared with just under 15% of girls with an EHC plan or a statement.

The 20 week process is presented below:

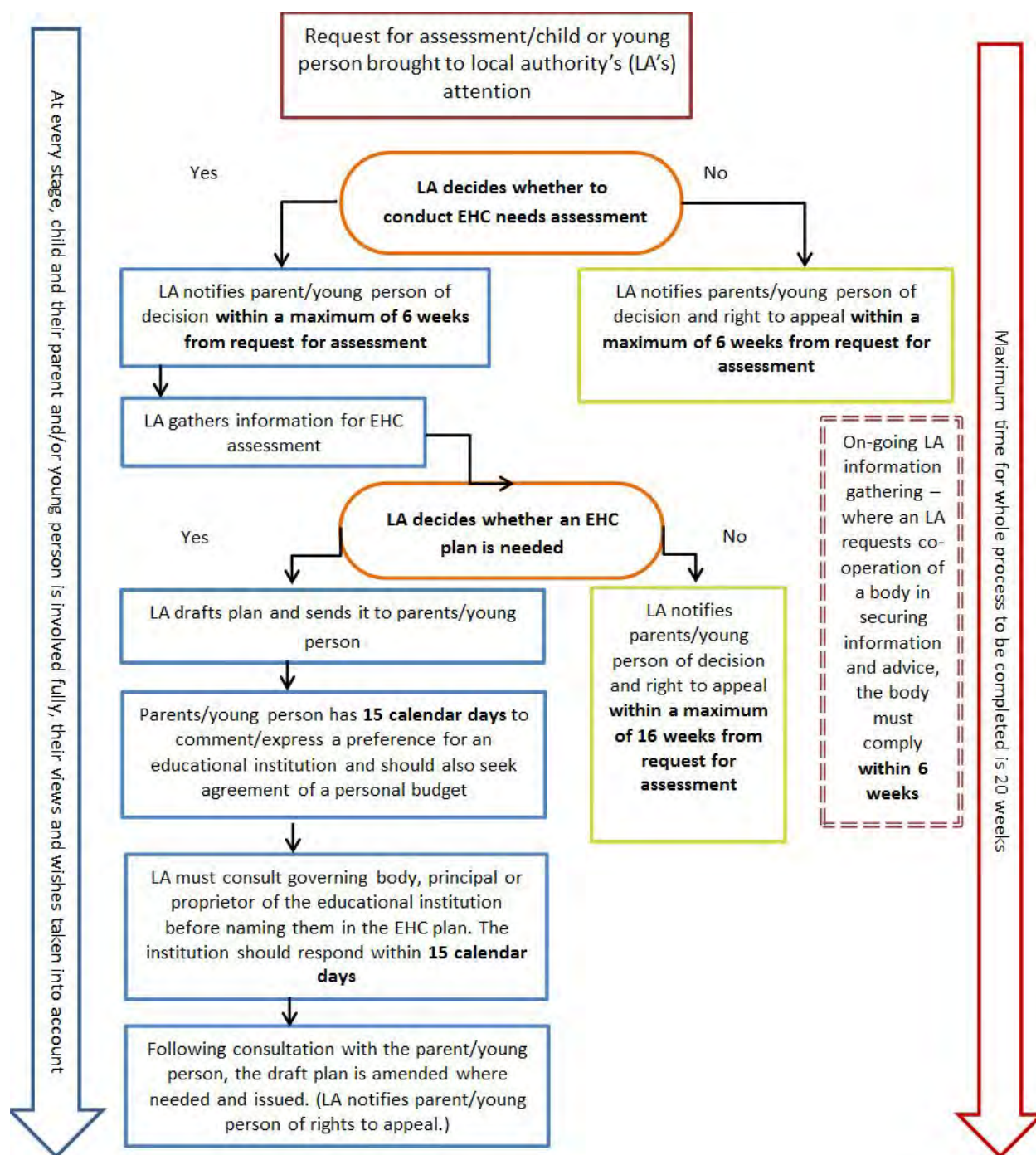


Figure 3: Statutory timescales for EHC needs assessment and EHC plan development (DfE, 2015a).

## 9.9 SEN Support

In addition to the Statement of SEN, the 2001 Code of Practice (DfES) detailed two additional layers of support for children identified with SEN; prior to applying for a Statement, children could be placed on 'School/Early Years Action,' or 'School/Early Years Action Plus.' The Children and Families Act (2014) eradicated this approach, instead replacing the two layers of support with one, entitled 'SEN Support.' Cowne (2015) clarifies that where children are in receipt of additional support, a record must be kept of the additional resources provided and progress made as a result of these.

SEN Support is defined by (DfE, 2016b, p. 4) as those children and young people where extra or different help is given from that provided as part of the school's usual curriculum. The SEND code of practice (DfE, 2015a, p. 100) is explicit that 'where a pupil is identified as having SEN, they should take action to remove barriers to learning and put effective special educational provision in place.' The class teacher and/or the special educational needs co-ordinator (SENCo) in a school may receive advice or support from outside specialists for children categorised as requiring SEN Support, if deemed appropriate by all agencies. The pupil on SEN Support does not have a Statement or Education, Health and Care Plan (EHC plan), as their needs are not deemed 'additional' enough to warrant the level of support afforded by one.

In their annual report 2015/16 Ofsted (2016a) shared that in some parts of the country, less than 40% of pupils in receipt of special educational needs support are progressing well. The report found that local areas were tracking the progress of these pupils less systematically, compared to pupils with statements or education, health and care plans. On a positive note they reported that local areas were becoming more accurate in their identification of children and young people who have special educational needs and/or disabilities. As a result of this the proportion of pupils identified as needing special educational needs support was at the lowest point in almost a decade (ibid).



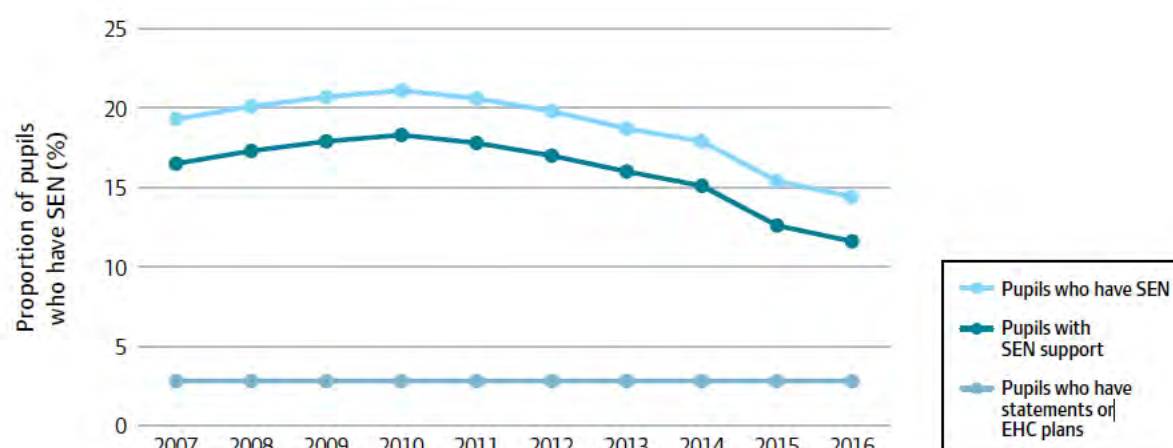


Figure 4: The proportion of pupils who have special educational needs (SEN) and SEN provision in schools, January 2007 - 2016 (Ofsted, 2016a).

### 9.10 Broad areas of need

The Children and Families Act 2014 also brought about changes to the categorisation of SEND. The previous category of ‘Behaviour, Emotional and Social Difficulties (BESD)’ was removed (DfES, 2001); a new classification ‘Social, Emotional and Mental Health (SEMH)’ was introduced, although this was not intended to be a direct replacement. The rationale for this change was to ensure that practitioners assessed the reason for their behaviour in order to meet the underlying need (Martin-Denham, 2015). The SEND code ‘SEN Support but no specialist assessment of type of need’ was also introduced in 2015. The introduction of four broad areas of need, are discussed in detail below; all definitions have been adapted from the DfE (2015a) Special Educational Needs and Disability Code of Practice. The following definitions include introductions to various primary types of need, which will be expanded in greater detail later in this chapter.

### **9.10.1 Communication and Interaction**

One of the most prevalent primary types of need nationally is speech, language and communication needs (SLCN). Children identified with SLCN display difficulties in communicating with others. This may be because they have difficulty in saying what they want to do, understanding what is being said to them or they do not understand or use social rules of communication. The profile for every child identified with SLCN is different and their needs may change over time. They may have difficulty with one, some, or all of the different aspects of speech, language or social communication at different times of their lives. Children and young people who are identified with Autism are likely to present specific difficulties with social interaction. They may also experience difficulties with language, communication and imagination, which can impact on how they relate to others.

### **9.10.2 Cognition and learning**

Difficulties with cognition and learning are often experienced as young people learning at a slower pace than their peers, even with appropriate differentiation. Special Educational Needs that affect learning covers a wide range of needs, including Moderate Learning Difficulties (MLD), Severe Learning Difficulties (SLD), where children are likely to need support in all areas of the curriculum and associated difficulties with mobility and communication, through to Profound and Multiple Learning Difficulties (PMLD), where children are likely to have severe and complex learning difficulties as well as Physical Disability or Sensory Impairment. The broad area of cognition and learning may also include children identified with specific learning difficulties (SpLD), which affect one or more specific aspects of learning, such as dyslexia, dyscalculia, dyspraxia and ADHD.

### **9.10.3 Social, Emotional and Mental Health difficulties**

This category represents a radical change in SEND policy, as it acknowledges mental health needs as special educational needs for the first time (Kennedy, 2015). The SEND code of practice (DfE, 2015a) explains that children and young people may experience a wide range of social and/or emotional difficulties throughout their childhood and adolescence, which may manifest themselves in different ways. This may include becoming withdrawn or isolated, as well as displaying challenges, 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 needs that fall under the broad area of social, emotional and mental health difficulties may include Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder or Attachment Disorder. The SEND code (DfE, 2015a) also highlights the importance of schools and colleges implementing clear processes for effectively managing behaviour, with the primary focus being to avoid disruption to other students.

### **9.10.4 Sensory and/or physical needs**

Children with needs that fall under 'sensory and/or physical needs' require additional provision because they have been identified with a disability which prevents or hinders them from making use of the educational facilities generally provided in their place of learning. The SEND code of practice (DfE, 2015a) explains that these difficulties are often age-related and can fluctuate over time. Many children with a Visual Impairment (VI), Hearing Impairment (HI), or a Multi-Sensory Impairment (MSI) will require specialist support and/or equipment to access their learning. Children identified with MSI have a combination of visual and hearing difficulties. Children identified with a Physical Disability (PD) also fall under this broad area of need, as they often require additional ongoing support and equipment to access all of the opportunities available to their peers.

### **9.11 The graduated approach**

The SEND code of practice (DfE, 2015a) advocates a graduated approach to meeting the needs of children that have been identified as requiring SEN Support. This support requires schools/colleges to implement practices that act to remove barriers to learning for that child and enable effective SEND provision to occur. There is a strong emphasis in early identification of children requiring SEN Support, therefore, it is anticipated that, in many cases, needs assessment takes place in the early years. Additionally, it explains that the graduated approach must emanate at whole school level and that the overall responsibility for the pupil identified with SEND lies with the class/subject teacher and not with the SENCo/learning support department.

In 2014, as a response to the Children and Families Act, 2014 earlier that year, NASEN (2014) released a report that distilled the graduated approach for practitioners in line with the SEND Code of Practice (DfE, 2015a). This report echoed the SEND code explaining that SEN Support should arise from a four-part cycle, known as the graduated approach, ‘through which earlier decisions and actions are revisited, refined and revised, leading to a growing understanding of the pupil’s needs and of what supports the pupil in making good progress and securing good outcomes’ (p.2). The graduated approach draws on personalised methods of support, with more frequent reviews and more specialist input. It is intended that this approach will better enable teachers to tailor interventions in meeting individuals’ needs. There are four distinct stages to the graduated approach, which form a cycle of effective practice in meeting the needs of children identified as needing SEN Support. These stages are entitled:

- Assess
- Plan
- Do
- Review

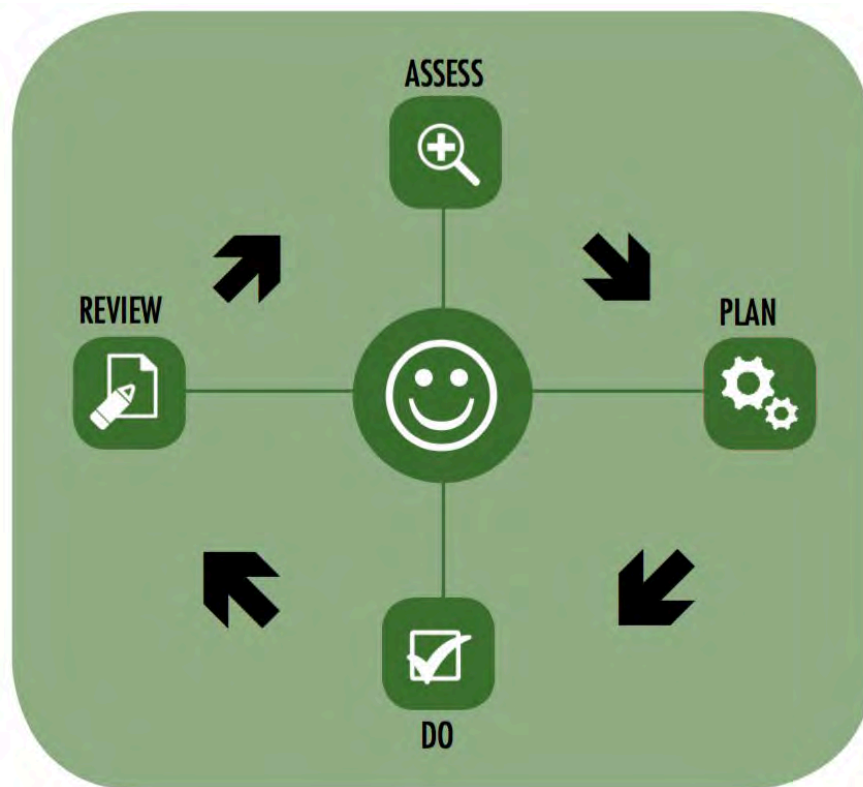


Figure 5: Graduated approach to SEND identification (NASEN, 2014, p.2).

### 9.11.1 Assess

The DfE (2015a) code of practice details the ‘assess’ stage as an early years practitioner carrying out an analysis of a child’s needs, with support from the SENCo and the child’s parents/carers. This initial assessment should be reviewed regularly to ensure that support is matched to need. Where there is little or no improvement in the child’s progress, more specialist assessment may be called for from specialist teachers or from health, social services or other agencies beyond the setting. Where professionals are not already working with the setting, the SENCo should contact them, with the parents’ agreement. As Farrell (2017) suggests identification and assessment across the range of special educational needs and disabilities will relate to the definitions and related criteria used. It is expected these will be supplemented by various other assessments including psychometric tests, observations and discussions with parents and carers.

### **9.11.2 Plan**

When professionals have decided that SEN Support is required, and having formally notified the parents, the practitioner and the SENCo should agree, in consultation with the parent, the outcomes they are seeking, the interventions and support to be put in place, the expected impact on progress, development or behaviour, and a clear date for review. Plans should take into account the views of the child and involve parental input. The support and intervention should be selected to meet the outcomes identified for the child, based on reliable evidence of effectiveness, and provided by practitioners with relevant skills and knowledge. Any related staff development needs should be identified and addressed.

### **9.11.3 Do**

This is the implementation phase of SEN Support. During this phase, the early years practitioner, usually the child's key person, remains responsible for working with the child on a daily basis. With support from the SENCo, they should oversee the implementation of the interventions or programmes agreed as part of SEN Support. The SENCo should support the practitioner in assessing the child's response to the action taken, in problem solving and advising on the effective implementation of support.

### **9.11.4 Review**

The DfE (2015a) code of practice explains that regular reviews of the effectiveness of support provided and its impact on the child's progress should occur. The impact and quality of the support should be evaluated by the practitioner and the SENCo working with the child's parents, taking into account the child's views. They should agree any changes to the outcomes and support for the child in light of the child's progress and development. Parents should have clear information about the impact of the support provided and be involved in planning next steps.

## **9.12 Primary types of need, prevalence and definitions**

The Department for Education (DfE) collect what is called a primary type of need for those pupils on SEN Support or with a Statement or EHC plan (2016b). This section presents each primary type of need and gives a research-informed definition of the needs. It should be noted that many of these needs are inter-connected and can present simultaneously in individuals, therefore, primary needs should not be thought of as entirely distinct from one another. This will be discussed in greater detail later in this chapter. It is also important to note that for many of these types of needs there isn't one agreed definition and that the severity of each type of need is not able to be categorised.

The legislative changes in the Children and Families Act (2014) resulted in changes to collection of primary need data between 2015 and 2016. Pupils who were previously categorised as being on School Action were not required to have a primary type of need recorded. From 2015, pupils who were on School Action and have transferred to SEN Support have been recorded as having a primary type of need. This has led to an increase in the number of pupils recorded as having a primary type of need. There may have been some pupils who were still on School Action in the 2015 collection who did not provide a primary type of need, however there were no pupils recorded as School Action in 2016.

The prevalence of a special educational need or a disability, for example ASD, refers to the proportion of a population estimated to have that type of need which is often given as a percentage or the number of individuals found in the population studied (Farrell, 2017). The incidence of a special educational need or a disability is important to allow for future planning in health providers and in educational contexts. It needs to be noted that determining prevalence is not straightforward due to the range of assessments used in diagnosis, the subjective nature of diagnosis and the variation in consideration of co-morbidity (Martin-Denham, 2015).

All figures presented in the remainder of this section have been taken from the DfE's (2016b) latest statistical first release, based on data gathered in January 2016, published in July 2016, which presents the national prevalence for each separate primary SEND need. The figures represent the percentages of primary need identification, within the national SEND population. The national percentages include all types of school. It should be noted that percentages have been rounded up; therefore, there may be discrepancies between total numbers of children and the sum of constituent parts.

Interestingly within the SEND code of practice (DfE, 2015a) definitions of primary needs are not provided. For the purposes of this research it was important to provide clarity by defining the range of special educational needs and disabilities referred to in the data sets and in the literature reviews. As Farrell (2017) notes, defining some disabilities is challenging. It is important not to be rigid within these definitions as there is overlap between mild, moderate and severe which is often reliant on interpretation and individual judgement.

### **9.12.1 SpLD: Specific Learning Difficulty**

**Definition:** Specific Learning Difficulties (or SpLDs), affect the way information is learned and processed. They are neurological (rather than psychological), usually run in families and occur independently of intelligence. They can have significant impact on education and learning and on the acquisition of literacy skills (British Dyslexia Association, 2017).

**Overview:** Zakopoulou et al. (2014) acknowledge that the term Specific Learning Difficulties (SpLD) integrates a number of difficulties which may affect communication, such as Dyspraxia, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Dysphasia, Asperger's Syndrome, Dyscalculia and Dyslexia. The British Dyslexia Association (2017) agree adding that SpLD is an umbrella term used to cover a range of frequently co-occurring difficulties. They also clarify that SpLDs can also co-occur with difficulties on the Autism Spectrum such as Asperger Syndrome (British Dyslexia Association, 2017).



**National prevalence:** The Driver Youth Trust (2015) suggest that nationally there are 13% of children and young people with Specific Learning Difficulties. The Department for Education present that SpLD are more prevalent in secondary aged pupils with SEN Support than primary aged pupils (DfE, 2016b). They add that 25.0% of 15 year olds on SEN Support had this primary type of need compared with 10.8% of 7 year olds of which Dyslexia is the most common need (British Dyslexia Association, 2017). In relation to Dyslexia and persistent literacy difficulties, identification is a barrier to accurate estimates of the number of young people with these difficulties in schools. Dyslexia Action estimates that 10% of children in the UK are dyslexic (Dyslexia Action, 2012). In addition, 15.6% of children on SEN Support have Specific Learning Difficulties; 4% of children identified with SEND have been issued a Statement/EHC plan for SpLD.

#### **9.12.2 MLD: Moderate Learning Difficulty**

**Definition:** Farrell (2017) refers to previous government guidance which states that students with 'moderate learning difficulties' will have attainments 'significantly below expected levels in most areas of the curriculum, despite appropriate interventions.' Also he adds that their needs will not be able to be met by usual differentiation and the flexibility of the National Curriculum (DCSF, 2009). Norwich et al. (2013) states that MLD is currently understood in the English school census definition to refer to significant general difficulties in literacy and numeracy learning and in understanding concepts. Furthermore, it is an important category to represent general learning difficulties and so acts as the reference point for specific learning difficulties (SpLD), which are understood as being distinct from MLD.

**Overview:** Norwich et al. (2012) comments that MLD is a term used to describe a group of pupils who continue to be the largest proportion of those identified as having a Special Educational Needs since 2010. Deforges (2006) suggested that compared to other areas of SEN, MLD is a neglected area for educational research and initiatives. Norwich and Kelly (2005) identify that one of the key questions to be considered is whether children and young people identified with MLD are simply those at the lowest end of the range of pupils with low attainment or whether they also have an intellectual disability. Farrell (2017) discusses the challenges of identification of children and young people with MLD because of a lack of agreed definitions.

**National prevalence:** MLD remains the most common primary type of need overall. 24.2% of pupils with special educational needs have this primary type of need. This percentage has increased since last year, from 23.8%. 26.8% of pupils on SEN Support have MLD as a primary type of need and 13.4% of all statements are allocated to children with Moderate Learning Difficulties. The large numbers of children identified with MLD may be explained by the ambiguous nature of the term; effective identification of this primary need can be challenging, as was discussed in the previous paragraph. This may be leading to significant over-diagnosis of this primary need, as many educational and health-focused needs could be identified under the umbrella term that is 'Moderate Learning Difficulty.'

### **9.12.3 SLD: Severe Learning Difficulty**

**Definition:** MacKay (2009) highlighted that the terminology and interpretation associated with severe and complex learning difficulties has been subject to ongoing debate and change across a range of professions. This has led to considerable diversity in the terminology used to denote the concepts involved in defining Severe Learning Difficulties. Historically, the definition of SLD was strongly rooted in the medical model of disability; a model in which within-child deficits was a prominent focus.

The rejection of the medical model of disability has inevitably resulted in the use of psychological and educational constructs in definitions. This has led to some disparity between medical diagnoses and educational concepts and, thus, has made a common definition of Severe Learning Difficulties across multi-agencies difficult. Additionally, there exists some widespread confusion, amongst educationalists and psychologists, as to what denotes the differences between the concepts of 'moderate' and 'severe' when diagnosing learning difficulties (MacKay, 2009).

**Overview:** It has been suggested that children identified with Severe Learning Difficulties take longer to process information than their non-SEN peers and often engage in the learning process passively, rather than actively participating (Lee, McGee and Ungar, 2001). They may also experience difficulties with attention or memory, reinforcing the argument made earlier in this paper, that Special Educational Needs and Disabilities are complex and involve a number of inter-related concepts. Furthermore, children with Severe Learning Difficulties are likely to experience significant barriers to effective communication, which can often lead to difficulties in forming attachments to their parents, teachers and/or peers (Goss, 2006).

**National prevalence:** Severe Learning Difficulties represent 0.4% of children on SEN Support nationally. Yet, 13.1% of children granted a Statement or EHC plan are identified with a Severe Learning Difficulty. This makes SLD the third most common primary need of children allocated a Statement of SEN/EHC plan. There are, therefore, many more children identified with SLD who have been given a Statement/EHC plan than those who are receiving SEN Support. This is likely explained by the fact that children with Severe Learning Difficulties likely require significant support to access learning; this support usually warrants a Statement/EHC plan, as the provision warranted under SEN Support does not meet the complexity of needs presented by a child/young person with SLD.

#### 9.12.4 PMLD: Profound and Multiple Learning Difficulty

**Definition:** Bellamy et al. (2010) suggest the following components as defining PMLD:

'extreme delays in intellectual and social functioning, limited verbal skills but responsive to environmental cues, dependence on familiar others to interpret communicative intent, frequent associated medical, physical or sensory impairments.' The DSM-5 (American Psychiatric Association, 2013, p.33) defines PMLD as 'deficits in both intellectual and adaptive functioning in conceptual social and practical domains' which start during the developmental period.

**Overview:** Glover et al. (2011) explain that PMLD is a description rather than a diagnostic category. Farrell (2017) describes how in terms of the conceptual domain the conceptual skills generally involve, 'the physical world rather than the symbolic processes.' He explains that the child or young person may use objects in a goal-orientated way for self-care, work and recreation. They may encounter challenges with motor and sensory impairments impacting on their ability to use objects functionally. In the social domain they may have very limited understanding of speech and gesture but may have some understanding of simple instructions and gestures. Finally, in the practical domain they will be depend on others for all aspects of physical care, health and safety. Male (2015) reflects that PMLD often co-occurs with physical difficulties sensory impairments or severe health conditions. She suggests causal factors as genetic syndromes and influences such as alcohol and drugs prior to birth. In addition, there are factors around the time of birth and difficulties with labour or delivery which can lead to problems with brain functioning in the new born child.

**National prevalence:** The percentages of children identified with SEN, whose primary need is categorised as PMLD is 4.6%. 4.5% of children have been allocated a Statement of SEN/EHC plan. Only 0.1% of children identified with SEND, with the primary need of Profound and Multiple Learning Difficulties are on SEN Support. As with MLD, there is some ambiguity surrounding the identification of PMLD, which may explain the low percentages of children in this category. This will be discussed in greater detail later in this chapter.

### 9.12.5 SEMH: Social, Emotional and Mental Health Difficulty

**Definition:** The World Health Organization (2011) describes mental health as:

‘A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.’

**Overview:** Department of Health (2013) state that there is a lack of nationally collated current data on the present extent of mental health problems and service provision. The report added that a total of 1 in 10 children and young people aged 5–15 years had a clinically diagnosable mental disorder and that self-harm is common, particularly in adolescence and those with a mental disorder. Mental health is described as being paramount to having a good quality of life, with children and young people who are happy and confident more likely to carry this into adulthood thus providing resilience in the face of adversity (WHO, 2012). The annual report of the Chief Medical Officer (2013) adds that psychiatric disorders among children and young people are common and persistent, the concern is they may increase in times of austerity due to increasing pressures on families and shrinking support available to them. She added that child mental health should be a high policy priority and that there was a desperate need for high-quality data on which to further develop services and to base the next generation of child mental health research programmes. Further to this there is a need for rigorous evaluations of different service models as well as more randomised trials of interventions and their implementation with fidelity into routine clinical practice. Also, improved co-ordination across children’s services and between child and adult mental health services is essential.

**National prevalence:** The percentage of children identified with SEND, whose primary need is recorded as Social, Emotional and Mental Health Difficulties is 19.6%. As was discussed earlier in this literature review, the Children and Families Act (2014) introduced this new categorisation of primary need. This was a significant reform as, for the first time; mental health was accepted as an area of SEND, requiring additional educational support. 17.3% of children identified with SEND are accessing SEN Support for their Social, Emotional and Mental Health Difficulties and 12.3% have been granted a Statement/EHC plan for this primary need. This makes Social, Emotional and Mental Health Difficulties the second most common primary need for children with a Statement/EHC plan, and third most common for children on SEN Support.

The Department of Health (2013), in their annual report, noted that the prevalence of psychiatric disorder among 5-15 year olds was 10% in two large national population-based surveys. The report acknowledged that the prevalence of disorder in this group has been overlooked internationally; it also highlighted that the combined data from these surveys revealed half of the 5-15 year olds with at least one psychiatric disorder also had a psychiatric disorder 3 years later.

Interestingly Social, Emotional and Mental Health Disorders are by far the most common primary need of children identified with SEND who are educated in Sunderland PRUs, yet there is no national data that details primary needs of children educated in PRUs so national comparison is limited.

As will be discussed in greater detail, later in this literature review, PRUs are a frequent place of education for children who have been excluded from mainstream schools. This suggests that a large number of exclusions are of children who are identified with Social, Emotional and Mental Health Disorders (McLaughlin, 2010).

Eames and Shippen (2017) SEMH argue joint working is essential if services are to survive, especially in times of financial hardship. However, this work is not always straightforward; each organisation has a different culture, language, and goals.

### 9.12.6 SLCN: Speech, Language and Communication Needs

**Definition:** Kersner (2015) defines speech as 'the mechanism by which most people communicate' requiring the use of the voice to make sounds. She explains it is not synonymous with language adding that speech is only one form of language, the spoken form, other being writing or signs.

**Overview:** Speech, Language and Communication Needs are one of the main primary needs within the board area of need entitled 'Communication and Interaction,' which was discussed earlier in this chapter. Public Health England (2015) identify that strong speech, language, and communication skills are associated with school readiness, and positive social and academic outcomes throughout childhood. The DfE (2016b) profile results show that for the aspect of speaking there is a year on year improvement in the percentage of children achieving at least the expected level. Ofsted (2014) highlight that, overall, children from low income backgrounds have fewer skills in language and communication. The preschool years therefore represent a prime opportunity to promote the language and communication of all children, but particularly those who may need additional input.

Farrell (2017) suggest a range of factors which may result in children and young people encountering challenges with speech, these include: physical difficulties with articulation, and /or problems with controlling pitch and or making sound contrasts that convey meaning. He adds that these difficulties are aspects respectively of phonetics, prosody and phonology. Just as the aspects are interrelated, so difficulties can co-exist.

**Phonetics:** Wright and Kersner (2015) refer to the study of articulation, which is explained as 'mastery of the sounds of the language.' They describe how it is a form of motor skill learning which leads to the automatic moving of speech articulators in the mouth in a fast and exact co-ordinated sequence.

**Prosody:** Farrell (2017) outlines how this refers to speech volume, patterns of intonation and changes in pitch. This involves rhythm and fluency of speech to convey meaning, enabling understanding from the listener.

**Phonology:** Wright and Kersner (2015) state that the definitions of phonology can be very broad, however, they suggest it concerns the differences in speech sounds carrying meaning and has been defined as 'the way in which individual sounds are put together to make words within a given language, such that changing a sound within a word will change meaning' p. 102.

**National Prevalence:** 34.9% of children identified with SEND have Speech, Language and Communication Needs listed as their primary need. 20.9% of children identified with SEND are on SEN Support to meet their Speech, Language and Communication Needs and 14% have been given a Statement/EHC plan for this primary need. Speech, Language and Communication Needs are the second most prevalent need of children on SEN Support, following Moderate Learning Difficulties (DoH, 2013).

#### **9.12.7 HI: Hearing Impairment**

**Definition:** Farrell (2017) outlines that hearing loss rarely affects all frequencies equally, so hearing is often distorted.

**Overview:** The newborn hearing screening programme for England (NHSP England) was introduced between 2002 and 2006 with full implementation achieved in March 2006. The aim of the programme is to screen eligible babies within the first few weeks of life and by three months of age at the latest, and to identify cases of congenital moderate to profound Permanent Childhood Hearing Loss (PCHI) by six months of age. Farrell (2017) clarifies that most deaf children are born to hearing parents.

**National prevalence:** 4.3% of children identified with SEND present with a Hearing Impairment. 2.7% of children identified with SEND have been granted a Statement of



SEND/EHC plan for Hearing Impairment; this is likely children who are profoundly deaf and require significant support in accessing learning. 1.6% of children identified with SEND and have a Hearing Impairment are on SEN Support; these children are likely to have their learning needs successfully met by schools following the four part cycle of SEN Support, as explained earlier in this chapter.

#### **9.12.8 VI: Visual Impairment**

**Definition:** Gray (2005) suggests that the term ‘Visual Impairment’ encompasses a broad spectrum of eye conditions and visual acuity levels. Visual acuity is defined as a person’s central vision which they use to see detail. The World Health Organisation (2016) states that in terms of visual function there are four levels; normal vision, moderate Visual Impairment, severe Visual Impairment and blindness. They add that moderate Visual Impairment combined with severe Visual Impairment are grouped under the term ‘low vision.’ low vision taken together with blindness represents all Visual Impairment. In addition to this the Royal institute of Blind People (RNIB, 2016) highlight that there are over thirty different types of Visual Impairment conditions. This view is shared by Willings (2017) who adds that there is such a wide range of Visual Impairments and that children and young people will have their own individual visual needs. It is widely accepted that there are a range of medical causes and that due to variation in the cause, type and severity the needs of children will vary accordingly (Salisbury, 2007; Gray, 2009; Glazzard et al. 2015 and Willings, 2017). It can be concluded that there are multiple causes of Visual Impairment which can include being genetically determined and can arise during the development of the foetus, during birth and throughout childhood stemming from a range of factors such as illness and trauma.

**National prevalence:** Children with a Visual Impairment comprise 2.4% of all children identified with SEND. The majority of children identified with a primary need of Visual Impairment have been successful in gaining a Statement of SEND/EHC plan, at 1.5% of the overall population of children identified with SEND. 0.9% of children identified with SEND are receiving SEND Support for a Visual Impairment.

### 9.12.9 MSI: Multi-Sensory Impairment

**Definition:** Multi-sensory impairment is the term used for a spectrum of conditions, including, but not limited to, individuals who are deafblind or have hearing and Visual Impairments as well as physical impairments and learning disabilities (Aitken, 2000).

**Overview:** It has been identified that children and young people with MSI experience numerous difficulties in many areas of daily life. McInnes and Treffry, 1982; McInnes, 1999 and Aitken, 2000 suggest that the characteristic areas of difficulty in MSI can be broadly summarised and grouped as follows:

- communication
- accessing and finding out information
- relationships
- mobility and orientation
- use of senses
- cognitive abilities

Aitken and Millar (2002) identify the impact that a Visual Impairment as well as additional difficulties can have on the communication skills of children and young people. The challenges can include: a reduced and confused experience of the world, becoming passive and isolated, and the tendency to be echolalic or repeating the last word said to them, all of which may limit their ability to make choices. Aitken and Millar (2002) highlight the effects of hearing impairment on individuals, including potential isolation from information and from other people. They add that a physical impairment in association with communication difficulties will also present additional challenges.

**National prevalence:** Multi-Sensory Impairment is the least prevalent primary need of children identified with SEND. A total of 0.5% of children identified with SEND present with a Multi-Sensory Impairment as their primary need. 0.3% of all children identified with SEND have been granted a Statement/EHC plan for a Multi-Sensory Impairment and 0.2% are accessing SEND Support for this primary need.

#### **9.12.10 PD: Physical Disability**

**Definition:** The term 'Physical Disability' covers a wide range needs and is challenging to define. The 2010 Equality Act defines a person with a physical, or mental, disability as one whose impairment has a long-term effect on their ability to carry out normal day-to-day activities (TSO). Research by Horridge et al. (2016) highlighted the multifaceted needs of physically disabled children and, indeed, their families. The authors conducted research in Sunderland, analysing over 8000 consultations with disabled children and young people attending paediatric disability clinics. The aim of the research was to develop a systemised and accepted nomenclature that encapsulated the multi-faceted and inter-related needs of disabled children. The researchers termed this nomenclature a Disabilities Terminology Set (DTS). The researchers identified a terminology set that included 296 terms to describe physical disabilities, highlighting the complexity of this primary need. The authors also identified that different physical disabilities can present different patterns of complexity, influenced by personal resilience, vulnerabilities, living and system environments as well as by the passage of time.

Ireland et al. (2016) argue that this devised terminology set should be used to better inform the discussions between health professionals, the child and their family. The Disabilities Terminologies Set was used by the authors in further research, to develop a Health, Functioning and Wellbeing Summary Traffic Light tool, which was given to children and their families immediately before their consultation with a health professional. This tool encouraged families to identify the key features of a child's physical disability that they required support with, and thus would prioritise in their forthcoming consultation. 60 families were involved in this study, again in Sunderland, and 87.1% of the resulting

consultations were thought to better address the needs of families than those in which the tool was not used.

Hinton and Kirk (2014) suggest there is a comparable lack of research on teachers' knowledge and perceptions of other conditions such as Arthritis, HIV and Cystic Fibrosis, for example, and research in these areas may identify additional and/or disease-specific issues, which have not been discussed here. A large scale national survey of teachers' knowledge of and attitudes towards pupils' long-term conditions may be useful to identify teachers' training needs in relation to pupils' long-term health conditions.

**National prevalence:** A total of 8% of children identified with SEND have a Physical Disability as their primary need. 5.8% of children identified with SEND have been successful in gaining a Statement/EHC plan for a Physical Disability; 2.2% are accessing SEND Support for a Physical Disability.

#### **9.12.11      ASD: Autism Spectrum Disorder**

**Definition:** Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them (National Autism Society, 2017). The DSM-5 specifies diagnostic criteria for Autism Spectrum Disorder (American Psychiatric Association, 2013). It specifies that Autism involves 'persistent deficits in social communication and social interaction, which occur in many contexts' (p. 50). Furthermore it adds that there may be limitations in social and emotional sharing, non verbal communication used in social interaction and being able to develop, sustain and understand relationships (ibid).

**National Prevalence:** ASD remains the most common primary type of need for pupils with a statement or EHC plan; 25.9% of pupils with a statement or EHC plan were categorised as having this primary need. This has increased slightly from 24.5% in 2015 (DfE, 2016b). 4.7% of pupils identified with SEN were receiving SEN Support for ASD. Therefore, the vast majority of children identified with ASD require the specialist co-ordinated support afforded by a Statement/EHC plan. This suggests that schools and colleges experience significant difficulties in educating children identified with ASD by following the graduated approach associated with SEN Support (DfE, 2015a).

#### **9.12.12 OTH: Other Difficulty/Disability**

**Definition:** There is no definition.

**National Prevalence:** The DfE's latest statistical first release (2016b) indicates that 7.9% of all children identified with SEND have a difficulty/disability that does not fall into the accepted diagnoses already explored in this chapter, and must be labelled as 'other.' 5.5% of children identified with SEND are accessing SEN Support for a difficulty/disability labelled as 'other,' and 2.4% have been given a Statement of SEND/EHC plan to meet their needs.

### **9.13 A Consideration of Co-morbidity**

As was presented above, the DfE (2016b) collect a primary type of need for those pupils on SEN Support or with a Statement of SEN/EHC plan. However, there is a wealth of evidence that highlights the multi-faceted nature of children's needs. Many children identified with SEND are likely to experience needs that fall under multiple categories and not simply that which is identified as their primary need (Kendall and Taylor, 2016; Riddick, 2012; Taylor et al., 2015). This is particularly common in children with ASD.

Horridge (2016a) suggests that population profiling to inform care pathways development and service design is essential. She proposes that by prompting families and clinicians to seek out associations, identifying them early and manage them in a timely way, ultimately results in better outcomes. This will impact positively on service planning and resource allocation as you are able to ensure there is sufficient capacity to meet needs within the NHS. It is suggested that it needs to be explored how this information can be securely shared with the Council to support service planning in education.

Gooch et al. (2014) outline that in recent years, there has been growing interest and research into the frequent co-occurrence of developmental disorders. Hulme and Snowling (2009) and Williams (2013) highlight that it is now well recognised that pure disorders are rare in development and that 'co-morbidity' is common.

Taylor et al. (2015) identified that one of the most common examples of co-morbidity is in relation to ADHD which is thought to be present in 30-60% of individuals whose primary needs has been identified as ASD. Pearson (2006) suggested that, for parents and teachers, these co-existing conditions can be of equal or greater concern than the core features of Autism and can have a significant impact on behaviour management, learning acquisition and the development of social relationships. Bradley and Bolton (2006) and Simonoff et al. (2008) reinforce that there is a very high prevalence of co-morbid mental health conditions associated with ASD, including ADHD, learning disabilities, emotional disorders, anxiety and phobic disorders. Furthermore, Murray et al. (2014) raise concerns that there is an under-reporting of neuropsychiatric co-morbidities within the British population of those with a diagnosis of ASD.

Those with ASD often experience additional health and mental health conditions and behavioural problems that can impact on their lives and on their families (Dominick et al. 2007; Hurtig et al. 2009). It is likely that the complexity of managing a child's ASD needs together with behaviour and mental health problems contributes to the higher levels of stress and distress seen in families of children with ASD compared to other families (Allik et al. 2006a; Lecavalier et al. 2006; Manning et al. 2010).

### 9.14 Identification/assessment of Special Educational Needs and/or Disabilities

Figure 6 below shows the opportunities to assess and record information about all children in England (Ofsted, 2014). Ofsted outline that when children are born, their birth is recorded and Health Visitors also visit immediately after the birth and assess the child's family environment to identify possible information and support that may be needed. There are further checks as part of the Healthy Child Pathway at six weeks, three to four months, five to eight months and one year. At around the age of two, all children should be assessed again by health services, and there should also be a check within the EYFS if the child is in an EYFS registered setting. Data on outcomes are critical to ensure that providers can be held to account for the impact they have.

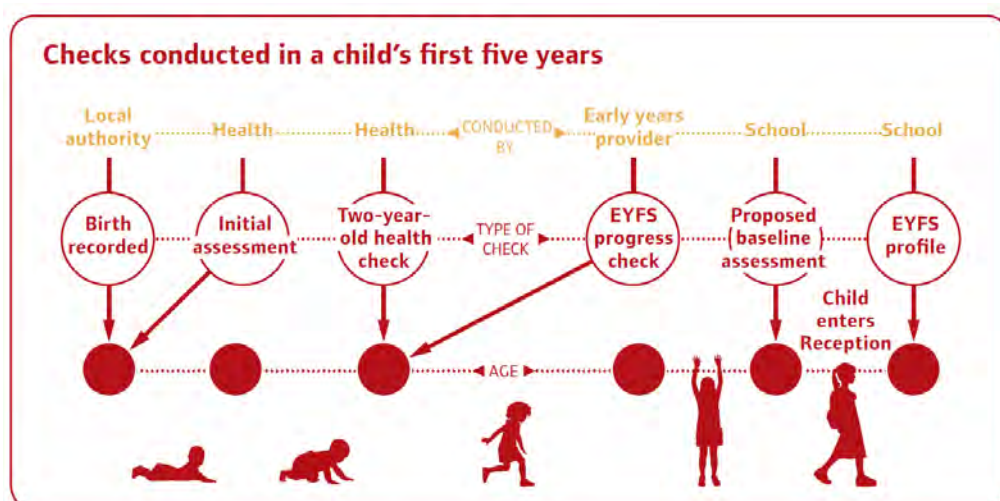


Figure 6: Checks carried out by early years providers and school within the child's first five years (Ofsted, 2014).

The current SEND code of practice (DfE, 2015a) repeats the previous recommendations of the earlier codes that SENCos and teachers should work collaboratively in identifying and assessing the special needs of children and young people (DfEE, 1994; DfES, 2001). In the 2015 guidance it states 'where a pupil is identified as needing SEN Support, the class teacher or subject teacher, working with the SENCo, should carry out a clear analysis of the pupils needs.'

Wedell (2017) discussed the issue of the term 'a clear analysis' proposing that this understates the complexity of achieving this. It was identified by SENCOs that there are insufficient tools available to identify needs accurately or reliably at school level. The identification of SEND should be built into the overall approach to monitoring the progress and development of all pupils (NASEN, 2015). Laija-Rodriguez et al. (2013) raise the concern that the primary issue of assessment in school is to identify deficits, especially when applying for support. They do acknowledge that strengths are noted on Individual Education Plans (IEPs)

The Driver Youth Trust (2015) highlighted that reforms to LA provision and regional variation have led to inconsistency in identifying pupils' needs. As a result several interviewees in the research suggested that parents are paying for private diagnostic assessments if they suspect their children have Dyslexia.

### **9.15 Special Educational Needs and/or Disability in the EYFS**

Ofsted (2014) describe the early years, otherwise known as the foundation years as the time between birth and the 31 August following their fifth birthday. They add that Local Authorities must now offer all children a place in a school Reception class from the September following their fourth birthday. Robert-Holmes (2012) wrote that the Early Years Foundation Stage (EYFS) framework, was published in March 2007 and implemented in September 2008 it built on and replaced the non-statutory Birth to Three Matters guidance (DfES 2003) and the Foundation Stage curriculum for three and four year olds (QCA 2000), and the National Standards for Day Care (Sure Start, 2003). Rogers (2011) described the EYFS as providing a 'long-awaited and distinctive educational phase' for children in English early years settings through a play based and developmentally relevant framework, designed with a focus on education and care.



The Tickell Review (2011) states that the earliest years in a child's life are absolutely critical. There is overwhelming international evidence that foundations are laid in the first years of life which, if weak, can have a permanent and detrimental impact on children's longer term development. A child's future choices, attainment, wellbeing, happiness and resilience are profoundly affected by the quality of the guidance, love and care they receive during these first years.

HM Government (2010) stated that the evidence was clear that children's experiences in their early years strongly influence their outcomes in later life, across a range of areas from health and social behaviour to their employment and educational attainment. It added that the most recent neuroscientific evidence highlights the particular importance of the first three years of a child's life. A strong start in the early years increases the probability of positive outcomes in later life; a weak foundation significantly increases the risk of later difficulties.

As Martin-Denham (2015) explained when it is becoming apparent that a child in the early years is not meeting expected levels of progress, practitioners and the SENCo need to gather information on the child's learning and development to allow early intervention to begin. It is important to consider causal factors such as the home environment, poverty and family circumstances. Ofsted (2016a) reported that good early years education, particularly for children from low-income backgrounds, is crucial to longer term academic success. In 2010/11, in some deprived areas of the country, less than half the early education provision available was good or outstanding. They have shared that in the last five years there have been considerable changes for the better:

- Across the country, 91% of early years providers are now good or outstanding: a 22 percentage point increase since 2010.
- The proportion of good and outstanding nurseries and pre-schools is now almost identical in the least and most deprived areas.
- This year, in every Local Authority area in the country, at least eight out of 10 childcare places are in registered providers of early education judged good or outstanding.

- In 2016, over two thirds of young children reached the government's 'good level of development' compared with just over a half in 2013 (ibid).

Nutbrown (2012) raised the concern of qualifications for early years professionals. Her concerns were that currently, early years group settings must be managed by someone with at least a relevant level 3 qualification but that at the time half the staff were only qualified to level 2. But many level 3 qualifications currently on offer are insufficient in content and standard. She recommended that the content of level 3 qualifications be strengthened, to include more child development and play, more on special educational needs and disability. More recently, Ofsted (2014) have recognised that children from low income families make the strongest progress when supported by highly qualified staff, particularly with graduate level qualifications.

## **9.16 The prime and specific areas of learning**

The DfE (2017) framework states that there are seven areas of learning and development that must shape educational programmes in early years settings. All areas of learning and development are important and inter-connected. Three areas are particularly crucial for igniting children's curiosity and enthusiasm for learning, and for building their capacity to learn, form relationships and thrive. The prime areas of learning are explored below:

### **9.16.1 Communication and language**

**Listening and Attention:** children listen attentively in a range of situations. They listen to stories, accurately anticipating key events and respond to what they hear with relevant comments, questions or actions. They give their attention to what others say and respond appropriately, while engaged in another activity.

**Understanding:** children follow instructions involving several ideas or actions. They answer 'how' and 'why' questions about their experiences and in response to stories or events.

**Speaking:** children express themselves effectively, showing awareness of listeners' needs. They use past, present and future forms accurately when talking about events that have happened or are to happen in the future. They develop their own narratives and explanations by connecting ideas or events.

### **9.16.2 Physical development**

**Moving and handling:** children show good control and co-ordination in large and small movements. They move confidently in a range of ways, safely negotiating space. They handle equipment and tools effectively, including pencils for writing.

**Health and self-care:** children know the importance for good health of physical exercise, and a healthy diet, and talk about ways to keep healthy and safe. They manage their own basic hygiene and personal needs successfully, including dressing and going to the toilet independently.

### **9.16.3 Personal, social and emotional development**

**Self-confidence and self-awareness:** children are confident to try new activities, and say why they like some activities more than others. They are confident to speak in a familiar group, will talk about their ideas, and will choose the resources they need for their chosen activities. They say when they do or don't need help.

**Managing feelings and behaviour:** children talk about how they and others show feelings, talk about their own and others' behaviour, and its consequences, and know that some behaviour is unacceptable. They work as part of a group or class, and understand and follow the rules. They adjust their behaviour to different situations, and take changes of routine in their stride.

**Making relationships:** children play co-operatively, taking turns with others. They take account of one another's ideas about how to organise their activity. They show sensitivity to others' needs and feelings, and form positive relationships with adults and other children.

The specific areas of learning are explored below:

#### **9.16.4 Literacy**

**Reading:** children read and understand simple sentences. They use phonic knowledge to decode regular words and read them aloud accurately. They also read some common irregular words. They demonstrate understanding when talking with others about what they have read.

**Writing:** children use their phonic knowledge to write words in ways which match their spoken sounds. They also write some irregular common words. They write simple sentences which can be read by themselves and others. Some words are spelt correctly and others are phonetically plausible.

#### **9.16.5 Mathematics**

**Numbers:** children count reliably with numbers from 1 to 20, place them in order and say which number is one more or one less than a given number. Using quantities and objects, they add and subtract two single-digit numbers and count on or back to find the answer. They solve problems, including doubling, halving and sharing.

**Shape, space and measures:** children use everyday language to talk about size, weight, capacity, position, distance, time and money to compare quantities and objects and to solve problems. They recognise, create and describe patterns. They explore characteristics of everyday objects and shapes and use mathematical language to describe them.

#### **9.16.6 Understanding the world**

**People and communities:** children talk about past and present events in their own lives and in the lives of family members. They know that other children don't always enjoy the same things, and are sensitive to this. They know about similarities and differences between themselves and others, and among families, communities and traditions.

**The world:** children know about similarities and differences in relation to places, objects, materials and living things. They talk about the features of their own immediate environment and how environments might vary from one another. They make observations of animals and plants and explain why some things occur, and talk about changes.

**Technology:** children recognise that a range of technology is used in places such as homes and schools. They select and use technology for particular purposes.

#### **9.16.7 Expressive Arts and Design**

**Exploring and using media and materials:** children sing songs, make music and dance, and experiment with ways of changing them. They safely use and explore a variety of materials, tools and techniques, experimenting with colour, design, texture, form and function.

**Being imaginative:** children use what they have learnt about media and materials in original ways, thinking about uses and purposes. They represent their own ideas, thoughts and feelings through design and technology, art, music, dance, role-play and stories.

Table 4

*Key differences between the prime and the specific areas (Tickell, 2011).*

| Prime areas                                                                                                                                                                | Specific areas                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Are time-sensitive. If not securely in place by the age of 5, they will be more difficult to acquire and their absence may hold the child back in other areas of learning. | Are less time-sensitive. Specific areas of learning reflect cultural knowledge and accumulated understanding. It is possible to acquire these bodies of knowledge at various stages through life. |
| Are characterised by their universality. They occur in all socio-cultural contexts.                                                                                        | Are skills and knowledge which are specific to priorities within socio-cultural contexts.                                                                                                         |
| Are not dependent on the specific areas of learning, although the specific areas of learning provide the context for their development.                                    | Are dependent on learning in the prime areas – the specific learning cannot easily take place without the prime.                                                                                  |

The DfE (2017) statutory guidance states that educational programmes must involve activities and experiences for children, as follows:

**Communication and language** development involves giving children opportunities to experience a rich language environment; to develop their confidence and skills in expressing themselves; and to speak and listen in a range of situations.

**Physical development** involves providing opportunities for young children to be active and interactive; and to develop their co-ordination, control, and movement. Children must also be helped to understand the importance of physical activity, and to make healthy choices in relation to food.

**Personal, social and emotional development** involves helping children to develop a positive sense of themselves, and others; to form positive relationships and develop respect for others; to develop social skills and learn how to manage their feelings; to understand appropriate behaviour in groups; and to have confidence in their own abilities.

**Literacy development** involves encouraging children to link sounds and letters and to begin to read and write. Children must be given access to a wide range of reading materials (books, poems, and other written materials) to ignite their interest.

**Mathematics** involves providing children with opportunities to develop and improve their skills in counting, understanding and using numbers, calculating simple addition and subtraction problems; and to describe shapes, spaces, and measure.

**Understanding the world** involves guiding children to make sense of their physical world and their community through opportunities to explore, observe and find out about people, places, technology and the environment.

**Expressive arts and design** involves enabling children to explore and play with a wide range of media and materials, as well as providing opportunities and encouragement for sharing their thoughts, ideas and feelings through a variety of activities in art, music, movement, dance, role-play, and design and technology.

### **9.17 The progress check**

The DfE (2017) framework advises that:

'When a child is aged between two and three, practitioners must review their progress... If there are significant emerging concerns, or an identified special educational need or disability, practitioners should develop a targeted plan to support the child's future learning and development p. 13.'

The EYFS framework adds that practitioners should encourage parents and/or carers to share information from the progress check with other relevant professionals, including their health visitor and the staff of any new provision the child may transfer to. Practitioners must agree with parents and/or carers when will be the most useful point to provide a summary. Where possible, the progress check and the Healthy Child Programme health and development review at age two (when health visitors gather information on a child's health and development) should inform each other and support integrated working. This will allow health and education professionals to identify strengths as well as any developmental delay and any particular support from which they think the child/family might benefit. Providers must have the consent of parents and/or carers to share information directly with other relevant professionals.

#### **9.18 Assessment in the Early Years Foundation Stage (EYFS): The EYFS Profile**

The Standards and Testing Agency (2016) confirmed that the EYFS profile was due to become non-statutory from September 2016. The DfE (2016f) has now confirmed that the EYFS profile will remain statutory for the 2016 to 2017 and 2017 to 2018 academic years. Wormwell (2016) shares that the current main method of assessment in reception is the EYFS Profile. Teachers assess a child's attainment against the 17 Early Learning Goals (ELGs) using a best fit judgement for each pupil. Pupils are judged as 'emerging' – not yet achieving the ELG, 'expected' - achieving the ELG, and 'exceeding' - achieving beyond the ELG and working within the National Curriculum. Points are awarded on a scale of 1-3, with 1 being the point for 'emerging'.



### **9.19 Good Levels of Development nationally and in Sunderland**

Ofsted (2014) detail that the only outcomes data for ages 0–5 that are consistently recorded and published are in the Early Years Foundation Stage Profile (EYFSP). They explain that the EYFSP is an assessment conducted by schools at the end of the Reception year. As well as individual judgements about the development of each child in different areas of learning, the EYFSP includes an assessment of whether each child has reached a ‘good level of development’, based on criteria set by the government.

Ofsted (2016a) reported that, the proportion of children achieving a good level of development in the early years was 69.3%, this was an increase of three percentage points since 2015. They acknowledged that the rate of improvement was not as rapid as in the previous two years. However, overall, the proportion of children achieving a good level of development has risen by 17.6 percentage points since 2013. In the last three years, each region in England has seen an increase in the percentage of children achieving a good level of development, with the North East showing the greatest improvement (ibid).

Table 5 overleaf shows a comparison of regional Local Authorities (LAs) in terms of the percentage of children on free school meals who achieve a good level of development at the end of reception year. Sunderland is the highest achieving LA in comparison to neighbouring areas. A Good Level of Development (GLD) is defined as the number and proportion of children achieving at least the expected level within the three prime areas of learning: communication and language; physical development and personal, social and emotional development; and the early learning goals within the literacy and mathematics areas of learning.

Table 5

Percentage of children on Free School Meals (FSM) achieving a Good Level of Development (GLD) at the end of EYFS (Ofsted, 2014).

| Local Authority     | % GLD |
|---------------------|-------|
| Sunderland          | 34    |
| Northumberland      | 30    |
| Newcastle upon Tyne | 28    |
| Stockton on Tees    | 22    |
| Durham              | 26    |
| South Tyneside      | 33    |

## 9.20 The Role of Special Educational Needs Co-ordinator (SENCo)

Oldham and Radford (2011) write that historically the position of SENCo was made statutory by the 1993 Education Act and the SEN Code of Practice set out its purpose (DfEE, 1994). Cheminais (2015) highlights that the SEN regulations (2014), the SEND code of practice (0-25) (2014) and Part 3 of the Children and Families Act (2014), formed the new SEND statutory framework, and these represented the biggest reforms in just over three decades. These changes have impacted on the role of the SENCo how is now seen as central in leading improvement for SEND.

The SEND Code of Practice (DfE, 2015a) requires governing bodies of maintained mainstream schools and the proprietors of academy schools (including free schools) to ensure that there is a qualified teacher designated as Special Educational Needs (SEN) co-ordinator (SENCo) for the school. The National award for SEN co-ordination is a mandatory award that must be accredited by universities, and individual courses may be chosen by local authorities or schools. The courses are designed to support professional development and help improve practice (NCTL, 2015). Wedell (2014) The most recent SEND code of practice (DfE, 2015a) increased the emphasis that previous versions placed on class teachers' responsibility for responding to the diversity of children's learning needs, through quality first teaching.

Done et al. (2016) discusses the shift in the SENCo role over recent years and suggests that instead of functioning as an 'in-house expert' to whom responsibility for inclusion could be delegated, the SENCo is now more likely to be engaged in whole-school organisational-level initiatives including, performance evaluation, the identification and leading of continuing professional development (CPD) requirements. The challenge with this is that the SEND code of practice (DfE, 2015a) states that the SENCo 'should' not 'must' be on the Senior Leadership Team. In light of this many SENCos remain unable to be a key leader in terms of co-ordinating provision and practice. It is evident from research that the role of the SENCo is challenging, stressful and demanding due to limited time to do the role.

Related to this, there has been concern raised nationally by university providers of the Post Graduate Certificate National Award for Special Educational Needs Co-ordination that some Head Teachers are changing their SENCo every three years to avoid funding their SENCos to complete the required qualification. It is recommended that the City Council keep a register of which schools have a qualified SENCo in post to develop expertise in identifying needs with stringent policies, processes and procedures, a lack of resources, funding and fear of litigation (Cole and Johnson, 2004).

The SENCo role includes the following duties (DfE, 2015a, NCTL, 2014).

- Overseeing the day-to-day operation of the school's SEN policy
- Coordinating provision for children with SEN
- Liaising with the relevant designated teacher where a looked after pupil has SEN
- Advising on a graduated approach to providing SEN Support
- Advising on the deployment of the school's delegated budget and other resources to meet pupils' needs effectively; Liaising with parents of children with SEN
- Liaising with other schools, educational psychologists, health and social care professionals, and independent or voluntary bodies
- Being a key point of contact with external agencies, especially the LA and LA support services

- Liaising with potential next providers of education to ensure a young person and their parents are informed about options and a smooth transition is planned
- Working with the head teacher and school governors to ensure that the school meets its responsibilities under the Equality Act (2010) with regard to reasonable adjustments and access arrangements
- Ensuring that the school or maintained nursery keeps the records of all children with SEN up to date

### **9.21 The Role of National Health Service (NHS) and Clinical Commissioning Groups (CCGs)**

Clinical Commissioning Groups (CCGs) were created following the 2012 Health and Social Care Act, and replaced Primary Care Trusts on 1 April 2013. CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. There are now 209 CCGs in England. NHS England is the statutory body responsible for overseeing the commissioning of health services by CCGs (Compact Voice, 2015).

The main role of CCGs is to ensure that the best possible health outcomes for the local population are supported, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc. It is an ongoing process, and CCGs must constantly respond and adapt to changing local circumstances. CCGs are responsible for the health of their entire population, and are measured by how much they improve outcomes.

CCGs are:

- Membership bodies, with local GP practices as the members
- Led by an elected Governing Body made up of GPs, other clinicians including a nurse and a secondary care consultant, and lay members
- Responsible for approximately 2/3 of the total NHS England budget; or £71.9 billion in 2016/17

- Responsible for healthcare commissioning such as mental health services, urgent and emergency care, elective hospital services, and community care
- Independent, and accountable to the Secretary of State for Health through NHS England
- Responsible for the health of populations ranging from under 100,000 to 900,000, although the average population covered by a CCG is about a quarter of a million people (NHS Clinical Commissioners, 2017)

Local Authorities are now responsible for public health, therefore, CCGs work closely with them through health and wellbeing boards to achieve the best possible outcome for the local community, by developing a joint needs assessment and strategy for improving public health. The figure below gives a visual representation of the different health bodies involved in health service commissioning.

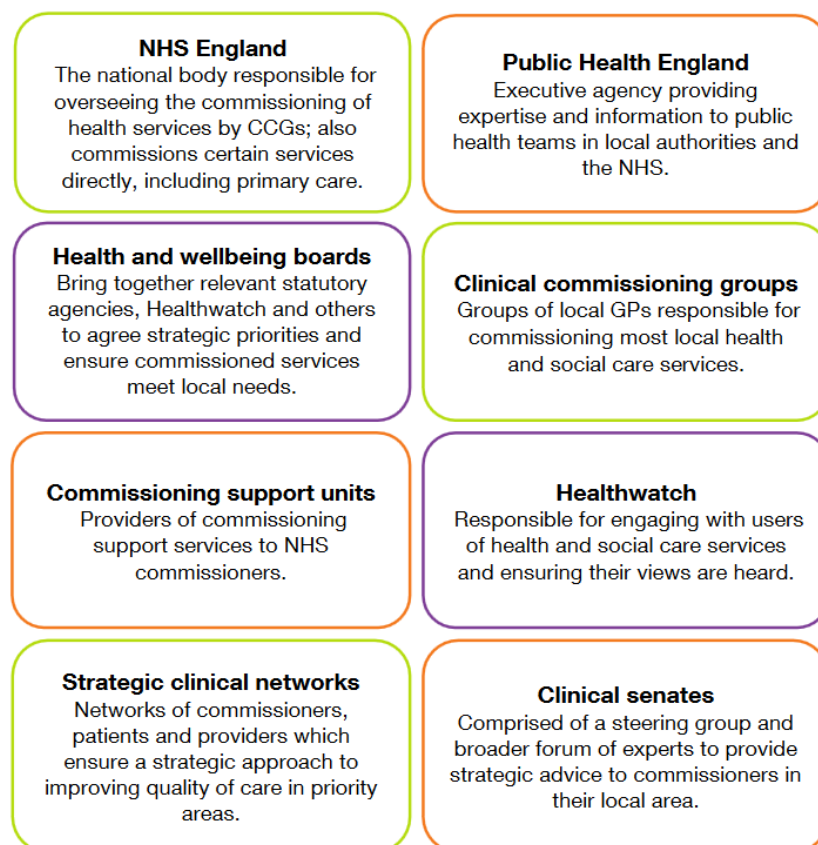


Figure 7: Health bodies involved in commissioning of services (Compact Voice, 2015).

NHS Sunderland Clinical Commissioning Group (CCG) is the statutory health body responsible for the planning and buying of local NHS care and services to meet the needs of the local community. Their vision is stated on their website as, 'to improve the health, wellbeing and life expectancy of the residents of Sunderland, by providing joined up health and social care, underpinned by effective clinical decision-making, reducing the disparities in health across the city and achieving 'better health for Sunderland.'

## **9.22 The Designated Medical Officer (DMO) role**

The Designated Medical Officer (DMO) plays a key role in supporting boroughs with implementing the SEND reforms initiated by the 2014 Children and Families Act. The DMO works to support children and young people aged 0-25 with SEND and provides the point of contact for local authorities, schools and colleges seeking health advice on children and young people who may have SEN or disabilities. They also provide a contact point for Clinical Commissioning Groups (CCGs) or health providers, so that appropriate notification can be given to the Local Authority of children who they think may have SEN or disabilities.

This is a non-statutory role which would usually be carried out by a Paediatrician, but there is local flexibility for the role to be undertaken by a suitably competent qualified and experienced nurse or other health professional (in which case the role would be the Designated Clinical Officer - DCO).

The Council for Disabled Children produced a handbook in September 2016, which set out practical advice and support for DMOs, DCOs and other professionals involved in implementing the health focused reforms presented in the 2014 Children and Families Act. The report highlighted that whilst the DMO has a clear role to play in supporting joined up working across Education, Health and Social Care, the appointment of a DMO cannot be viewed as an independent solution to ineffective multi-agency working. The report explained that the DMO must be supported by all stakeholders to support children identified with SEND. In order for optimally effective multi-agency working to occur, the DMO role must have clear and realistic expectations associated with it. This must translate to reasonable and carefully considered responsibilities, within the role descriptor.

These responsibilities should also reflect the specific logistical arrangements and requirements of the local area.

The Council for Disabled Children (2016) suggested the following key responsibilities of the DMO role, as informed by workshops held involving over 600 health professionals from across England:

1. **Oversight** across all health professionals delivering healthcare to individual disabled children, young people and those with special educational needs. This may include a focus on:
  - Processes for identification of disabled children and young people and those with special educational needs, particularly pre-school children
  - The process for securing health assessment and key principles for health advice in EHC plans
  - Oversight and assurance of health provision specified in EHC plans
  - Provision of information and advice in the Local Offer on available health services for children and young people with SEN and disability, their parents and those who may care for them or want to refer them for assessment
  - The assessment of health needs and provision of services to young offenders with EHC plans
  - Working with schools to support pupils with medical conditions.
2. **Coordination** to ensure:
  - All health services are reflected in the Local Offer and that health providers are co-operating with the Local Authority in its development/review
  - A clear process for mediation arrangements regarding the health element of EHC plans
  - Co-ordination of EHC assessments with other key health assessments e.g. Children and Young People's Continuing Care assessment, Looked-after Children's Health Assessment.

3. **Strategic** contribution to the development of:

- A joint commissioning strategy that works towards the integration of services to improve outcomes
- A participation and engagement strategy with children and young people with SEN and disability and their families

### **9.23 Care co-ordination: NHS Digital**

In 2016 the current Health Secretary, Jeremy Hunt, announced that £4.2bn had been set aside for digital and technology projects in the NHS; this was to be for the duration of the current parliament (Thornton, 2016). The key aim of this technology project (NHS Digital) is to drive improvements in care co-ordination, with a secondary aim to be the use of data in health research and service planning.

As stated in the King's Report by Honeyman et al. (2016), data sharing is described as essential for conducting research and improving patient care. The Wachter Review (2016) presented that the goal of digitalisation of health systems was to promote the 'healthcare's triple aim:' better health, better healthcare and lower cost. It added that IT, data systems and information sharing are critical to delivering integrated care and can help to co-ordinate care delivered by professionals across different organisations.

Imison et al. (2016) stated that it is also critical that information governance is not a barrier to progress. Data captured by digital technologies could improve service planning, and to support the alignment of capacity more closely with demand. Wachter (2016) agrees, explaining that privacy and safeguarding is extremely important but this should not hinder data sharing as it adds value to patient care and research. He suggests that with regulation and governance, where patient's rights are respected, there could be enormous benefits to data sharing.



It is evident that much of the literature around NHS digital focuses on data sharing within health organisations, solely on an internal basis. Department of Health (2012), in a report for the NHS Future Forum, argued that there is a poor flow of information within the NHS about individuals and this is a key barrier to ensuring that there is effective joined-up service working, particularly for those with multiple and complex disabilities who care crosses organisational boundaries. The overwhelming view in this report was that with appropriate consent, all individuals involved in caring for a patient should have access to their records to share and communicate information; at this time the argument does not extend to sharing information with City Councils.

Horridge (2016b) piloted data collection at the point of care using a defined terminology set to examine the feasibility of data collection during paediatric clinic consultations. The outcome of the study was that paediatricians felt this data collection at the point of clinical care was possible without being disruptive. They were able to count the number of needs and quantify complexity in a way which then informed clinical care. She reported that this system was effective at the mapping of needs and suggested that knowing how many children are dependent on specific technologies or have specific needs in a school population will, once the issues of data sharing across agencies are resolved, permit planning for their need to be met in the early years, schools and into adult services. If it were possible to share this information with the Council this would actively support the forward planning of services as the multifaceted needs will be clearly defined.

#### **9.24 The Healthy Child Programme (HCP)**

- By the 12th week of pregnancy;
- The neonatal examination;
- The new baby review (around 14 days old);
- The baby's six to eight-week examination;
- By the time the child is one year old;
- Between two and two-and-a-half years old.

One of the HCP's core functions is to recognise disability and developmental delay. This includes a responsibility to provide information, support, referral and notification to others, and in particular there is a duty to inform the local education authority if it is suspected that a child may have special educational needs.

The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children, through health and development reviews, health promotion, parenting support, and screening and immunisation programmes. Its goals are to identify and treat problems early, help parents to care well for their children, change health behaviours, and protect against preventable diseases.

## **9.25 Funding models**

In December 2016, the National Audit Office gave notice to schools that they would be facing 'real-term cuts in funding and would have to make savings of 8 per cent by 2019-2020' (NAO, 2016). It would therefore appear that schools are facing increasing financial challenges, as the number of schools in deficit has risen by 10 percentage points between 2015 and 2017 to 18 per cent (NAHT, 2017). This will undoubtedly affect the pupils within the commissioning Local Authority including those with SEND and may lead to increase in requests for EHCs and SEN Support in the education sector. The NAHT report also highlighted a statistic that a 66% proportion of respondents had reduced the number of support hours available to pupils in school due to funding pressures.

The Children and Families Act 2014 significantly changed the role of Local Authorities by ensuring that needs of all young people with SEND are met in a way that is outcome focussed. It also broadened the remit of LAs to ensure that needs are met from birth-25 years. There is a transitional funding system in place for children with high level needs until a National Funding Formula is introduced in 2018-2019. The current system is based on a series of 'top-up' payments that are provided for pupils with the most significant need who require an EHC plan (with Statements of SEN being phased out on a rolling programme until April 2018 (DfE, 2016a)). The current system for top-up funding works as shown in Figure 8.

|       | Mainstream settings                                                   | Specialist Settings                                   |               |
|-------|-----------------------------------------------------------------------|-------------------------------------------------------|---------------|
| 10k - | Top-up funding for individual pupils determined by LA                 | Top-up funding for individual pupils determined by LA | Funding Bands |
|       | School contributes up to £6k for additional needs from its SEN budget | Base funding of £10k per planned pupil place          |               |
|       | Core funding for all pupils (approximately £4k per pupil)             |                                                       |               |

#### Proposed SEN funding arrangements (pre-16)

Figure 8: The current system for top up funding (DfE, 2012a).

The allocation of top-up funding varies between local Authorities with Sunderland City Council utilising a banding system based on costed provisioning mapping. Local Authorities utilise various banding systems based on different criteria with Sunderland City Council using a 4 point banding system, North Tyneside City Council a 5 point system and Northumberland City Council a 15 point banding system. The reason for the differing banding systems is due to individual Local Authorities determining their own systems.

A difficulty that schools are currently experiencing is around the 'up to £6,000 contribution from the schools SEND budget' in terms of meeting the needs of pupils with SEND including provision and resources. In order to provide an inclusive learning environment in mainstream schools they 'have had to make huge compromises' financially due to limited budgets (Smith, 2017). This will undoubtedly impact on the number of requests for EHC plan and High Needs Funding and ultimately alternative provision.

There is a risk that schools will be unable to meet the needs of children on SEN Support due to decreases in budgets. When this is considered alongside the NAHT Report (2017) there will be increasing pressures placed on the system going forwards that will require strategic leadership and considered provision planning.

An initial DfE (2014a) consultation of the High Needs Funding Block which relates to the funding of pupils with the most significant SEND who require an EHC plan was conducted with a view to introducing a National Funding Formula in 2017-2018. This target has since been extended to begin 2018-2019 based on the outcomes of a second consultation which closed December 2016 (no date for feedback has been provided at time of publication).

In December 2016, the government stated that their, 'proposals ensure that no Local Authority would see any reduction in funding as a result of the proposed 2018-2019 funding formula' (DfE, 2016a). This further secures financial support to meet high needs within a Local Authority during this period. This can provide some stability in terms of provision planning but may mean that LAs may find difficulty in meeting emerging increases in need while, as stated previously, schools struggle to deal with real-terms financial cuts (NAO, 2016). As part of the proposed formula 72 LAs would see an immediate increase of High Needs Funding in their 2018-2019 allocation (ibid). The DfE are currently looking at a formula which will distribute funding for High Needs in a more equitable manner based on deprivation and the evidential link between hardship and High Needs. They will be conducting research alongside LAs producing their own strategic SEND which will be used to shape funding levels going forward.

Inclusion, 'while not a simple concept' (NASEN, 1998) has been proven to be effective when considered as the provision rather than placement for pupils with SEND which will include a range of needs for the pupils discussed in this report. Some concerns are raised about the effect of SEND pupils being taught alongside mainstream peers; however, Farrell et al. (2007) conducted an in-depth systematic review placing learners in mainstream has no adverse consequences for all pupils' achievement, attitudes and behaviours which is worth further consideration. Although it is also worth considering the evidence suggesting that for some learners segregated education (specialist provision) may be the most beneficial

practice for the individual (Wang, 2009). Considering inclusive practices across the Local Authority and sharing of best practice may lead to more pupils with high SEND needs being successful in mainstream schools or prevent them from even becoming pupils with High Needs.

## **10 Literature Review: Part Two**

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### **A critical discussion on the prevalence of Autism**

#### **10.1 What is Autism?**

Bakian et al. (2015) described Autism as a neurodevelopmental disorder with a complex aetiology, which is characterised by challenges with social, communicative and behavioural functioning. The most frequent variations in symptoms presented included: levels of social interaction; patterns of verbal and non-verbal communication; repetition in behaviours; sensory processing deficits; specific and rigid interests; and, severity of needs (American Psychiatric Association, 2013). Molteni and Maggiolini (2014) recognised that children identified with ASD often experienced challenges with interaction and communication, frequently due to low levels of social competence. Children often present with behaviours that are easily attributed to the condition, often accompanied by sensory issues; this can engender stereotyping from peers and may have life-long effects. DeBooth and Reynolds (2017) agreed, describing Autism as a complex and multi-faceted neurological disorder which often impacts on those affected in a range of ways. The American Psychiatric Association (2017) highlighted that Autism often engenders repetitive behaviours in children identified with the condition, as well as restricted interests and persistence on sameness. Anagnostou et al. (2014) suggested that the varied nature in presentation of ASD, particularly varying levels of social interaction, patterns of verbal and non-verbal communication, repetitive behaviours, sensory processing difficulties, restricted interests and severity of need, are problematic for both research and clinical practice.

## 10.2 What are the known causes of Autism?

Historically, it was thought that parenting styles were responsible for Autism (Kanner, 1943). However, Wing (2007) later identified that Autism was caused by irregularities in brain development, prior to birth. DeBooth and Reynolds (2017) highlighted that there is no single cause or biomarker which has been identified related to Autism. It is believed that genetics play a role in the aetiology of Autism (Sutcliffe, 2008; Geschwind, 2008). A recent study led by the University of North Carolina found that altered distribution of cerebrospinal fluid (CSF) in high risk infants can predict whether or not they will develop ASD (Observatory, 2017). The authors explained that the fluid was once considered a shock absorber, protecting the brain from the skull.

The North Carolina study confirmed earlier research that suggested infants with increased CSF in the subarachnoid space have an increased risk of Autism. The project included 343 infants at 6, 12 and 24 months. It was also identified that 221 of the babies had older siblings with a diagnosis of ASD, suggesting that ASD may have genetic links. The conclusion was that those children who went on to later develop ASD had significantly more subarachnoid CSF at six months of age compared to those who did not develop Autism (ibid). Building on this study, Patra (2017) explored brain images of high risk infants, which revealed expansion of cortical surface to be highly associated with later diagnosis of Autism Spectrum Disorders. Children diagnosed with Autism at 24 months of age showed cortical surface overgrowth at six months and increased brain volume in MRI scans at one year of age (Hazlett et al., 2017). These MRI images can be understood as early predictors of social and communication deficits which appear much later and hence are potential biomarkers for Autism. Patra (2017) suggested identification of at risk infants before two years of age to increase the effectiveness of early interventions.

Swartz (2016) highlighted that 'genome sequencing' has already found mutations in 65 genes that increase the risk of developing Autism. He suggested that some are passed from the DNA of the mother, the father or, sometimes, from both parents to the child. Others arise spontaneously, meaning they aren't present in either parent's genetic makeup. To date, genetic causes have been pinpointed in only about 20 percent of Autism cases, usually those that are associated with certain rare diseases, such as Fragile X syndrome, Phelan-McDermid syndrome or Williams syndrome. It is still largely unknown which genes drive the development of the disorder (ibid). However, London and Etzel (2000) and Hallmayer et al. (2011) suggested that genetic factors in isolation do not fully explain the occurrence of Autism, although the evidence highlights that genetics do play a central role (Sutcliffe, 2008; Abrahams and Geschwind, 2008).

Farrell (2017) summarised that there are no definite causes of ASD currently known. The heritability of ASD are thought to range from 37-90%, based on concordance rates in twins. Farrell reported that as much as 15% of instances of ASD seem to be associated with a known genetic mutation (American Psychiatric Association, 2013, p.57). Farrell (2017) cites strong evidence that ASD has a biological basis and a major genetic component. This is supported by twin studies which examine the co-occurrence of Autism in identical and non-identical twins and other siblings. He summarised that there may be several genes which act with environmental factors leading to ASD.

ASD is more prevalent in males than females (National Autism Society, 2017). Although the gender disparity in prevalence has often been mentioned, only few studies examine differences in the clinical presentation of males and females with ASD (Kauschke et al., 2016). The Simons Foundation Autism Research Initiative SPARK (2017) has recently launched a landmark Autism research project in the United States due to the significant increase in prevalence over the last two decades. They recognised that the rise in ASD may be due to a recently broadened diagnostic criteria and an increase in awareness; though the authors believe that a better understanding is needed due to recent research indicating genes playing a role. This is a long term study which aims to advance understanding of Autism. They are aiming to collect 50,000 DNA samples and medical information to allow



scientist to analyse genetic changes and understand more about the gender prevalence of the condition.

In addition to the genetic factors previously discussed, there has been consideration of environmental risks, such as prenatal and perinatal factors, that have been associated with the development of Autism. These can include parental age, breech position, maternal pregnancy, weight gain and maternal fever during pregnancy (Croen et al., 2007; Bilder et al., 2009; Grether et al., 2009; Bilder et al., 2013 and Zerbo et al., 2013). Other environmental factors have been suggested such as chemical and pollutant exposures, heavy metals and pesticides (Windham et al., 2006, Roberts et al., 2007. Kalkbrenner et al., 2010; and Volk et al., 2013). Furthermore, links between Autism and prescription medications including valproic acid, thalidomide and selective serotonin reuptake inhibitors have also been suggested (Bromley et al., 2008, Croen et al., 2011).

There have been many research projects into environmental causes of ASD. Croen et al. (2011) examined whether prenatal exposure to antidepressants medications was associated with increased risk of ASD. They suggested that prenatal exposure to antidepressants during the first trimester may increase the risk of ASD, although they stated that their results needed to be considered with caution until there are further studies to provide a comparison. Bakian (2015) noted that the links to these environmental factors requires further exploration, as many studies examining environmental Autism risk factors have been proven to be inconclusive. Gardener et al., (2011) reviewed multiple studies investigating this phenomenon which all showed inconsistent results that were not statistically significant. These studies examined: abnormal foetal presentation, umbilical-cord complications, foetal distress, birth injury or trauma, multiple birth, maternal haemorrhage, summer birth, low birth weight, low Apgar score, feeding difficulties and neonatal anaemia. However, the authors were able to conclude that exposure to multiple neonatal complications could increase the risk of ASD.

### **10.3 What are the prevalence rates of Autism internationally, nationally and regionally?**

Baren-Cohen et al. (2009) proposed that prevalence estimates for ASD have steadily increased over the past four decades. In 1978, the accepted estimate for classic Autism prevalence was 4 in 10 000; Autism (including classic Autism) is thought to currently affect approximately 1% of the population. Karim, Cook and O'Reilly (2012) specifically noted the apparent increase in the prevalence of ASD in children. In the late 1970s it was estimated that the prevalence of ASD in children was thought to be 20 in 10 000 (Wing and Gould, 1979). More recently this is believed to have increased to one in 100 children in the UK (Baird et al., 2006; National Autism Society, 2017; and, Farrell, 2017). When specifically considering Tyne and Wear school aged children, the prevalence rate is 1.32%, based on deductions from the DfE (2016b) special educational needs in England data set. This indicates a higher than average prevalence of ASD in Tyne and Wear, compared to national figures. In the US there is a higher prevalence rate than the UK (Bakian, 2015) with 1 in 68 children being diagnosed by the age of eight (CDC, 2014). Bakian (2015) noted the sharp rise in ASD diagnoses over the past three decades in the US. This is comparable with the situation in the UK where there is a rising prevalence of ASD diagnosis, which, as previously highlighted, affects approximately 1% of children (Baird et al., 2006; Baron-Cohen et al., 2009; National Autism Society, 2017).

### **10.4 Possible causes of an apparent increase in ASD prevalence**

Farrell (2017) suggested possible reasons for an apparent increase in prevalence of ASD could include: widening of the definition; increased awareness; and, differences in research methods used in studies of ASD (American Psychiatric Association, 2013). He also acknowledged that the increase in prevalence could be due to an increase in real terms. This view is supported by National Institute of Mental Health (2012), who suggested that the increase in the prevalence of children identified with ASD may be attributed to several factors, including the growing awareness of the condition, the expanded definition of Autism, or, indeed, a true increase in incidence of Autism. Charman (2002) theorised that since Kanner's (1943) criteria for diagnosis, the diagnostic boundary of the core

presentation of Autism has broadened over the decades. Hoffman et al. (2014) presented a number of reasons for the increasing ASD prevalence, highlighting that they are multi-faceted and challenging to measure. Yet, greater Autism awareness among parents, educators, and clinicians, along with increased access to diagnostic and treatment services, is believed to be one of the most significant contributing factors (Charman, 2002; Blaxil, 2004; Fombonne, 2005; Williams et al., 2006; Newschaffer et al., 2007; Matson and Kozlowski, 2011). Murray et al. (2014) also highlighted that UK primary care has experienced an increase in prevalence of ASD between 1992 and 2008. The authors suggested that this is likely to be due to widening diagnostic criteria, alongside increased awareness and acceptance of Autism. More recently, Atladottir et al. (2015) indicated that the increasing prevalence of ASD in Denmark, Sweden, Finland and Western Australia was due to non-etiological factors, such as improved availability to services, the broadening of diagnostic criteria and increased awareness of neuropsychiatric difficulties in professional communities. With similar findings Bakel (2015) suggested an increase in prevalence in France could be due to changes in classification and diagnostic procedures, improved service availability, alongside better acceptance and increased awareness.

### **10.5 Co-morbidity in Autism Spectrum Disorders**

It is widely recognised that ASD can co-exist with co morbid disorders, including Down's Syndrome, Cerebral Palsy, Tourette's Syndrome, Turner Syndrome and individuals with Hearing and Visual Impairments (Charman, 2012). In a study by Simonoff et al. (2008), it was reported that 70% of the sampled population of 112 children aged 10 - 14 years displayed at least one co-morbid psychiatric disorder alongside ASD. Salazar (2015) further highlighted additional, recent studies which have demonstrated that psychiatric disorders commonly co-occur in children with ASD; many studies have reported high aggregated rates of co-morbidity, with some as high as 70–90 % (Leyfer et al., 2006; de Bruin et al., 2007; Simonoff et al., 2008; Mattila et al., 2010; Mukaddes and Fateh 2010).

Maskey (2013) emphasised that co-existing conditions can include a range of emotional and behavioural difficulties such as aggression, self-injury, issues with sleep, feeding, eating problems, sensory sensitivities, intellectual disabilities, as well as co-morbid health and mental health diagnosis including Epilepsies, ADHD, Anxiety, Obsessive and Tic Disorders. Further studies have reported that there are common co-occurring disorders with ASD, often identified in later childhood, including Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Anxiety Disorders, with the emergence of Depression and Obsessive Compulsive Disorder in adolescence/adult life (Mazefsky et al., 2008; Simonoff et al., 2008; Skokauskas et al., 2010; van Steensel et al., 2013).

Autism and associated co-morbid disorders often significantly impact on social outcomes, education and health of children and adults (Bolton et al., 1998). This is primarily due to the frequent early onset of Autism, its lifelong persistence and associated pervasive impairments (Simonoff et al., 2008). The annual societal cost in the UK of supporting children identified with Autism has been calculated as £2.7 billion; these costs amount to £25 billion per annum for adults identified with ASD, with estimated lifetime costs of £1.7 million for those with intellectual disabilities and £0.8 million for those without (Knapp et al., 2009).

Lane et al., (2010); Lane et al., (2011) and Lane et al., (2014) suggested that grouping children with ASD based on similar traits could lead to more focused treatment groups for practitioners to direct their efforts, and allow targeted intervention for the symptoms of greatest severity and that impact on functional performance.

## **10.6 Identification of Autism Spectrum Disorders**

Molteni and Maggiolini (2015) in their research claimed that the majority of parents (71%) noticed the indicators of Autism within the first two years of a child's life; in (72%) of the cases it was the mother who initially raised concerns. The authors added that a third of parents observed the initial differences between the third and fourth year. These findings have been echoed in international studies, which suggest concerns being noted between

twelve and twenty four months of age, particularly when the child is not the parents' first (Ozonoff et al., 2002 and Morgan et al., 2008). As Frenette et al., (2011) and DfE (2015a) acknowledge, early identification of Autism facilitates diagnosis, therefore allowing timely access to educational and therapeutic services.

Mandell (2012); Nealy et al., (2012) and Pozo et al., (2011) highlighted the challenges that families who take care of children and young people with Autism can often face. There can be high levels of stress and anxiety for families and the child due to misunderstandings from society about Autism (Autism Europe, 2001 and Brennan, 2011). Additionally, due to the natural spectrum of characteristics experienced by children identified with Autism, families can find it difficult to strike an effective balance between under and over-support for children.

### **10.7 Socio-economic factors**

It is possible to undertake geographical mapping of ASD prevalence in a given locality, to determine any socio-economic factors that may be associated with ASD prevalence. Bakian's (2015) US-based study utilised spatial analysis and mapping tools to identify localised regions of heightened risk, in being diagnosed with ASD, which he termed 'residential segregation.' These regions were then used to generate hypotheses concerning aetiology. This study highlighted that higher than expected ASD prevalence was identified in 4/5 areas in Utah. The findings of this study were consistent with California-based studies, which highlighted 'hotspots' of ASD prevalence; areas in which ASD prevalence was much higher than that expected when compared to the population concentrations in those areas (Hoffman, et al., 2014).

These studies were; therefore, able to highlight that children who are born into particular communities were three times more likely to have Autism. The authors suggested that increased Autism prevalence was linked to higher socio-economic status (SES) in the majority of hotspots, as parents in the 'hotspot' communities were of elevated socio-economic status. This link was tentatively explained by the authors; they suggested that parents of higher socio-economic status possessed the skills to push for formal diagnoses for their children, therefore explaining the higher prevalence of ASD in these areas. Fombonne (2003) and Newschaffer et al. (2007) suggested that the increase in prevalence of ASD in areas of elevated socio-economic status may reflect better identification and knowledge of Autism in these areas.

Research by Rai et al. (2012); Larsson et al. (2005) and Bilder (2009) also highlighted a heterogeneous relationship between Autism and elevated socio-economic status. However, findings have shown inconsistencies, with one study finding no association between ASD and higher maternal education. Hoffman et al., (2014) investigated differences in geographical distribution of ASD in North Carolina made an interesting observation that regions with low risk in the early years of surveillance became similar to those with high risk in later years. This suggested to the researchers that practices in remote regions caught up with those in resource-rich areas, or that clinicians and educators were becoming better trained to identify children with Autism.

## **10.8 Summary**

In summary, it is clear that there is no one single cause of Autism; however, there is significant evidence that suggests ASD has a biological basis. As Glazzard (2015) highlighted, 'Autism is explained as a product of nature rather than a product of nurture, although this does not exclude the possibility of environmental factors at the pre-natal stage' (p. 90). As Bakian (2015) summarised, there are studies examining environmental ASD risk factors, which tentatively indicate that there may be a link between ASD prevalence in communities of elevated socio-economic status. However, it is important to note that these studies have

not been consistent in their findings. Therefore, there is a need for further research into the link between socio-economic status and ASD prevalence.

As SPARK (2017) identified, the prevalence of Autism has increased significantly over the past two decades. There are indications that ASD may be more prevalent in the North East of England, than in the UK as a whole. This increase in prevalence is largely attributed to broader diagnostic criteria for ASD and an increase in overall awareness of Autism.

Researchers have highlighted that there has never been a greater need to gain a better understanding of ASD, as it affects so many children, young people and adults that early intervention to meet needs is essential (DeBoth and Reynolds, 2017 and Gardener et al., 2017).

## **11 Literature Review: Part Three**

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### **11.1 Types of provision**

There is clear policy guidance for local authorities provided by the DfE (2013a) regarding ensuring a good education for children who cannot attend school due to health needs. The Government's policy intention is that all children, regardless of circumstance or setting should receive a good education to enable them to shape their own futures. Therefore alternative provision and the framework surrounding it should offer good quality education on par with that of mainstream schooling, along with the support pupils need to overcome barriers to attainment. This support should meet a pupil's individual needs, including social and emotional needs, and enable them to thrive and prosper in the education system (p.3).

Ko (2015) concluded that special educational provision is defined according to the age of the young person:

- For children aged two or more: Educational or training provision that is additional to or different from that is generally available in mainstream settings.
- For a child under 2 years of age: Special educational provision means educational provision of any kind.

The percentage of pupils with a statement or EHC plan attending maintained special schools has gradually increased each year DfE (2016b). In 2010, 38.2% of pupils with statements attended maintained special schools and this has increased to 42.9% of pupils with statements or EHC plans in 2016. The percentage of pupils with statements or EHC plans attending independent schools has also increased between 2010 and 2016, from 4.2% to 5.7%.



## 11.2 Alternative Provision (AP)

The definition of Alternative Provision was provided by the DfE in (2013b) as 'education arranged by local authorities for pupils who, because of exclusion, illness or other reasons, would not otherwise receive suitable education; education arranged by schools for pupils on a fixed period exclusion; and pupils being directed by schools to off-site provision to improve their behaviour.' More recently alternative provision is commonly defined as education outside school, arranged by local authorities or schools themselves (Ofsted, 2016b). They have highlighted that 'alternative provision remains a largely uninspected and unregulated sector'. The most recent School Inspection Handbook (Ofsted, 2016c) suggested that inspectors should make every effort to telephone or meet staff in the institutions where pupils are taught off-site to help assess the school's quality assurance arrangements. Inspectors are required to evaluate the rigour with which the school monitors the attendance, behaviour, learning and progress of the pupils who attend them. Ofsted added that units dealing with pupils' behaviour may exist away from the school site, but be run by the school. Sometimes, this provision may be shared by one or more schools. It is important to find out how this is monitored and evaluated, both day to day and over time. An inspector should visit the unit briefly to assess safeguarding procedures, the quality of teaching and how effectively the unit helps to improve pupils' behaviour, learning and attendance. The visit should be proportionate to the number of pupils who attend and the length of time they spend there. This can be full-time provision for a number of pupils over several weeks, so it is important to evaluate it thoroughly (ibid).

Beyond pupil referral units and other full-time provision, there is no requirement for the majority of alternative providers to register with any official body and no formal arrangements to evaluate their quality (Ofsted, 2016b). Historically, Ofsted (2011) was critical of the format and quality of the information that schools gave to providers about the pupils' needs. A quarter of the schools in that survey gave only oral information to the providers. Even where the information was written, too many providers did not receive any information about the pupils' literacy and numeracy skills, health needs or special educational needs, or specific behavioural difficulties.

### **11.3 What are Pupil Referral Units (PRUs)?**

The 1996 Education Act gave local authorities (LAs) the duty to provide suitable education for excluded children (DfEE, 1996, section 19). PRUs are Local Authority establishments which provide education for children unable to attend a mainstream school including children who are excluded (Bruder and Spensley, 2015). Harrison (2008) suggested that the most common alternative provision in the UK is the PRU. It is intended that a PRU provides alternative education provision for a short time to prepare children for a successful re-integration into mainstream education (Pirrie and Macleod, 2009). Pirrie et al. (2011) highlights that amongst the research and policy related literature in the previous decade there is widespread consensus that young people who have been permanently excluded from school are at a far greater risk of a range of negative outcomes than young people who have not had this experience. They added that these negative outcomes include prolonged periods out of education and/or employment; poor mental and physical health; involvement in crime; and homelessness. Lawrence (2011) argued that understanding the factors that support successful re-integration of young people from PRUs to mainstream education can contribute to increasing positive outcomes for this vulnerable group.

The Department for Children, Schools, and Families strategy Back on Track (2008) reported that just under half of the pupils in PRUs were there because they had been excluded and over half of children go to their first Alternative Provision placement via a PRU.

### **11.4 Who are PRUs for?**

Swann (2013) agreed that PRUs cater for a diverse range of children and young people. This includes predominantly those who are excluded from school on a fixed term or permanent basis but also those who are unable to attend school for medical reasons, pregnant teenagers, those who are school phobic, school refusers and those awaiting a school place. Roffey (2016) shares that most pupils have access to social and emotional resources that facilitate their learning and development but adds that significant numbers of children in the UK do not. She adds that this can be due to them living with chronic adversity or

experiencing acute stress due to family breakdown and trauma. As theorised by (Bradley and Crowyn, 2002; Farah et al., 2006 and Mani et al., 2013) we know that highly stressful experiences and/or negative life situations will be detrimental on self-worth, concentration, attendance, behaviour and mental health. In light of this Roffey (2016) stresses that schools are working with children whose life experiences make learning and compliance difficult. Therefore, it is imperative that schools focus on building relationships through a whole school focus on wellbeing and care.

### **11.5 What are fixed and permanent exclusions?**

Permanent exclusions refer to a pupil who is excluded and who will not come back to that school (unless the exclusion is overturned) (DfE, 2016g). As DfE (2012b) explained a decision to exclude a pupil permanently should only be taken: in response to a serious breach, or persistent breaches, of the school's behaviour policy; and where allowing the pupil to remain in school would seriously harm the education or welfare of the pupil or others in the school. As the DfE (2013a) guidance clarifies 'LAs are responsible for arranging suitable full-time education for permanently excluded pupils, and for other children who, because of illness or other reasons – would not receive suitable education without such provision.'

Fixed Term exclusions refer to pupils who are excluded from a school for a set period of time. This can involve a part of the school day and it does not have to be for a continuous period. A pupil may be excluded for one or more fixed periods up to a maximum of 45 school days in a single academic year. This total includes exclusions from previous schools covered by the exclusion legislation (DfE, 2016g).

### **11.6 How many children and young people are excluded from school and why?**

In their annual report 2015/16 Ofsted (2016a) stated that a small number of young children (under the age of 4) are permanently excluded from schools for serious misbehaviour, totalling 30 children in 2015. They reported that the number of younger children who were

given fixed period exclusions each year has been increasing steadily. While proportions of children remain very small (less than 1%) this is an increase of over 1,000 exclusions a year compared with five years ago.



Figure 9: Fixed period exclusions for children aged four and under (2009/10 to 2014/15).

The number of permanent exclusions across all state funded primary, secondary and special schools has increased from 4,950 in 2013/14 to 5,800 in 2014/15 (DfE, 2016g). This corresponds to an average of around 31 permanent exclusions per day in 2014/15, up from an average of 26 per day in 2013/14. Re-integration to mainstream school was concluded to be successful where the receiving school was highly inclusive, the LA gave high levels of support to the school and the young person wanted to make a success of their re-integration (Lawrence, 2011).

The DfE (2016g) reported that pupils identified with Special Educational Needs (SEN) accounted for just over half of all permanent exclusions and fixed period exclusions. Persistent disruptive behaviour is still the most common reason for both permanent and fixed period exclusions in state funded primary secondary schools and special schools. It accounts for just under a third of all permanent exclusions and just over a quarter of all fixed period exclusions (DfE, 2016g).

The DfE (2016h) data stated that Sunderland City Council was ranked first out of all LAs in the North East for the highest number of permanent exclusions in primary schools (10 children). In terms of fixed period exclusions, Sunderland has the second highest in the

region at 200 primary aged children in 2014/15. In secondary schools it is evident that Sunderland are performing well in comparison to other Local Authorities in the region in terms of the number of permanent and fixed period exclusions. In state-funded Secondary schools, Sunderland is seventh at 21 permanent exclusions and eleventh at 578 fixed period exclusions in 2014/15.

Table 6

*Permanent and fixed period exclusions in North East LAs by type of school (2014/15).*

| Area                 | State-funded primary schools |             |               |             | State-funded secondary schools |             |                |             | Special schools |             |               |              |
|----------------------|------------------------------|-------------|---------------|-------------|--------------------------------|-------------|----------------|-------------|-----------------|-------------|---------------|--------------|
|                      | Permanent                    |             | Fixed period  |             | Permanent                      |             | Fixed period   |             | Permanent       |             | Fixed period  |              |
|                      | N                            | %           | N             | %           | N                              | %           | N              | %           | N               | %           | N             | %            |
| <b>ENGLAND</b>       | <b>920</b>                   | <b>0.02</b> | <b>49,650</b> | <b>1.10</b> | <b>4,790</b>                   | <b>0.15</b> | <b>239,240</b> | <b>7.51</b> | <b>90</b>       | <b>0.09</b> | <b>14,080</b> | <b>13.54</b> |
| <b>NORTH EAST</b>    | <b>30</b>                    | <b>0.01</b> | <b>1,470</b>  | <b>0.68</b> | <b>270</b>                     | <b>0.18</b> | <b>12,230</b>  | <b>7.84</b> | <b>10</b>       | <b>0.12</b> | <b>660</b>    | <b>9.78</b>  |
| Darlington           | -                            | -           | 72            | 0.78        | -                              | -           | 703            | 12.14       | -               | -           | 69            | 25.65        |
| Durham               | 6                            | 0.01        | 547           | 1.32        | 73                             | 0.26        | 2,058          | 7.44        | -               | -           | 234           | 18.50        |
| Gateshead            | x                            | x           | 62            | 0.39        | 54                             | 0.46        | 580            | 4.91        | -               | -           | 25            | 5.08         |
| Hartlepool           | -                            | -           | 20            | 0.21        | x                              | x           | 348            | 6.34        | -               | -           | 7             | 3.63         |
| Middlesbrough        | x                            | x           | 79            | 0.53        | 33                             | 0.43        | 3,227          | 42.36       | x               | x           | 123           | 25.73        |
| Newcastle upon Tyne  | x                            | 0.00        | 117           | 0.55        | 5                              | 0.03        | 1,070          | 6.86        | x               | x           | 51            | 7.16         |
| North Tyneside       | -                            | -           | 45            | 0.27        | 13                             | 0.10        | 499            | 3.81        | -               | -           | 7             | 1.02         |
| Northumberland       | x                            | x           | 144           | 0.75        | 37                             | 0.14        | 1,350          | 5.14        | x               | x           | 59            | 8.77         |
| Redcar and Cleveland | -                            | -           | 73            | 0.56        | -                              | -           | 890            | 10.77       | -               | -           | 0             | 0.00         |
| South Tyneside       | x                            | x           | 23            | 0.19        | 19                             | 0.23        | 242            | 2.94        | -               | -           | 17            | 3.81         |
| Stockton-on-Tees     | -                            | -           | 91            | 0.48        | 15                             | 0.14        | 681            | 6.55        | -               | -           | 19            | 3.52         |
| Sunderland           | 10                           | 0.04        | 200           | 0.84        | 21                             | 0.13        | 578            | 3.69        | -               | -           | 51            | 7.61         |

*Note.* National and regional totals and totals across each local authority have been rounded to the nearest 10.

*Source: School Census*

There may be discrepancies between totals and the sum of constituent parts. 'x' denotes less than 5, or a percentage based on less than 5. '-' denotes zero values. (DfE, 2016j).

The national data for special school permanent exclusions shows there were no permanent exclusions across the North East for children in a specialist school. However, there were a number of fixed period exclusions with Sunderland ranking fifth overall with 51 fixed period exclusions.

Table 7

*Permanent and fixed period exclusions in North East LAs by type of school (2013/14).*

| Area                 | State-funded primary schools |             |               |             | State-funded secondary schools |             |                |             | Special schools |             |               |              |
|----------------------|------------------------------|-------------|---------------|-------------|--------------------------------|-------------|----------------|-------------|-----------------|-------------|---------------|--------------|
|                      | Permanent                    |             | Fixed period  |             | Permanent                      |             | Fixed period   |             | Permanent       |             | Fixed period  |              |
|                      | N                            | %           | N             | %           | N                              | %           | N              | %           | N               | %           | N             | %            |
| <b>ENGLAND</b>       | <b>870</b>                   | <b>0.02</b> | <b>45,010</b> | <b>1.02</b> | <b>4,000</b>                   | <b>0.13</b> | <b>210,580</b> | <b>6.62</b> | <b>70</b>       | <b>0.07</b> | <b>13,890</b> | <b>13.86</b> |
| <b>NORTH EAST</b>    | <b>30</b>                    | <b>0.01</b> | <b>1,390</b>  | <b>0.66</b> | <b>200</b>                     | <b>0.13</b> | <b>9,610</b>   | <b>6.11</b> | <b>10</b>       | <b>0.08</b> | <b>800</b>    | <b>12.44</b> |
| Darlington           | -                            | -           | 72            | 0.78        | -                              | -           | 428            | 7.41        | -               | -           | 73            | 28.63        |
| Durham               | 12                           | 0.03        | 606           | 1.48        | 70                             | 0.25        | 1,714          | 6.13        | -               | -           | 207           | 16.82        |
| Gateshead            | x                            | x           | 67            | 0.43        | 18                             | 0.15        | 503            | 4.22        | -               | -           | 16            | 3.43         |
| Hartlepool           | -                            | -           | 13            | 0.14        | x                              | x           | 321            | 5.78        | -               | -           | x             | x            |
| Middlesbrough        | x                            | x           | 87            | 0.60        | 23                             | 0.30        | 1,819          | 23.50       | x               | x           | 169           | 36.74        |
| Newcastle upon Tyne  | x                            | x           | 62            | 0.30        | x                              | x           | 1,001          | 6.54        | x               | x           | 33            | 5.08         |
| North Tyneside       | -                            | -           | 40            | 0.25        | 11                             | 0.08        | 501            | 3.77        | -               | -           | 19            | 2.88         |
| Northumberland       | 9                            | 0.05        | 132           | 0.70        | 29                             | 0.11        | 1,196          | 4.46        | x               | x           | 108           | 17.06        |
| Redcar and Cleveland | -                            | -           | 61            | 0.48        | -                              | -           | 602            | 7.18        | -               | -           | x             | x            |
| South Tyneside       | -                            | -           | 5             | 0.04        | 12                             | 0.15        | 212            | 2.57        | -               | -           | 35            | 8.64         |
| Stockton-on-Tees     | -                            | -           | 70            | 0.37        | 19                             | 0.18        | 676            | 6.52        | -               | -           | 23            | 4.34         |
| Sunderland           | 6                            | 0.03        | 178           | 0.76        | 14                             | 0.09        | 637            | 4.02        | -               | -           | 112           | 17.81        |

Note. National and regional totals and totals across each local authority have been rounded to the nearest 10.

Source: School Census

There may be discrepancies between totals and the sum of constituent parts. 'x' denotes less than 5, or a percentage based on less than 5. '-' denotes zero values. (DfE, 2015c; 2015d).

### 11.7 What are the outcomes for children in PRUs?

Research studies by Sameroff, et al. (1993) and Hall-Lande et al. (2007) indicated links between exclusion and social isolation, youth offending, drug and alcohol misuse, crime, susceptibility to mental health problems and reduced cognitive functioning. Hayden (1998) added that those excluded are argued to be the most vulnerable young people in society therefore it is essential that organisations support effective re-integration of these pupils to mainstream education.

Table 8

*Number of children and young adults attending PRUs and Alternative Provision academies (2013 – 2016) in the North East.*

| Local Authority      | Year       |            |            |            |
|----------------------|------------|------------|------------|------------|
|                      | 2013       | 2014       | 2015       | 2016       |
|                      | N          | N          | N          | N          |
| <b>NORTH EAST</b>    | <b>544</b> | <b>565</b> | <b>618</b> | <b>803</b> |
| Darlington           | 4          | 8          | 9          | 9          |
| Durham               | 105        | 97         | 88         | 98         |
| Gateshead            | 77         | 56         | 41         | 88         |
| Hartlepool           | 6          | x          | 4          | 7          |
| Middlesbrough        | 64         | 54         | 63         | 84         |
| Newcastle upon Tyne  | 156        | 199        | 225        | 280        |
| North Tyneside       | 9          | 45         | 46         | 73         |
| Northumberland       | 7          | x          | 12         | 9          |
| Redcar and Cleveland | 17         | 8          | 16         | 19         |
| South Tyneside       | 17         | 16         | 8          | 19         |
| Stockton-on-Tees     | 28         | 32         | 39         | 42         |
| Sunderland           | 54         | 50         | 67         | 75         |

*Note.* National and regional totals have been rounded to the nearest 5. 'x' denotes less than 5, or a percentage based on less than 5. There may be discrepancies between the sum of constituents and the totals as shown (DfE, 2013c; 2014b; 2015d; 2016k).

*Source School Census*

From Table 8 (above) and Figure 10 (overleaf) it can be seen that the number of children and young adults in pupil referral units is at its highest in 2016. The data set for this does not include children who are dual placed and so these children do not appear on these representations.

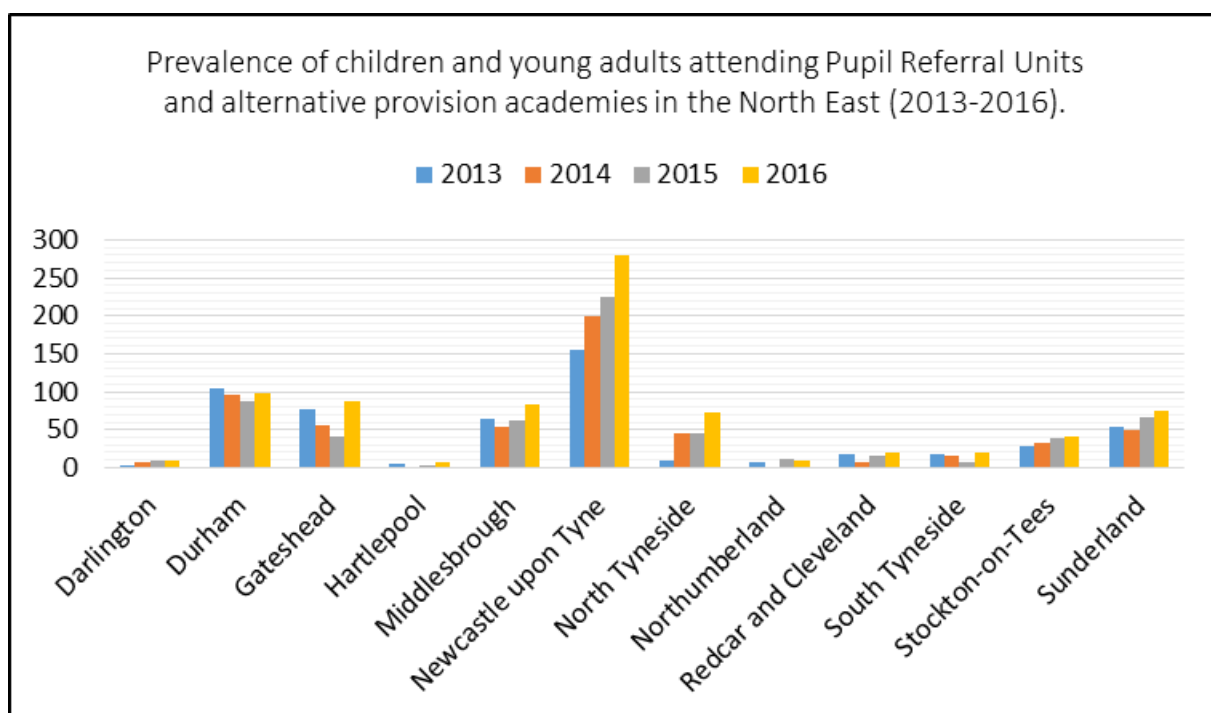


Figure 10: Prevalence of children and young adults attending PRUs and alternative provision academies in the North East (2013-2016).

The DfE (2012b) reported that in some areas PRU provision is of poor quality. Once placed there, children rarely return to mainstream school, the curriculum is narrow, the teaching poor and pupils do not achieve academic success. Rather than improving behaviour, the atmosphere of the worst PRUs feeds their pupils' behavioural difficulties. Some of the most vulnerable children, with a range of differing needs, end up in bleak one-size-fits-all provision. The DfE added that the most effective PRUs have strong, authoritative leaders who are respected partners of their mainstream colleagues. These PRUs are seen as a local resource, where the expertise of staff is used to help mainstream schools to improve their practice.

Lawrence (2011) carried out research examining the process of re-integration of secondary aged pupils from a PRU to mainstream education. The concern was raised that some have successful re-integration and others do not. The research outcomes of a one year pilot by Bruder and Spensley (2015) demonstrated that providing a clinical psychologist to a PRU for one day a week supported the mental health of the young people. Those who participated



in the study reported that they had an experience of being listened to, were taken seriously and felt able to express themselves to somebody. In addition, teaching staff reported that they felt better equipped to understand the complexities around their pupils' presentation of needs and, if necessary, felt supported in adjusting the way that they managed and supported some pupils.

### **11.8 Implications of findings for the place of Pupil Referral Units**

The findings of this research should be utilised by the LA to develop a guidance document for schools and PRU staff regarding the factors contributing to successful re-integration or "a good practice guide", which can be considered to be "evidence based". In addition, the resulting research report could facilitate a discussion between the PRU and mainstream schools regarding the wider issue of working relationships, communication systems and perceptions of role and function. More generally, the results could also be used to demonstrate the importance of an inclusive ethos and approach in mainstream schools. There are also numerous implications for the educational psychologist and educational psychology practice.

### **11.9 Children missing or out of education**

The DfE (2013b) guidance for Local Authorities clarified that:

'The law does not define full-time education but children with health needs should have provision which is equivalent to the education they would receive in school. If they receive one-to-one tuition, for example, the hours of face-to-face provision could be fewer as the provision is more concentrated' (p.6).

Furthermore, 'Where full-time education would not be in the best interests of a particular child because of reasons relating to their physical or mental health, LAs should provide part-time education on a basis they consider to be in the child's best interests. Full and part-time education should still aim to achieve good academic attainment particularly in English, Maths and Science (ibid)'.

Ofsted (2016b) have proposed that when children go missing from education or have poor attendance, this can be an indicator that they are at risk of abuse or neglect. This is why it is so important for schools to keep accurate attendance records and take action when children go missing.

Wilshaw claimed that 'many thousands of children and young people in England do not attend full-time education' (Ofsted, 2013) which undoubtedly impacts on their outcomes and causes significant safeguarding concerns. They even go as far to say that 'too often, children and young people who receive only a part-time education, or who have none at all, can become invisible to the Local Authority' (ibid). This report 'pupils missing out on education' highlighted the key role of LAs in monitoring pupils who receive less than full time education and secure provision for those pupils who have been removed from roll through permanent exclusion for example. Ofsted, as of August 2016, now are required to 'evaluate the rigour with which the school [they are inspecting] monitors the attendance, behaviour, learning and outcomes of the pupils' who attend partnership or off-site arrangements which strengthens the accountability for pupils who may be at risk from missing out on education (Ofsted, 2016c).

## **12 Data presentation, analysis and recommendations**

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This chapter presents the key themes to have emerged from analysis of the data gathered. The data are presented alongside the findings for ease of navigation and comparison. Details on the data analysis process are given in the methodology chapter of this report. Recommendations are presented in this chapter, according to the ten themes identified by the stakeholder. The data analysis has enabled the research team to formulate 35 recommendations. While the large number of recommendations are necessary it must be acknowledged these have been produced to support a five year plan.

### **12.1 Theme 1: Analysis of the prevalence trends based on identified primary need: children and young people 5-16 years in Sunderland (2013-2017).**

Theme 1 explores the prevalence of identified primary needs in Sunderland across 2013-2017. Data are presented in Table 9 and Figure 11 (overleaf) highlight that Moderate Learning Difficulties, Social Emotional Mental Health, Speech Language and Communication, Autism Spectrum Disorders and Specific Learning Difficulties are the most prevalent primary needs in Sunderland.

Table 9

*Prevalence of identified Primary Needs in Sunderland: children and young people 5-16 years (2013-2017).*

| Primary Need        | Year  |        |       |        |       |        |       |        |       |        |
|---------------------|-------|--------|-------|--------|-------|--------|-------|--------|-------|--------|
|                     | 2013  |        | 2014  |        | 2015  |        | 2016  |        | 2017  |        |
|                     | N     | %      | N     | %      | N     | %      | N     | %      | N     | %      |
| SpLD                | 482   | 1.51   | 420   | 1.30   | 423   | 1.30   | 460   | 1.40   | 424   | 1.28   |
| MLD                 | 2454  | 7.68   | 2179  | 6.74   | 1665  | 5.11   | 1498  | 4.56   | 1445  | 4.37   |
| SLD                 | 113   | 0.35   | 103   | 0.32   | 89    | 0.27   | 79    | 0.24   | 78    | 0.24   |
| PMLD                | 8     | 0.03   | 7     | 0.02   | 8     | 0.02   | 7     | 0.02   | 4     | 0.01   |
| SEMH                | 1337  | 4.18   | 1337  | 4.14   | 1217  | 3.74   | 1124  | 3.42   | 1228  | 3.71   |
| SLCN                | 1064  | 3.33   | 1161  | 3.59   | 1009  | 3.10   | 1014  | 3.09   | 1037  | 3.13   |
| HI                  | 84    | 0.26   | 88    | 0.27   | 91    | 0.28   | 94    | 0.29   | 103   | 0.31   |
| VI                  | 40    | 0.13   | 42    | 0.13   | 42    | 0.13   | 42    | 0.13   | 44    | 0.13   |
| MSI                 | 5     | 0.02   | 4     | 0.01   | 6     | 0.02   | 4     | 0.01   | 4     | 0.01   |
| PD                  | 170   | 0.53   | 182   | 0.56   | 184   | 0.57   | 172   | 0.52   | 192   | 0.58   |
| ASD                 | 378   | 1.18   | 413   | 1.28   | 497   | 1.53   | 572   | 1.74   | 653   | 1.97   |
| OTH                 | 221   | 0.69   | 205   | 0.63   | 152   | 0.47   | 147   | 0.45   | 136   | 0.41   |
| NSA                 | -     | -      | -     | -      | 19    | 0.06   | 38    | 0.12   | 36    | 0.11   |
| Not SEND Identified | 25602 | 80.11  | 26190 | 81.01  | 27156 | 83.41  | 27594 | 84.01  | 27718 | 83.74  |
| Total               | 31958 | 100.00 | 32331 | 100.00 | 32558 | 100.00 | 32845 | 100.00 | 33102 | 100.00 |

*Note.* Data includes state-funded primary schools, secondary schools, special schools and Pupil Referral Units. '-' denotes zero values. Boxed values highlight figures of interest.

*Source: PLASC*

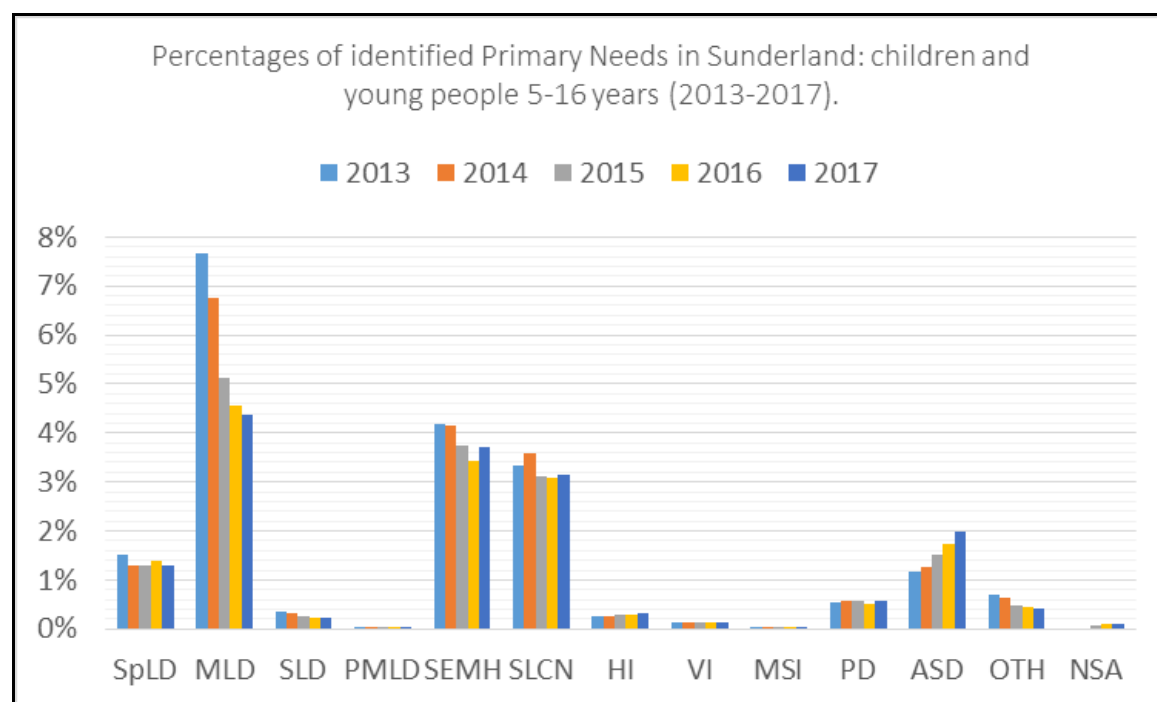


Figure 11: Percentages of identified Primary Needs in Sunderland: children and young people 5-16 years (2013-2017).

- **Moderate Learning Difficulties:** There has been a notable decrease in the prevalence of MLD across Sunderland, falling from 7.68% in 2013 to 4.37% in 2017, as a percentage of all children educated in Sunderland. However, MLD remains the most prevalent SEND in Sunderland. The notable decrease in the prevalence of MLD between 2013 and 2017 suggests that this primary need will continue to decrease in prevalence. This decrease may be explained by what Norwich et al. (2013) explained as the misunderstood nature of MLD as a primary need, in terms of what constitutes effective diagnosis of this need and the definition of the need itself. This phenomenon is also confirmed by the lead researcher's professional experiences of working with SENCos. Many have identified that their understanding of MLD, both definition and characteristics, is very limited. Additionally, there is a significant lack of current specific guidance on what constitutes an effective definition of MLD in the SEND Code of Practice (Norwich and Kelly, 2005; Farrell, 2017).

**Recommendation 1:** For the Council to examine with SENCos their knowledge and understanding of Moderate Learning Difficulties and to use this information to plan CPD to support educational contexts in accurate assessment and identification to meet the needs of children and young people with MLD.

**Recommendation 2:** For the Council to carry out a random audit of children and young people identified with MLD to understand the range of needs within the sample and to assess the accuracy of the identification.

The vision for the Sunderland Clinical Commissioning Group is 'We want to improve the mental health and emotional wellbeing of all children, young people living in Sunderland and to narrow the gap in outcomes between those who do well and those who do not.'

- Social Emotional Mental Health:** SEMH is the second most prevalent primary need of children identified with SEND in Sunderland. As was explored in the literature review, the 2014 Children and Families Act introduced the category SEMH, which was not intended as a direct replacement for the previous category BESD, however, for the purposes of this research SEMH was deemed the most appropriate category for direct comparison. Between 2013 and 2014, when BESD was in place, the numbers of children identified with this need was similar. After the introduction of SEMH as a broad area of need there was an initial decrease in numbers of children identified with this need. This has been followed, in recent years, by fluctuations in rates of identification. There are currently 1228 children and young people identified with SEMH in Sunderland, which is an increase since 2016 and are indicative of effective implementation of the SEND reforms. It is likely that the numbers of children identified with SEMH will rise over the coming years, in light of trends identified in the Chief Medical Officer's report (DoH,2013), which highlighted that one in ten children of ages 5 to 15 are likely to experience a clinically diagnosable medical disorder.

**Recommendation 3:** Due to increase in prevalence of SEMH between 2016 and 2017, it is recommended that the Council support a focus on early identification of SEMH and ensure that all educational settings in Sunderland are equipped to support children and young people with this primary need. This can be achieved by providing high quality, accredited CPD to relevant stakeholders, both in schools and within core services.

- Speech Language Communication Needs:** The rates of identification for SLCN have remained fairly constant over the last 5 years. SLCN remains the third most prevalent primary need of children identified with SEND in Sunderland. Support for children identified with SLCN is particularly important; given both the high numbers of children identified with SLCN as a primary need and the strong prevalence of SLCN within other primary needs, as was identified in the Code of Practice (DfE, 2015a). Consequently, it is likely that the prevalence of children displaying SLCN

characteristics in Sunderland is far greater than that represented by primary need data. Recommendations for this primary need are presented within Theme 2.

- **Autism Spectrum Disorder:** ASD is the third most diagnosed primary need of children identified with SEND in Sunderland. The rates of ASD diagnosis have steadily increased between 2013 and 2017. It is important to note that an anomaly has been identified between numbers of children identified with ASD from the PLASC data and those recorded on the postcode data shared by the Autism Outreach Team to Sunderland Council.

**Recommendation 4:** As there has been an increase in the number of children diagnosed with Autism, it is advised that the Council reviews all recording and tracking procedures for these children to ensure their needs are optimally met. The local offer should include service provision, quality information, guidance and signposting to support children and families.

- **Specific Learning Difficulty:** Based on estimations made by the Driver Youth Trust, Sunderland presents with a significant under-identification of SpLD (2015). Estimates suggest that approximately 13% of children and young people in Britain experience SpLD (Driver Youth Trust, 2015). In 2017, 424 children and young people in Sunderland were identified with SpLD; this represents 1.28% of the population. This figure is significantly lower than the national estimates, which suggests that there is an under-identification of SpLD in Sunderland.

**Recommendation 5:** For the Council to work closely with nursery/school leaders and SENCos to ensure that all children with SpLD have their needs assessed and identified by an Educational Psychologist or other trained professional.

**Recommendation 6:** For the Council to respond to the under identification of SpLD by evaluating the effectiveness or impact of arrangements for identifying and assessing the needs of specific groups of children and young people with SpLD across provision in Sunderland. This will require the Council to provide school based training on neurodiversity.



## 12.2 Theme 2: Analysis of the prevalence of identified primary need: children and young people 5-16 years based on school year and key stage in Sunderland (2017).

Theme 2 explores the prevalence of identified primary need in more detail, by examining the data across the following age phases:

- Primary Phase (Year 1 to Year 6)
- Secondary Phase (Year 7 to Year 11)
- All phases combined, primary and secondary
- By Key Stage (KS1,KS2,KS3 and KS4)

The analysis identifies the most prevalent primary needs based on year groups.

### Primary Phase

Table 10

*Prevalence of identified Primary Needs in Sunderland: children and young people 5-11 years based on school year (2017).*

| Primary Need        | School Year |        |        |        |        |        |        |        |        |        |        |        |
|---------------------|-------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|                     | Year 1      |        | Year 2 |        | Year 3 |        | Year 4 |        | Year 5 |        | Year 6 |        |
|                     | N           | %      | N      | %      | N      | %      | N      | %      | N      | %      | N      | %      |
| SpLD                | 11          | 0.34   | 14     | 0.44   | 21     | 0.67   | 32     | 0.98   | 40     | 1.25   | 46     | 1.49   |
| MLD                 | 86          | 2.68   | 124    | 3.91   | 121    | 3.88   | 158    | 4.82   | 171    | 5.33   | 171    | 5.55   |
| SLD                 | 3           | 0.09   | 2      | 0.06   | 4      | 0.13   | 7      | 0.21   | 5      | 0.16   | 18     | 0.58   |
| PMLD                | -           | -      | 1      | 0.03   | 1      | 0.03   | 1      | 0.03   | 1      | 0.03   | -      | -      |
| SEMH                | 75          | 2.34   | 86     | 2.71   | 69     | 2.21   | 90     | 2.74   | 129    | 4.02   | 125    | 4.06   |
| SLCN                | 197         | 6.14   | 174    | 5.49   | 134    | 4.30   | 150    | 4.57   | 105    | 3.27   | 75     | 2.43   |
| HI                  | 8           | 0.25   | 2      | 0.06   | 9      | 0.29   | 7      | 0.21   | 7      | 0.22   | 14     | 0.45   |
| VI                  | 4           | 0.12   | 4      | 0.13   | 3      | 0.10   | 3      | 0.09   | 2      | 0.06   | 5      | 0.16   |
| MSI                 | 1           | 0.03   | -      | -      | 1      | 0.03   | -      | -      | -      | -      | 2      | 0.06   |
| PD                  | 24          | 0.75   | 20     | 0.63   | 21     | 0.67   | 25     | 0.76   | 24     | 0.75   | 19     | 0.62   |
| ASD                 | 53          | 1.65   | 72     | 2.27   | 75     | 2.41   | 65     | 1.98   | 63     | 1.96   | 60     | 1.95   |
| OTH                 | 11          | 0.34   | 26     | 0.82   | 18     | 0.58   | 12     | 0.37   | 15     | 0.47   | 14     | 0.45   |
| NSA                 | 6           | 0.19   | 6      | 0.19   | 3      | 0.10   | 5      | 0.15   | 3      | 0.09   | 2      | 0.06   |
| Not SEND Identified | 2730        | 85.07  | 2640   | 83.25  | 2638   | 84.61  | 2725   | 83.08  | 2642   | 82.38  | 2531   | 82.12  |
| Total               | 3209        | 100.00 | 3171   | 100.00 | 3118   | 100.00 | 3280   | 100.00 | 3207   | 100.00 | 3082   | 100.00 |

Note. Data includes state-funded primary schools, special schools and pupil referral units. '-' denotes zero values. Boxed values highlight figures of interest.

Source: PLASC

## Secondary Phase

Table 11

*Prevalence of identified Primary Needs in Sunderland: children and young people 11-16 years based on school year (2017).*

| Primary Need        | School Year |        |        |        |        |        |         |        |         |        |
|---------------------|-------------|--------|--------|--------|--------|--------|---------|--------|---------|--------|
|                     | Year 7      |        | Year 8 |        | Year 9 |        | Year 10 |        | Year 11 |        |
|                     | N           | %      | N      | %      | N      | %      | N       | %      | N       | %      |
| SpLD                | 35          | 1.21   | 56     | 1.96   | 52     | 1.84   | 50      | 1.90   | 67      | 2.38   |
| MLD                 | 152         | 5.24   | 125    | 4.38   | 136    | 4.81   | 92      | 3.49   | 109     | 3.87   |
| SLD                 | 10          | 0.34   | 6      | 0.21   | 10     | 0.35   | 6       | 0.23   | 7       | 0.25   |
| SEMH                | 105         | 3.62   | 117    | 4.10   | 141    | 4.99   | 121     | 4.59   | 170     | 6.03   |
| SLCN                | 49          | 1.69   | 47     | 1.65   | 33     | 1.17   | 39      | 1.48   | 34      | 1.21   |
| HI                  | 8           | 0.28   | 8      | 0.28   | 17     | 0.60   | 13      | 0.49   | 10      | 0.35   |
| VI                  | 4           | 0.14   | 5      | 0.18   | 2      | 0.07   | 3       | 0.11   | 9       | 0.32   |
| PD                  | 13          | 0.45   | 12     | 0.42   | 10     | 0.35   | 14      | 0.53   | 10      | 0.35   |
| ASD                 | 63          | 2.17   | 54     | 1.89   | 55     | 1.95   | 46      | 1.74   | 47      | 1.67   |
| OTH                 | 15          | 0.52   | 10     | 0.35   | 3      | 0.11   | 5       | 0.19   | 7       | 0.25   |
| NSA                 | -           | -      | 6      | 0.21   | 1      | 0.04   | 2       | 0.08   | 2       | 0.07   |
| Not SEND Identified | 2445        | 84.34  | 2407   | 84.37  | 2366   | 83.72  | 2246    | 85.17  | 2348    | 83.26  |
| Total               | 2899        | 100.00 | 2853   | 100.00 | 2826   | 100.00 | 2637    | 100.00 | 2820    | 100.00 |

*Note.* Data includes state-funded secondary schools, special schools and pupil referral units. '-' denotes zero values. Boxed values highlight figures of interest.

*Source: PLASC*

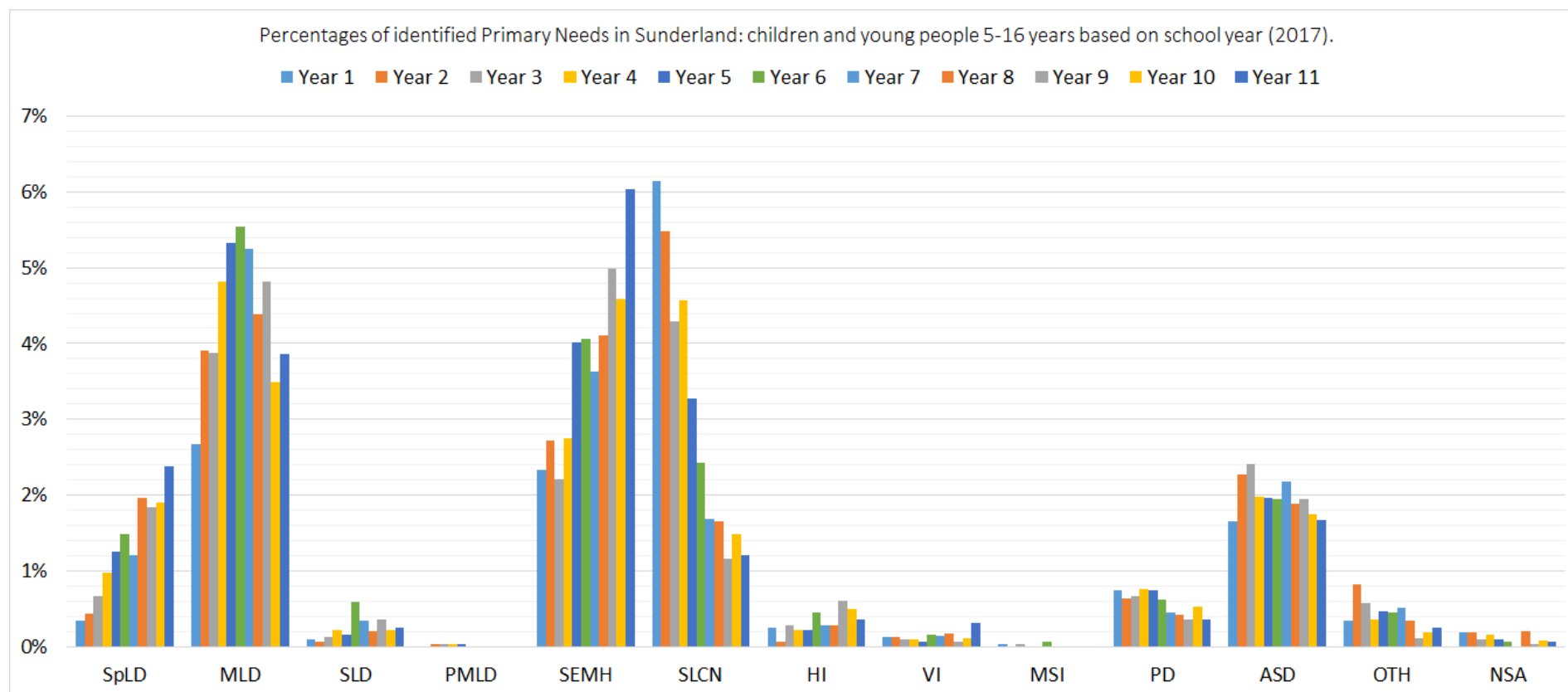


Figure 12: Percentages of identified Primary Needs in Sunderland: children and young people 5-16 years based on school year (2017).

## By Key Stage

Table 12

*Prevalence of identified Primary Needs in Sunderland: children and young people 5-16 years based on Key Stage (2017).*

| Primary Need        | Key Stage |        |       |        |      |        |      |        |
|---------------------|-----------|--------|-------|--------|------|--------|------|--------|
|                     | KS1       |        | KS2   |        | KS3  |        | KS4  |        |
|                     | N         | %      | N     | %      | N    | %      | N    | %      |
| SpLD                | 25        | 0.39   | 139   | 1.10   | 143  | 1.67   | 117  | 2.14   |
| MLD                 | 210       | 3.29   | 621   | 4.89   | 413  | 4.81   | 201  | 3.68   |
| SLD                 | 5         | 0.08   | 34    | 0.27   | 26   | 0.30   | 13   | 0.24   |
| PMLD                | 1         | 0.02   | 3     | 0.02   | -    | -      | -    | -      |
| SEMH                | 161       | 2.52   | 413   | 3.26   | 363  | 4.23   | 291  | 5.33   |
| SLCN                | 371       | 5.82   | 464   | 3.66   | 129  | 1.50   | 73   | 1.34   |
| HI                  | 10        | 0.16   | 37    | 0.29   | 33   | 0.38   | 23   | 0.42   |
| VI                  | 8         | 0.13   | 13    | 0.10   | 11   | 0.13   | 12   | 0.22   |
| MSI                 | 1         | 0.02   | 3     | 0.02   | -    | -      | -    | -      |
| PD                  | 44        | 0.69   | 89    | 0.70   | 35   | 0.41   | 24   | 0.44   |
| ASD                 | 125       | 1.96   | 263   | 2.07   | 172  | 2.01   | 93   | 1.70   |
| OTH                 | 37        | 0.58   | 59    | 0.47   | 28   | 0.33   | 12   | 0.22   |
| NSA                 | 12        | 0.19   | 13    | 0.10   | 7    | 0.08   | 4    | 0.07   |
| Not SEND Identified | 5370      | 84.17  | 10536 | 83.05  | 7218 | 84.15  | 4594 | 84.19  |
| Total               | 6380      | 100.00 | 12687 | 100.00 | 8578 | 100.00 | 5457 | 100.00 |

*Note.* Data includes state-funded primary schools, secondary schools, special schools and pupil referral units. Boxed values highlight figures of interest.

*Source: PLASC*

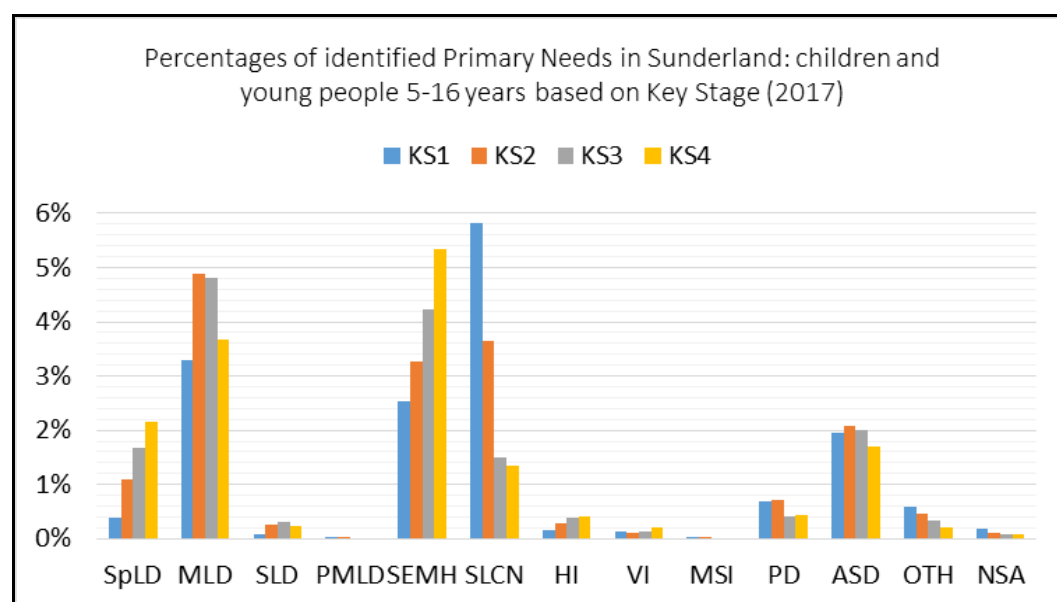


Figure 13: Percentages of identified Primary Needs in Sunderland: Children and Young People 5-16 years based on Key Stage (2017).

- **Social, Emotional and Mental Health (SEMH):** The PLASC data indicates that the numbers of children identified with SEMH in Sunderland steadily increases, ending as the most prevalent primary need by Year 11. There is a notable rise in children identified with SEMH from Year 5 to Year 6, in Year 9 and in Year 11. These are the points in the education system at which standardised and summative testing occurs. It is also possible that the peaks seen across Key Stages 3 and 4 could be explained by a range of social pressures, including puberty and digital technology. The steady increase in prevalence of SEMH as children get older highlights the importance of early intervention in supporting children and young people with this primary need by qualified and well trained staff and pastoral teams. This requires effective multi-agency working to implement.

Prevalence note: In the current academic year, the highest rates of SEMH prevalence, as a percentage of all children and young people in Sunderland are in: Year 5 (4.02%), Year 6 (4.06%), Year 8 (4.10%), Year 9 (4.99%), Year 10 (4.59) and Year 11 (6.03%).

**Recommendation 7:** For the Council to review existing models for effective multi-agency working and explore means by which greater collaboration between clinical teams, educational psychologists, SENCos and CAMHS can work together to support early intervention in educational contexts, by identifying geographical and age related hotspots (DfE, 2015a; Eames and Shippen, 2017).

**Recommendation 8:** Due to the high rate of SEMH prevalence in Year 11 at 6.03% of all children in Sunderland, the Council should analyse the number of children in education, employment and training 16-18 years to identify the level of need and inform provision planning based on findings.

- **Moderate Learning Difficulties:** In the primary age phase, there is a notable increase from 2.68% of all children in Year 1 to 5.55% in Year 6 of MLD identification. As explained in Theme 1 data analysis, this could be due to a lack of understanding of the definition of MLD prior to identification. MLD peaks between the Key Stage Two and Key Stage Three transition, we recommend that the Council explore this via further research. Suggested triggers for this peak in identification could include, curriculum changes and increased demands or standardised testing. There is a general trend of reduction in identification of MLD between Key Stage 3 and 4. This supports the findings of Ofsted (2016a), who reported that the numbers of children identified with SEND has fallen by 3.5% since 2014.

Prevalence note: In the current academic year, the highest rates of MLD prevalence, as a percentage of all children and young people in Sunderland, are in: Year 4 (4.82%), Year 5 (5.33%), Year 6 (5.55%), and Year 7 (5.24%).

- **Speech Language Communication Needs:** The number of children identified with SLCN in Sunderland peaks in year 1 at 6.14%. There is a dramatic reduction in rate of identification between Year 1 and Year 6, by Year 7 only 1.69% of all children in Sunderland are identified with SLCN. The reduction in SLCN rate presents the most dramatic change in identification rate across all primary needs and ages in Sunderland. This indicates that the early years and early primary age phases are effectively supporting children in developing age-appropriate speech, language and communication skills. This is meeting the needs of children identified with this primary need early on in their education, thus, better enabling children to progress without additional support later in their schooling. It is likely that the formal and full-time nature of the learning environment in Key Stage 1 is accelerating children's language skills. It would also be useful to investigate the availability and quality of non-formal educational provision in the early years, across communities in Sunderland to ensure that children are being supported to develop age-appropriate language and communication skills before entering formal, full-time education.

Prevalence note: In the current academic year, the highest rates of SLCN prevalence, as a percentage of all children and young people in Sunderland, are in: Year 1 (6.14%), Year 2 (5.49%), Year 3 (4.30%) and Year 4 (4.57%).

**Recommendation 9:** For the Council to complete a geographical mapping exercise of the children on the SEN register with a primary need of SLCN, to locate their local community and identify links between the level of need and the services available in their area through the local offer. This would better inform forward planning and early intervention to reduce the high levels of prevalence on entry into formal education.

- **Autism Spectrum Disorder:** The numbers of children identified with ASD as a primary need in Sunderland remains relatively constant across year groups. However, there are notable peaks in prevalence following Key Stage transition points.

Prevalence note: In the current academic year, the highest rates of ASD prevalence, as a percentage of all children and young people in Sunderland, are in: Year 2 (2.27%), Year 3 (2.41%) and Year 7 (2.17%). As was previously discussed, there is an anomaly in the rates of prevalence between the PLASC data and the Autism Outreach Team data collected by the Council.

- **Specific Learning Difficulties:** The numbers of children identified with SpLD in Sunderland are exceptionally low, as a proportion of all children identified with SEND. This could be due to a lack of staff knowledge and confidence in identifying and assessing for SpLD across all age ranges and Key Stages. The numbers of children with an identified SpLD do steadily increase from Year 1 to Year 11, though these numbers are still exceptionally low.

Prevalence note: In the current academic year, the highest rates of SpLD prevalence, as a percentage of all children and young people in Sunderland, are notable in Key Stage 4, as the numbers of children increase as they progress through school years.

### 12.3 Theme 3: Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support in Sunderland (2017).

Theme 3 explores the proportion of SEN classifications for each identified primary need for 2017 and the data are given in Table 13 and Figure 14; the main findings and subsequent recommendations are given below.

Table 13

*Prevalence of Primary SEND classification in Sunderland: Statement of SEN, EHC plan and SEN Support (2017).*

| Primary Need | SEND Classification |        |          |        |             |        |
|--------------|---------------------|--------|----------|--------|-------------|--------|
|              | Statement of SEN    |        | EHC plan |        | SEN Support |        |
|              | N                   | %      | N        | %      | N           | %      |
| SpLD         | -                   | -      | 4        | 0.83   | 420         | 9.17   |
| MLD          | 23                  | 7.14   | 22       | 4.57   | 1400        | 30.56  |
| SLD          | 30                  | 9.32   | 32       | 6.65   | 16          | 0.35   |
| PMLD         | 2                   | 0.62   | 2        | 0.42   | -           | -      |
| SEMH         | 59                  | 18.32  | 118      | 24.53  | 1051        | 22.94  |
| SLCN         | 54                  | 16.77  | 85       | 17.67  | 898         | 19.60  |
| HI           | 9                   | 2.80   | 8        | 1.66   | 86          | 1.88   |
| VI           | 3                   | 0.93   | 2        | 0.42   | 39          | 0.85   |
| MSI          | -                   | -      | -        | -      | 4           | 0.09   |
| PD           | 45                  | 13.98  | 42       | 8.73   | 105         | 2.29   |
| ASD          | 97                  | 30.12  | 165      | 34.30  | 391         | 8.54   |
| OTH          | -                   | -      | 1        | 0.21   | 135         | 2.95   |
| NSA          | -                   | -      | -        | -      | 36          | 0.79   |
| Total        | 322                 | 100.00 | 481      | 100.00 | 4581        | 100.00 |

*Note.* Data includes state-funded primary schools, secondary schools, special schools and Pupil Referral Units. '-' denotes zero values. Boxed values highlight figures of interest.

*Source: PLASC*



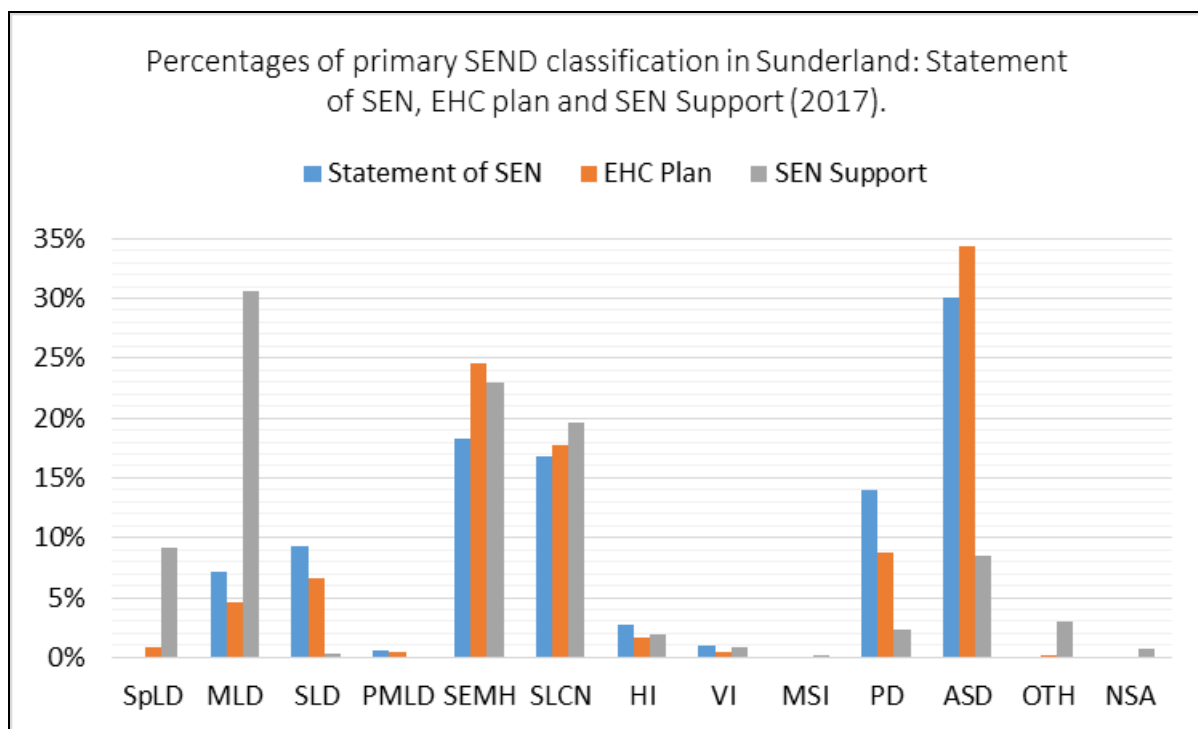


Figure 14: Analysis of the prevalence of primary SEND classification: Statement of SEN, EHC plan and SEN Support (2017) in Sunderland.

The data shows that 322 children and young people in Sunderland currently have a Statement of SEN, with 481 children currently in receipt of an EHC plan. This represents 40% of all children who require significant additional support, provided by an EHC plan/Statement, who need to be transferred to an EHC plan by April 2018 to be compliant with national legislation (DfE, 2016b).

- Moderate Learning Difficulties:** MLD is the most prevalent primary need of all children identified with SEND in Sunderland. 30.56% of all children on SEN Support in Sunderland are identified with MLD. This means that more children on SEN Support are identified with MLD than any other primary need. However, there are few Statements/EHC plans issued for children identified MLD (45 in total), than those on SEN Support identified with MLD, at 1400 children. This is a stark difference in categorisation of support level, therefore, requires reviewing to ensure that it is representative of additional needs presented by children identified with MLD.

- **Social Emotional Mental Health:** SEMH is the second most prevalent primary need of all children identified with SEND in Sunderland, with 1228 children within this broad area of need. The significant majority of these children are on SEN Support, at 1051. However, SEMH is the second most prevalent need in all children awarded a Statement/EHC plan in Sunderland.
- **Speech Language Communication Needs:** SLCN is the third most prevalent primary need in Sunderland, with the majority of children (898/4581) on SEN Support. A total of 139 children with SLCN have been awarded a Statement/EHC plan in Sunderland.
- **Autism Spectrum Disorder:** Approximately a third of all Statements/EHC plan issued by Sunderland City Council are to support children identified with ASD. However, a relatively low percentage of Sunderland's SEN Support children are identified with ASD, at 8.54%.

**Recommendation 10:** For the Council to ensure the timely transfer of all 322 children currently in receipt of a Statement of SEN to an EHC plan, by April 2018.

**Recommendation 11:** A high number of children identified with ASD have been awarded Statements/EHC plans. This indicative of a particularly high prevalence of ASD in Sunderland. It is important that the Council reviews all provision for children identified with ASD to inform future planning and CPD needs of staff over the next 5 years (see appendix 5 for an example of a training audit).

## 12.4 Theme 4: Analysis of national data compared to Sunderland City Council data based on primary type of need identified in children and young people 5-16 years (2016).

Theme 4 compares National and Sunderland City Council data regarding the prevalence of identified primary need in children and young people aged 5-16 years. Data are presented in Table 14, with main findings and recommendations given below:

Table 14

*Analysis of national and Sunderland City Council data based on identified Primary Needs: children and young people 5-16 years (2016).*

| SEND Primary Need | SEN Support % |            |        | Statement of SEN or EHC plan % |            |        |
|-------------------|---------------|------------|--------|--------------------------------|------------|--------|
|                   | National      | Sunderland | % Diff | National                       | Sunderland | % Diff |
| SpLD              | 15.6          | 10.32      | -5.28  | 4.0                            | 0.37       | -3.63  |
| MLD               | 26.8          | 32.72      | +5.92  | 13.4                           | 5.93       | -7.47  |
| SLD               | 0.4           | 0.45       | +0.05  | 13.1                           | 7.29       | -5.81  |
| PMLD              | 0.1           | 0.05       | -0.05  | 4.5                            | 0.62       | -3.88  |
| SEMH              | 17.3          | 20.32      | +3.02  | 12.3                           | 26.33      | +14.03 |
| SLCN              | 20.9          | 20.07      | -0.83  | 14.0                           | 15.33      | +1.33  |
| HI                | 1.6           | 1.83       | +0.23  | 2.7                            | 1.61       | -1.09  |
| VI                | 0.9           | 0.79       | -0.11  | 1.5                            | 0.87       | -0.63  |
| MSI               | 0.2           | 0.07       | -0.13  | 0.3                            | 0.12       | -0.18  |
| PD                | 2.2           | 2.03       | -0.17  | 5.8                            | 10.14      | +4.34  |
| ASD               | 4.7           | 7.25       | +2.55  | 25.9                           | 31.03      | +5.13  |
| OTH               | 5.5           | 3.25       | -2.25  | 2.4                            | 0.37       | -2.03  |
| NSA               | 3.9           | 0.86       | -3.04  | 0.1                            | -          | -0.10  |
| Total             | 100.00        | 100.00     |        | 100.00                         | 100.00     |        |

*Note.* Percentages expressed include pupils with SEN provision only. Percentages are rounded to the nearest 0.1. '-' denotes zero values. Data includes state-funded primary, middle (where applicable), secondary and special schools. Data excludes nurseries, independent schools and pupil referral units (DfE, 2016c).

*Source: PLASC and School Census*

There is higher prevalence of children on Statements/EHC plan, compared to national data, with the following primary needs:

- **Social Emotional Mental Health:** National prevalence = 12.3%; Sunderland = 26.3%. This represents an increase in prevalence of **+14.03%** in Sunderland.
- **Autism Spectrum Disorders:** National prevalence = 25.9%; Sunderland = 31.03%. This represents an increase in prevalence of **+5.13%** in Sunderland.
- **Physical Disability:** National prevalence = 5.8%; Sunderland = 10.14%. This represents an increase in prevalence of **+4.34%** in Sunderland.

There is lower prevalence of children on Statements/EHC plan, compared to national data, with the following primary needs:

- **Moderate Learning Difficulty:** National prevalence = 13.4%; Sunderland = 5.93%. This represents a decrease in prevalence of **-7.47%** in Sunderland.
- **Severe Learning Difficulty:** National prevalence = 13.1%; Sunderland = 7.29%. This represents a decrease in prevalence of **-5.81%** in Sunderland.
- **Specific Learning Difficulty:** National prevalence = 4%; Sunderland = 0.37%. This represents a decrease in prevalence of **-3.63%** in Sunderland.

**Recommendation 12:** For the City Council to use the National Data to monitor the prevalence rates of SEMH in Sunderland to inform future service planning and CPD needs of educational contexts. There needs to be further analysis carried out as to why SEMH is 14.03% above the national average.

There is higher prevalence of children on SEN Support, compared to national data, with the following primary needs:

- **Moderate Learning Difficulty:** National prevalence = 26.8%; Sunderland = 32.72%. This represents an increase in prevalence of **+5.92%** in Sunderland.
- **Social, Emotional and Mental Health difficulties:** National prevalence = 17.3%; Sunderland = 20.32%. This represents an increase in prevalence of **+3.02%** in Sunderland.
- **Autism Spectrum Disorder:** National prevalence = 4.7%; Sunderland = 7.25%. This represents an increase in prevalence of **+2.55%** in Sunderland.

There is lower prevalence of children on SEN Support, compared to national data, with the following primary needs:

- **Specific Learning Difficulty:** National prevalence = 15.6%; Sunderland = 10.32%. This represents a decrease in prevalence of **-5.28%** in Sunderland.
- **No Statutory Assessment:** National prevalence = 3.9%; Sunderland = 0.86%. This represents a decrease in prevalence of **-3.04%** in Sunderland.
- **Other:** National prevalence = 5.5%; Sunderland = 3.25%. This represents a decrease in prevalence of **-2.25%** in Sunderland.

## 12.5 Theme 5: Analysis of Early Years data (Reception year) by primary type of need and Good Level of Development in Sunderland (2014 - 2017).

Theme 5 explores the identified primary needs and achieved Good Level of Development (GLD) rates of children in Reception for academic years 2013/14, 2014/15 and 2015/16. The data were captured each year in January as part of the school census, with children now in the following year groups: 2013/14 - Year 3, 2014/15 - Year 2 and 2015/16 - Year 1. Data are presented in Tables 15 - 17 and Figure 15 - 17, with main findings and recommendations given below.

### 12.5.1 Primary needs of Reception aged children in Sunderland

Table 15

*Prevalence of identified Primary Needs with Reception aged children in Sunderland (2014-2017).*

| Primary Need | Year |        |      |        |      |        |      |        |
|--------------|------|--------|------|--------|------|--------|------|--------|
|              | 2014 |        | 2015 |        | 2016 |        | 2017 |        |
|              | N    | %      | N    | %      | N    | %      | N    | %      |
| SpLD         | 19   | 4.31   | 14   | 2.73   | 10   | 2.15   | 6    | 1.53   |
| MLD          | 110  | 24.94  | 118  | 23.00  | 83   | 17.81  | 41   | 10.46  |
| SLD          | 4    | 0.91   | 2    | 0.39   | 2    | 0.43   | 2    | 0.51   |
| PMLD         | 1    | 0.23   | 1    | 0.19   | -    | -      | -    | -      |
| SEMH         | 62   | 14.06  | 81   | 15.79  | 73   | 15.67  | 45   | 11.48  |
| SLCN         | 129  | 29.25  | 171  | 33.33  | 195  | 41.85  | 218  | 55.61  |
| HI           | 9    | 2.04   | 2    | 0.39   | 8    | 1.72   | 5    | 1.28   |
| VI           | 3    | 0.68   | 4    | 0.78   | 3    | 0.64   | 1    | 0.26   |
| MSI          | 1    | 0.23   | -    | -      | 1    | 0.21   | -    | -      |
| PD           | 16   | 3.63   | 19   | 3.70   | 24   | 5.15   | 21   | 5.36   |
| ASD          | 68   | 15.42  | 71   | 13.84  | 51   | 10.94  | 43   | 10.97  |
| OTH          | 17   | 3.85   | 24   | 4.68   | 10   | 2.15   | 9    | 2.30   |
| NSA          | 2    | 0.45   | 6    | 1.17   | 6    | 1.29   | 1    | 0.26   |
| Total        | 441  | 100.00 | 513  | 100.00 | 466  | 100.00 | 392  | 100.00 |

Note: '-' denotes zero values. Boxed values highlight figures of interest.

Source: School Census

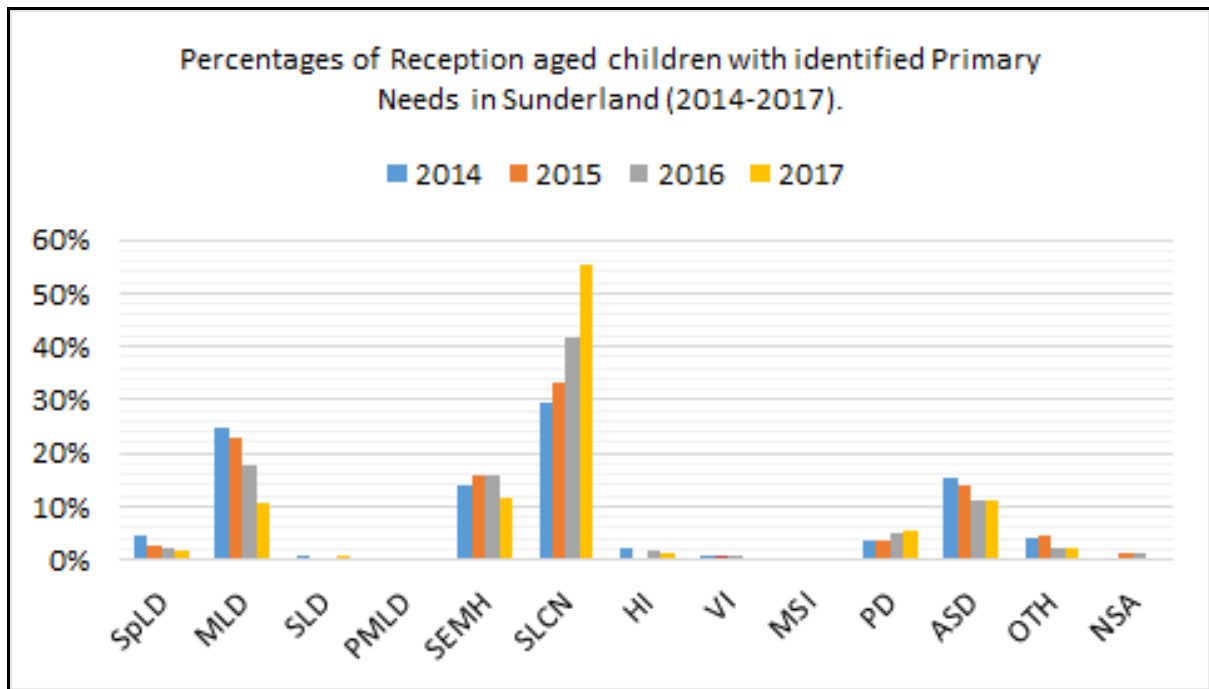


Figure 15: Percentages of Reception aged children with identified Primary Needs in Sunderland (2014-2017).

**Analysis of early years data provided by the City Council from 2014-2016 indicates the following:**

- SLCN is the most prevalent need and is rising year on year; currently this is the most prevalent primary need of children in the reception year with 41.85% of all children with SEND having this need.
- MLD is the second most prevalent need however, this is showing a year by year decrease from 24.94% in 2014 to 17.81% in 2016.
- SEMH is variable but still the third most prevalent need in 2016 within the SEND population.
- ASD remains the fourth most prevalent need but is reducing year on year as a primary need according to this data set.
- There are also early indications that the prevalence of PD is increasing with time in the early years, making it the fourth most prevalent need in both 2016 and 2017.

The analysis also includes the PLASC data for early years who are the children currently in reception 2016/2017.

**The 2017 PLASC data on early years in Sunderland indicates some changing trends from previous years:**

- The main primary need within early years in the current academic year remains SLCN with 55.61% of all children with identified need.
- The second highest primary need has become SEMH, with 11.48% of the SEND population. This raises the concern that that these children may not be school ready for the demands of Key Stage One.
- ASD is the primary need of 10.97% of the SEND population, reducing from 2016. This statistic does not include those children yet to be identified, assessed and diagnosed. These children will need to be supported with the transition to year one.
- MLD is the primary need with 10.46% of the children with SEND, reducing to the fourth most prevalent need amongst the Early Years population. There is a concern as to whether this is the correct classification for this group of 41 children, due to the possible difficulties associated with MLD identification and assessment, as has been previously discussed.



## 12.5.2 SEND classifications of Reception aged children in Sunderland

Table 16

*Prevalence of primary SEND classification with Reception aged children in Sunderland: Statement of SEN, EHC plan, and SEN Support (2017).*

| Primary Need | SEND Classification |        |          |        |             |        |
|--------------|---------------------|--------|----------|--------|-------------|--------|
|              | Statement of SEN    |        | EHC plan |        | SEN Support |        |
|              | <i>N</i>            | %      | <i>N</i> | %      | <i>N</i>    | %      |
| SpLD         | -                   | -      | -        | -      | 1           | 0.26   |
| MLD          | -                   | -      | -        | -      | 41          | 10.85  |
| SLD          | -                   | -      | -        | -      | 1           | 0.26   |
| PMLD         | -                   | -      | 1        | 3.03   | 1           | 0.26   |
| SEMH         | -                   | -      | -        | -      | 49          | 12.96  |
| SLCN         | 1                   | 33.33  | 11       | 33.33  | 199         | 52.65  |
| HI           | -                   | -      | 2        | 6.06   | 3           | 0.79   |
| VI           | -                   | -      | -        | -      | 6           | 1.59   |
| MSI          | -                   | -      | -        | -      | 1           | 0.26   |
| PD           | 1                   | 33.33  | 9        | 27.27  | 10          | 2.65   |
| ASD          | 1                   | 33.33  | 10       | 30.30  | 37          | 9.79   |
| OTH          | -                   | -      | -        | -      | 18          | 4.76   |
| NSA          | -                   | -      | -        | -      | 11          | 2.91   |
| Total        | 3                   | 100.00 | 33       | 100.00 | 378         | 100.00 |

Note. '-' denotes zero values. Boxed values highlight figures of interest.

Source: PLASC

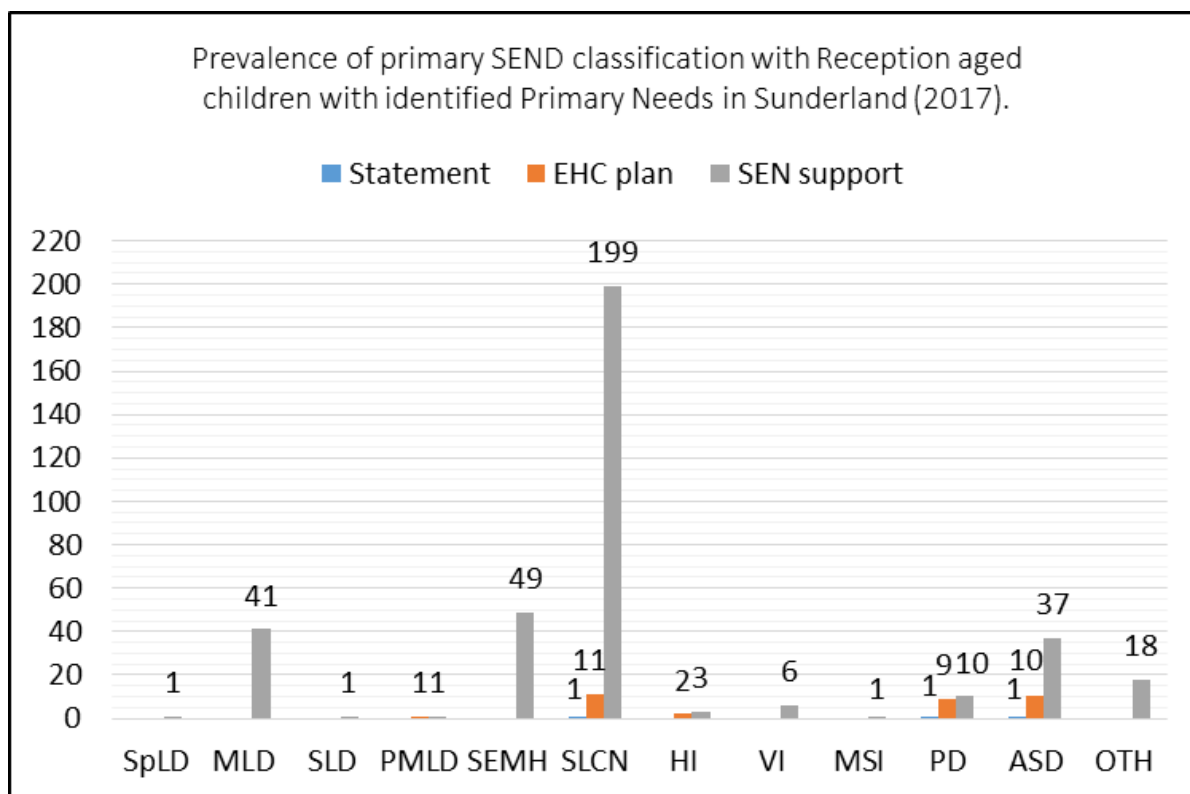


Figure 16: Prevalence of primary SEND classification with Reception aged children with identified Primary Needs in Sunderland (2017).

### Analysis of SEND classification of Reception children in Sunderland

- The classification data indicates that there are only three children of Reception age that have Statements of SEN. These children need to be moved to EHC plans by April 2018, which will result in a total of 36 children on EHC plans in this year group but April 2018.
- There are a total of 378 children, currently in Reception, who are on SEN Support. Of these children:
  - 52.68% are identified with SLCN, which represents 199 children. Consequently, supporting early years practitioners with meeting the needs of children identified with SLCN is imperative.
  - 12.96% are identified with SEMH, which represents 49 children. These children are likely to require effective multi-agency working, in meeting their needs, to make a successful transition into primary school.

- 10.85% are identified with MLD, which represents 41 children. As discussed earlier in this report, the identification and assessment of these children requires review.
- 9.79% are identified with ASD, which represents 37 children.
- There are a total of 33 children currently with an EHC plan in Reception. Of these children:
  - 33.33% are identified with SLCN, which represents 11 children.
  - 30.30% are identified with ASD, which represents 10 children.
  - 27.27% are identified with PD, which represents 9 children. This suggests that it is particularly important for early years practitioners to have adequate training and CPD to support children with Physical Disabilities. This will likely better support the transition of these children through the phases of their education, as their needs have been identified and support early.

### 12.5.3 Good Levels of Development with Reception aged children identified with SEN in Sunderland

Table 17

*Prevalence of identified Primary Needs and achieved Good Level of Development with reception children in Sunderland (2014-2016).*

| Primary Need | Year |        |      |        |      |       |
|--------------|------|--------|------|--------|------|-------|
|              | 2014 |        | 2015 |        | 2016 |       |
|              | N    | %      | N    | %      | N    | %     |
| SpLD         | 3    | 15.79  | 1    | 7.14   | 2    | 20.00 |
| MLD          | 6    | 5.45   | 12   | 10.17  | 5    | 6.02  |
| SLD          | -    | -      | -    | -      | -    | -     |
| PMLD         | -    | -      | -    | -      | -    | -     |
| SEMH         | 14   | 22.58  | 19   | 23.46  | 18   | 24.66 |
| SLCN         | 10   | 7.75   | 14   | 8.19   | 35   | 17.95 |
| HI           | 5    | 55.56  | 2    | 100.00 | 5    | 62.50 |
| VI           | -    | -      | -    | -      | 2    | 66.67 |
| MSI          | 1    | 100.00 | -    | -      | -    | -     |
| PD           | 4    | 25.00  | 4    | 21.05  | 5    | 20.83 |
| ASD          | 10   | 14.71  | 16   | 22.54  | 4    | 7.84  |
| OTH          | 2    | 11.76  | 8    | 33.33  | 4    | 40.00 |
| NSA          | -    | -      | -    | -      | 1    | 16.67 |
| Total        | 55   | 12.47  | 76   | 14.81  | 81   | 17.38 |

*Note . '-' denotes zero values. Boxed values highlight figures of interest.*

*Source: School Census*

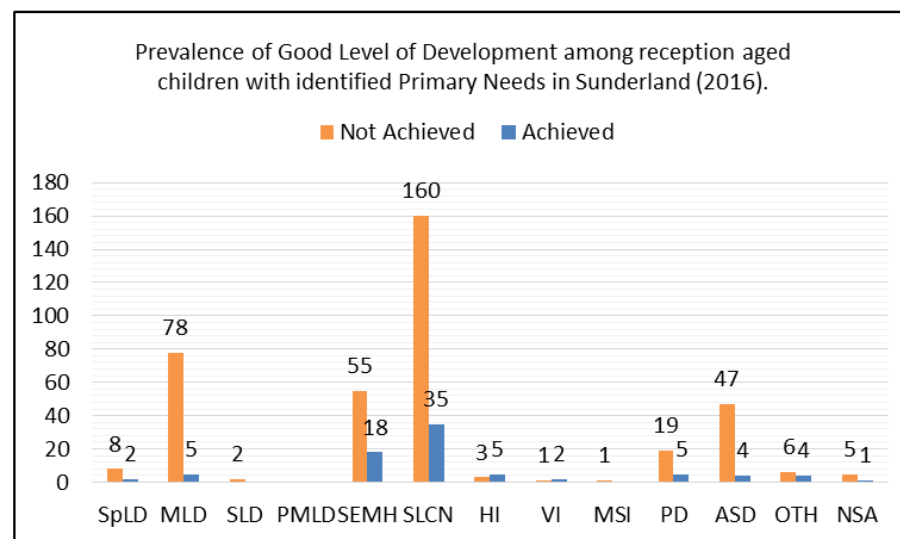
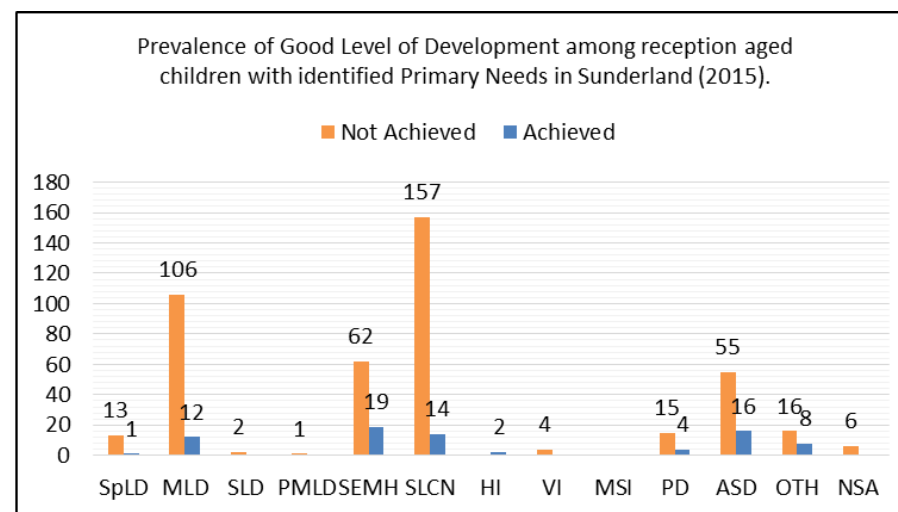
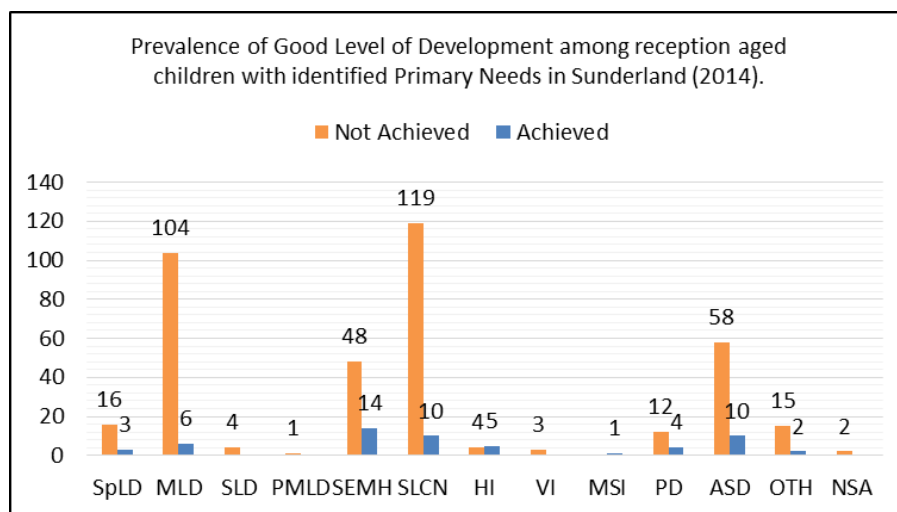


Figure 17: Prevalence of Good Level of Development among reception aged children with identified Primary Needs in Sunderland (2014 – 2016).

## **Analysis of data regarding Good Levels of Development in Reception aged children identified with SEN in Sunderland**

Analysis of data indicates that the proportion of children identified with SEN in the early years that achieve Good Levels of Development (GLD) is extremely low. Of all children identified with SEN in Reception, **only 17.38% of those children achieved a GLD in 2016**. It appears that children identified with the following primary needs are having significant difficulties in meeting Good Levels of Development in Reception:

- **MLD:** 6.02% of Reception aged children achieved a GLD in 2016 this represents 5 out of eighty-three children. The rates of GLD attainment in children identified with MLD remain consistently low over time.
- **ASD:** The rate of GLD attainment in children identified with ASD was 7.85%, or 4 out of forty-seven children, in 2016. This indicates a significant reduction in children identified with ASD meeting GLD since 2015 and should investigate via further research.
- **SLCN:** 17.95%, or thirty-five out of one hundred and ninety-five children identified with SLCN achieved a GLD in 2016. Although this figure is very low, it has increased slightly since 2014, indicating good practice in supporting these pupils to meet GLD.
- **SEMH:** 24.66% of children identified with SEMH reached a GLD in 2016. This represents eighteen out of fifty-five children. Again, the rates of children achieving a GLD do appear to be slightly increasing over time; however, they are still low.

Key recommendations pertaining to the early years are presented below:

**Recommendation 13:** For the Council to provide training to nurseries in collaboration with speech and language therapists, playgroup leaders and parents and carers on how to create language rich environments. This should be targeted to early years settings rated requires improvement or in special measures initially.

**Recommendation 14:** For the Council to further investigate and analyse the specific needs of children identified with SEMH in Sunderland and to develop in conjunction with TaMHS a good practice model for use in early years setting to address the range of SEMH needs. This would require appropriate staff training on identification for optimum implementation to occur.

**Recommendation 15:** For the Council to investigate the support provided to children identified with SEN in meeting a GLD, given the current low levels of GLD attainment amongst these children. This will inform strategies to better support professionals, families and children with improving the levels of GLD amongst the SEN population. The 2016 reduction in the achievement of a GLD for Reception aged children identified with ASD should also be investigated.

**Recommendation 16:** For the Council to use the Local Offer to make it easier for parents and carers to compare the quality of early years services, including childcare for children before the start of Reception.

## **12.6 Theme 6: Analysis of interviews with the NHS and CCG**

The key findings presented under this theme have emerged from the analysis of transcript data gathered from two participants, one a representative of the NHS in Sunderland and one a representative of the CCG in Sunderland. It should be noted that the assertions made in this section are not widely generalisable and may not be wholly representative of the bodies involved, as they are based upon data gathered from a small number of participants. However, they should be relevant to the region and themes explored within this report. It is recommended that further research be conducted to identify perspectives on the themes explored in this report involving participants from the Social Care sector, to better inform recommendations for effective multi-agency working.

Interviews with representatives from the NHS and CCG, working in Sunderland, highlight that there is a large amount of effective practice with regard to supporting children identified with SEND in Sunderland. The NHS in Sunderland appears to have particularly well defined care pathways to support children with an identified primary need (for example Diabetes, Epilepsy and ASD). The interviewed participant from the NHS stated that there are, “very clear pathways about who gets picked up and when.” These pathways often require strong multi-agency working, however, and this can be very challenging, particularly at a time of significant funding cuts to public bodies. Several specific challenges to multi-agency working were identified by the participants involved in this study. This has enabled a range of recommendations to be made, with the aim of promoting better joined up working amongst the stakeholders involved in supporting children identified with SEND.

### **12.6.1 Multi-agency working**

As was discussed earlier in this paper, the 2014 Children and Families Act replaced Statements of SEND with Education, Health and Care plans with immediate effect. This approach was thought to engender better more integrated, multi-agency working for all children identified with SEND (NASEN, 2014). Yet, the focus on bringing together education, health and social care has provided logistical challenges to the implementation of this



reform. Transcript analysis of the interviews conducted with participants suggest that multi-agency working between education and health is largely deemed to be effective. This is thought to be due to the open and honest communication between stakeholders. However, the participant from the NHS considered working closely with social care to be more challenging, than with partners in education. She explained that social care have higher thresholds, than education and health, for determining the children and families that they can support, due to demands on the service and growing financial pressures. This means that the social care system is likely to predominantly support children and young people who are at a Safeguarding risk, or those who have a Severe Learning Difficulty; whereas health and education are more likely to support those identified with a range of SEND needs.

Nevertheless, the respondent also highlighted that representatives from health and social care meet once a month on a Friday afternoon to, “problem solve together, communicate about any issues and iron out any issues.” The regularity of that meeting is likely to support more effective sharing of information, as all stakeholders involved are aware that they have a regular forum through which to air any concerns, challenges or opportunities with the relevant people. It was suggested by one respondent that both social care and CAMHS teams may have experienced re-structures over recent months, which has resulted in significant changing of appointments. Changes in staffing may have presented challenges to building effective multi-agency relationships in Sunderland, as representatives from Health and Education may not have been able to have regular conversations about children’s needs with a consistent representative from social care/CAMHS which then delays intervention. If this is an accurate representation of the facts then a recommendation is presented below:

**Recommendation 17:** For the Council, in collaboration with stakeholders to examine ways of consistently engaging social care to promote effective multi agency working. Introductory meetings for new staff members involved in assessing children’s SEND needs should be arranged across all stakeholder groups, to ensure consistent sharing of information. This should be a meeting independent of EHC plan review meetings.

### **12.6.2 Relationships with parents**

Good practice with regard to the engagement of families was expressed by one interviewed participant in this study. It was highlighted that Sunderland has a specialist health visitor, carer centre and parent carer network, all of whom are primarily concerned with building sustained engagement with parents and carers. The role of parents as decision-makers for their children was further endorsed by the 2014 Children and Families Act; therefore, it is particularly encouraging for Sunderland to have built such strong networks for engaging parents in communicating their priorities in meeting their children's needs. A specific example of early intervention in involving parents was given by one respondent, that Neonatal specialists often contact a paediatrician when a premature baby has been born who is likely to need specific and sustained SEND care; the paediatrician then visits the Neonatal unit to meet the parents, resulting in, as the respondent articulated, "smooth transition of care and continuity of care right from the outset."

It was suggested by one participant that parents may initially be averse to the involvement of a Social Worker in determining the support for their child. This suggests that an underlying stigma exists in Sunderland, regarding the involvement of social care. Yet, the participant went on to explain that open and honest communication with parents frequently always any fears that the parent may have with the involvement of social care. This further reinforces the importance of good communication in effective multi-agency working.

### **12.6.3 Changes in need prevalence**

It was suggested by interviewed participants that there has been a significant and visible increase in the number of children and young people identified with ASD, Diabetes, Child Obesity and Child Mental Health Difficulties in Sunderland over recent years. The PLASC data sets from 2017 support this finding with regard to numbers of children identified with ASD. Additionally, the complexity of needs that children present with is also deemed by the participants to have increased. The 2017 PLASC data does not support nor discredit this

assertion, as it only presents the primary need of an individual, therefore is unable to provide us with rates of co-morbidity for individuals.

Autism has seen a significant rise in diagnosis rates across Sunderland, which the NHS participant believed to be due to better diagnosis techniques, rather than an actual increase in prevalence, supporting findings the literature review. The NHS respondent highlighted that over a third of all referrals to a paediatric doctor are now for investigation into ASD, highlighting prevalence of this need in the region. However, as was highlighted in the literature review section of this paper, ASD is a complex and multi-faceted condition, often involving inter-related needs. Therefore, Horridge et al. (2016a) Identified that structuring support for a child around their primary need is not always appropriate, as it may not take into account the child's multi-faceted needs. The authors suggest that recording the number of needs that a child/young person presents with, rather than the primary need, is likely to be more effective in meeting their overall needs. It is highly likely that many children and young people identified with ASD in Sunderland present with a range of inter-connected needs, which may not be optimally accommodated through the care pathway that they assigned to.

**Recommendation 18:** In addition to recording children and young people's primary needs, the Council should explore recording the number of additional needs that a child presents with. This may then better enable them and educational contexts to review care pathways, in ensuring that they consider the multi-faceted needs of children and young people identified with SEND, particularly those identified with ASD (Horridge, 2016a., 2016b).

The increase in number of children presenting with mental health difficulties in Sunderland is particularly noticeable with younger children, according to our interviewed Health participant. The NHS in Sunderland is often accepting immediate referrals from young children presenting with Social, Emotional and Mental Health difficulties, rather than the immediate referral going to Children and Young People's Services (CYPS). In the interests of effective multi-agency working it was suggested by the participant that, as far as possible, CYPS, the NHS and CAMHS undertake assessments of children presenting Social, Emotional

and Mental Health needs concurrently, to inform provision. This may better support the child to remain in mainstream school, as early intervention would be better enabled. Notifying SENCOs of ongoing assessment was also highlighted, in ensuring that schools are made aware of joined up working.

**Recommendation 19:** Identify a key person with responsibility for promoting multi-agency working between CYPS, Paediatricians and CAMHS, to undertake initial assessments of children presenting with Social, Emotional and Mental Health difficulties concurrently, wherever possible. This will ensure that needs are clearly understood and plans swiftly drawn up to meet them.

#### **12.6.4 Training of teaching staff supporting children identified with SEND**

Ensuring that teaching staff and assistants are supported to meet the needs of all of Sunderland's children and young people identified with SEND is vital, especially in a climate of reform. The interviewed NHS respondent shared good practice examples of providing teachers with training and CPD support to meet the needs of SEND learners. She highlighted the practice of maximising the skills, knowledge and expertise of Sunderland's specialist nurses by having them provide outreach work to schools and sharing their knowledge of specific needs with teachers in schools, for example on managing Epilepsies or Diabetes in schools. Additionally, it was shared that some specialist nurses are now permanently based in Sunderland's specialist schools, to support with the health needs that a child might present with. This is an example of joined up and effective multi-agency working which, as was previously discussed, is vital to meeting the demands of creating and managing a successful EHC plan for a child/young person in Sunderland. However, it is important to acknowledge that support is needed for staff at all levels, who work with children identified with SEND.

The role of Teaching Assistants (TAs) in supporting both the academic achievement and social inclusion of children identified with SEND has been the subject of much debate over recent years and is especially pertinent in the North East, as Durham County Council is the first LA in the country to recently commit to reducing TAs' wages across the LA. Yet, TAs' high contact time with children means that they have a very strong influence on the educational experiences of many children and young people identified with SEND and there is strong evidence to show that when TAs are deployed effectively they can have strong, positive impacts on pupils' outcomes (EEF, 2015; Saddler, 2014). However, TAs require access to training and CPD to enable them to build the skills, knowledge and expertise required to support children identified with SEND effectively. The NHS respondent in this study highlighted that she felt Sunderland have improved their approach to care by taking into consideration young people's rights and pastoral management of needs; therefore, are very much engaging with the child before the disability model of SEND. It is important to acknowledge the influence of TAs on the pastoral management of children's needs, due to the strong pastoral relationships that they frequently build with pupils they support. The respondent called for additional TA training in Sunderland, stating that training TAs was 'crucial to meeting needs.'

**Recommendation 20:** Audit CPD and training opportunities for Teaching Assistants in Sunderland, to better meet the needs of children and young people identified with SEND.

Regarding Teacher CPD and 'on the job' training, one of the respondents in this study called for more training in schools that was specifically related to Autism and was inclusive in nature, stating that there was a real need to 'make sure that the workforce is disability aware and disability welcoming, have got can do attitudes and problem solve.' There was also a call for training on what the SEND definition terms as 'reasonable adjustments.' This would need to cover what the 'reasonable adjustments' look like in mainstream schools, to ensure that teachers and SENCos can consistently devise and implement an effective EHC plan for an individual. This would also support SENCos and senior management teams with decision-making regarding the place of a child's education.

Additionally, the NHS respondent indicated that there is currently no standardised exemplar EHC plan shared across Sunderland's schools. This is causing delays in assessing children's needs during SEN Panel meetings, due to excessive time required to identify children's needs from inconsistent written submissions. Therefore, it is recommended that the Council devise an exemplar EHC plan for all SENCos to use in recording pupils' needs, which will then afford better efficiency across the authority. The NHS respondent highlighted that Sunderland has created a 'Specialist Support Team' that goes into schools and trouble shoots with teachers, undertakes risk assessments, provides support and looks at ICT solutions for children identified with a Physical Disability. This team may be well placed to provide training and CPD for teachers on what constitutes 'reasonable adjustments,' as described in the 2015 SEND Code of Practice, and may also be well placed to distribute an EHC plan exemplar to SENCos.

**Recommendation 21:** For the Council to devise and distribute an exemplar Education, Health and Care Plan and accompanying evidence to support SENCos. This will have the added benefit of improving the efficiency of the SEN Panel meetings.

#### **12.6.5 Supporting children in specialist provision (PRUs, special schools and young offenders' institutions)**

The interviews conducted for this study highlight that it is often more difficult to meet the needs of children/young people identified with SEND if they have been educated in multiple educational settings. This may be due to poor data sharing between the multiple settings that a child may have attended and/or the difficulties associated with establishing effective multi-agency working for a child that has moved between different educational settings over a short period of time.

The NHS respondent identified that there is difficulty in identifying a common and agreed framework for identifying children that would most benefit from education in Sunderland's specialist provisions. This may be a contributing factor to some children being educated in multiple settings across the city, as the conditions under which it is most appropriate to

educate a child in a special school/PRU/mainstream school can be argued to be somewhat unclear. It is, therefore, recommended that Sunderland City Council work towards devising guidelines that indicate the criterion for placement in its various types of educational setting, to ensure consistency in decision-making regarding placements. It is acknowledged that all decisions of educational placement must be made on a case by case basis, due to the unique nature of each child/young person's needs, however, guidelines would likely support provide a starting point for discussions and would likely engender a more structured process for decision-making.

The NHS respondent also highlighted that she has noticed an increase in the number of children and young people educated in young offenders' institutions who are presenting with undiagnosed learning difficulties. Additionally, the respondent identified that there needs to be better support pathways for children educated in a PRU. These young people are highly likely to have passed through a range of different educational settings, therefore, are more at risk of what the respondent calls 'dropping off the radar,' particularly those in a young offenders' institution. Devising an agreed framework for placement decisions should help in reducing the number of Sunderland's young people who are educated in a Young Offenders' Institution, as their additional needs are likely to be identified earlier and support to meet those needs is likely to be put in place earlier. However, further research is recommended to explore the educational pathways taken by children educated in both PRUs and young offenders' institutions to identify the additional support they have accessed and to identify good practice examples of early identification of need and support pathways for those children.

**Recommendation 22:** To assess children and young people in a PRU context on entry, to ensure that their range of needs are identified early and that EHC plan can be either created or updated to reflect their current needs. This assessment must involve multi-agencies, as it is highly likely that the child will require support from CAMHS as well as from the educational setting itself.

### 12.6.6 Role of Designated Medical Officer

Both respondents interviewed in this study highlighted that the responsibilities associated with the DMO role require clarification. Currently, the DMO role is shared between a consultant paediatrician and the CCG. This means that clear, contractual role descriptions are imperative in facilitating joined up working. It is important for Sunderland to identify the main focus of the role to better support quality provision for children identified with SEND across education, health and care. This will then inform better delegation of responsibilities to the two parties undertaking the role.

**Recommendation 23:** For the Council to devise role descriptions, clearly delegating specific responsibilities to the two parties sharing the DMO role. These should focus on supporting joined up working across education, health and care.

### 12.6.7 Children under the age of three identification of need/Early Identification

The NHS respondent indicated that there is a clear pathway for early identification of physical needs in Sunderland. She explained that there are a range of pre-natal screening programmes that support early identification of SEND before birth. These practices then allow for early treatment to occur, with children identified as having SEND often accessing a clear care pathway from birth. The respondent is currently reviewing drafts of forthcoming guidance from NICE. The new guidance will outline that children born prematurely will require a cognitive test at age of 4 and will split out support given for children born at levels of prematurity. The respondent's involvement in reviewing drafts of this guidance indicates that Sunderland is well placed to adapt in meeting legislative changes around early identification of needs.

The respondent also explained that Neonatalists often contact her when a child has been born prematurely and is likely to present with SEND, so that she may go into the neonatal unit and meet the families soon after the birth. The respondent explained that this initiates 'smooth transition of care and continuity of care right from the outset.' It was also made



clear that parental consent to sharing of information between relevant stakeholders is often gained early in Sunderland, so that SENCos in educational settings can be made aware of needs early and GPs can inform SENCos of when to get an Educational Psychologist involved in meeting children's needs. It is important that this practice occurs after all initial meetings between parents of children identified with SEND and GPs to better support early identification of needs.

Both interviewed respondents identified that there is currently no forum via which stakeholders who are interested in early intervention for SEND can meet. Setting up a steering group for early intervention approaches is recommended, however, this should not present a substantial additional strain on officers' time. Analysis of interview data indicated that there appear to be many regular meetings undertaken across education, health and/or care. This is encouraging in supporting multi-agency working, however, it did appear to represent a significant time commitment. It is, therefore, recommended that all multi-agency meetings are reviewed to ensure that meetings make best use of officers' time and involve all interested parties to ensure that relaying of information to other stakeholders outside of meetings is avoided. Perhaps some meetings may be combined for efficiency.

**Recommendation 24:** For the Council should review all regular, scheduled multi-agency meetings between education, health and care for efficiency. An opportunity for stakeholders interested in early identification of SEND to meet regularly should be afforded within the recommendations from this review.

#### **12.6.8 Data sharing**

Both respondents interviewed identified that there are opportunities for improvements in data sharing across the Local Authority. It was highlighted that the CCG currently do not share data from Neonatal screenings and NHS Digital with the Local Authority; it was deemed by both participants that sharing of this data would be useful for early intervention and financial forward planning. The NHS data includes information on how many children in Sunderland have a diagnosis of ASD and how many children have technological

dependent/physical needs. The CCG respondent suggested that a server should be created that would hold all relevant data regarding children's needs in Sunderland. This would require careful review of the CCG's current data protection policies, but is strongly advocated in the interests of better meeting children's needs and efficiency of resources. As was recommended in the previous section, reviewing of the contractual responsibilities associated with the DMO role should be helpful in identifying who is best placed to take this recommendation forward.

**Recommendation 25:** Review current data sharing policies to enable sharing of data, where appropriate, between CCG, NHS Digital, LA and DMO to inform better identification of needs and local decision-making around SEND. A meeting should be arranged with Horridge (2016a) to discuss the outcomes of her research into recording multifaceted needs of children and ways in which this information can be ethically shared.

## 12.7 Theme 7: Analysis of the prevalence of Autism Spectrum Disorder in the City of Sunderland (3-16 years) (2017)

Postcode data were provided by Sunderland City Council and the Autism Outreach Team, relating to this theme. The data were used to geographically plot the residences of the children and young people, from 3-16 years, identified with SEN across the City of Sunderland. This data were filtered via categorisation, as to whether children were in receipt of a Statement of SEN, an EHC plan or were receiving SEN Support by each Key Stage. It was reported by the City Council that the number of children with a diagnosis of Autism Spectrum Disorder in 2017 was 1548 this is an increase of 353% since 2005 when there were 342 children diagnosed.

Table 18

*The number of children with a diagnosis of ASD in Sunderland as recorded by the Autism Outreach Team.*

|                                                                               | Year        |      |      |      |      |      |      |
|-------------------------------------------------------------------------------|-------------|------|------|------|------|------|------|
|                                                                               | 2005        | 2007 | 2009 | 2011 | 2013 | 2015 | 2017 |
| <i>Number of pupils with a diagnosis of ASD under 19 on the AOT database.</i> | 342         | 390  | 532  | 705  | 880  | 1193 | 1548 |
| <i>Percentage increase.</i>                                                   | 2005        | 2007 | 2009 | 2011 | 2013 | 2015 | 2017 |
|                                                                               | 2007        | 2009 | 2011 | 2013 | 2015 | 2017 |      |
|                                                                               | 14%         | 36%  | 33%  | 25%  | 36%  | 30%  |      |
| <i>Overall percentage increase.</i>                                           | 2005 - 2017 |      |      |      |      |      |      |
|                                                                               | 353%        |      |      |      |      |      |      |

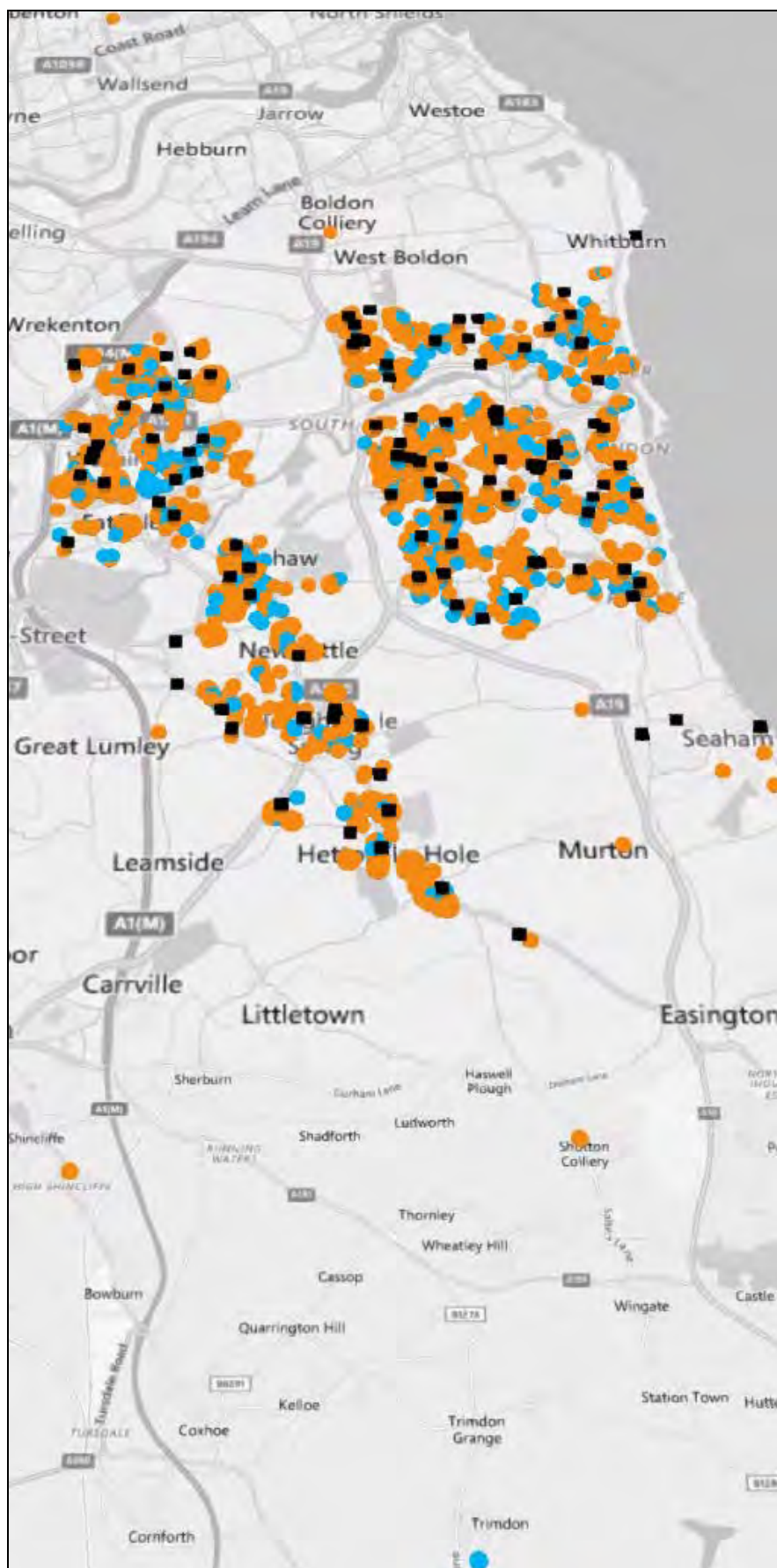
*Note.* The percentage increase between years 2011 and 2013 has been corrected from 24% to 25%.

*Source: Autism Outreach*

The figures in red are as of February 2017, all the other figures were taken in July of the previous year.

Bakian et al. (2015) recommended the use of mapping tools to identify any localised regions of heightened risk of ASD. Exploratory geographical analysis was chosen to identify trends related to areas of Sunderland where there are hotspots in ASD prevalence.

The original sample that we were able to obtain consisted of 1477 children and young people with ASD living and attending schools in Sunderland. The data included the postcodes, year groups and schools relating to most of these children. The dataset was cleaned using 'listwise deletion', removing missing data, pupils living and attending school outside Sunderland, post sixteen pupils, erroneous postcodes, and school entries. The final sample consisted of 1187 pupils. Microsoft Excel 2016 and a 3D mapping add-on were used to create a series of maps.

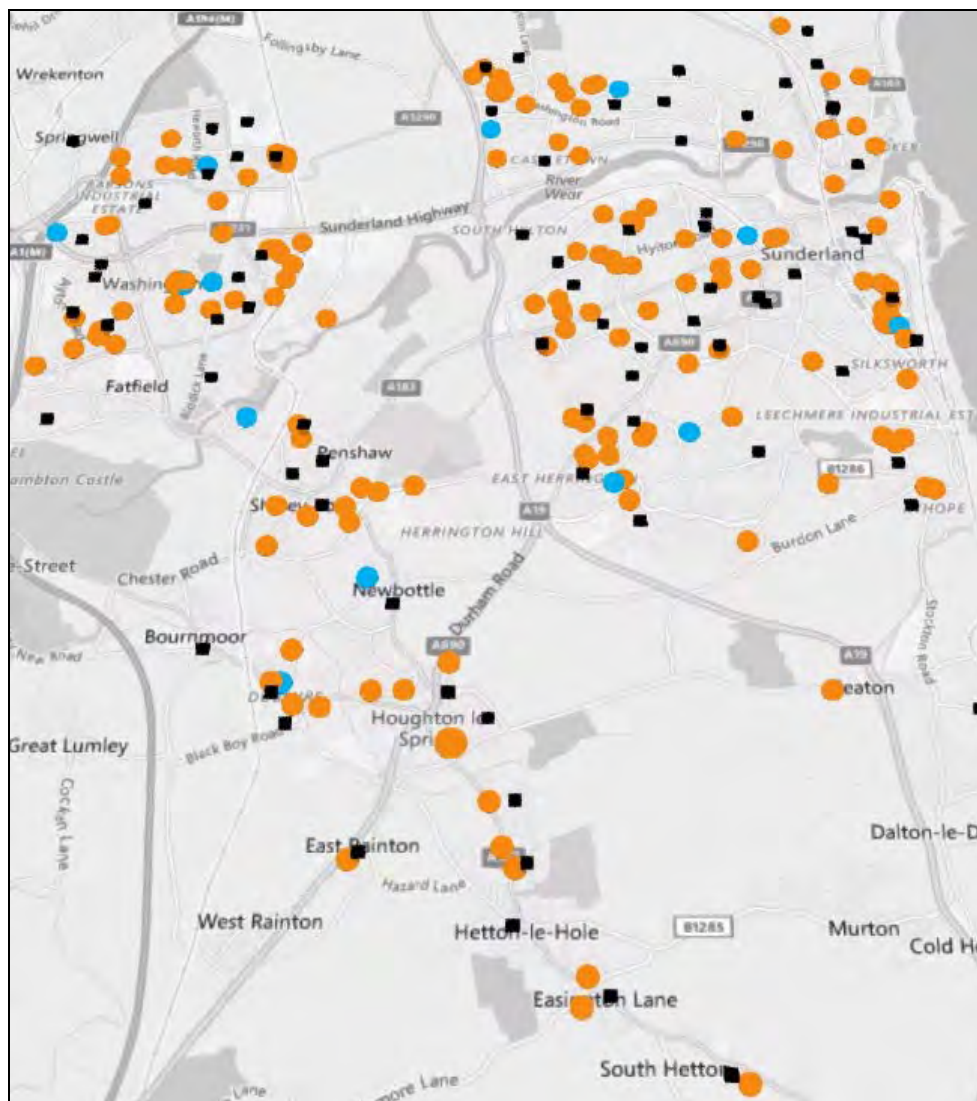


## All Pupils

| Key |                |
|-----|----------------|
| ■   | School/Nursery |
| ●   | SEN Support    |
| ●   | EHCP/Statement |

| Ward                   | All Pupils |            | Total       |
|------------------------|------------|------------|-------------|
|                        | SEN        | EHCP/St    |             |
| Barnes                 | 37         | 5          | 42          |
| Castletown             | 45         | 9          | 54          |
| Copt Hill              | 39         | 12         | 51          |
| Doxford                | 21         | 14         | 35          |
| Fulwell                | 24         | 11         | 35          |
| Hendon                 | 34         | 8          | 42          |
| Hetton                 | 45         | 9          | 54          |
| Houghton               | 37         | 10         | 47          |
| Millfield              | 24         | 8          | 32          |
| Pallion                | 34         | 5          | 39          |
| Redhill                | 36         | 11         | 47          |
| Ryhope                 | 26         | 7          | 33          |
| Sandhill               | 38         | 19         | 57          |
| Shiney Row             | 52         | 19         | 71          |
| Silksworth             | 41         | 11         | 52          |
| Southwick              | 25         | 13         | 38          |
| St Anne's              | 43         | 7          | 50          |
| St Chad's              | 33         | 12         | 45          |
| St Michael's           | 21         | 13         | 34          |
| St Peter's             | 26         | 9          | 35          |
| Washington Central     | 30         | 27         | 57          |
| Washington East        | 44         | 13         | 57          |
| Washington North       | 57         | 18         | 75          |
| Washington South       | 32         | 9          | 41          |
| Washington West        | 38         | 10         | 48          |
| <b>Subtotal</b>        | <b>882</b> | <b>289</b> | <b>1171</b> |
| Dawdon                 | 3          | -          | 3           |
| Durham South           | 1          | -          | 1           |
| Lumley                 | 1          | -          | 1           |
| Murton                 | 1          | -          | 1           |
| Seaham                 | 1          | -          | 1           |
| Shotton                | 2          | -          | 2           |
| Trimdon                | -          | 1          | 1           |
| Birtley                | -          | 1          | 1           |
| Battle Hill            | 1          | -          | 1           |
| Northumberland         | 2          | -          | 2           |
| Biddick and All Saints | 1          | -          | 1           |
| Boldon Colliery        | 1          | -          | 1           |
| <b>Subtotal</b>        | <b>14</b>  | <b>2</b>   | <b>16</b>   |
| <b>Total</b>           | <b>896</b> | <b>291</b> | <b>1187</b> |

Map 1: Geographical representation of children with a diagnosis of ASD aged 3-16 years based on home postcode in Sunderland. The schools and nurseries shown above are attended by foundation, KS1, KS2, KS3 and KS4 pupils.



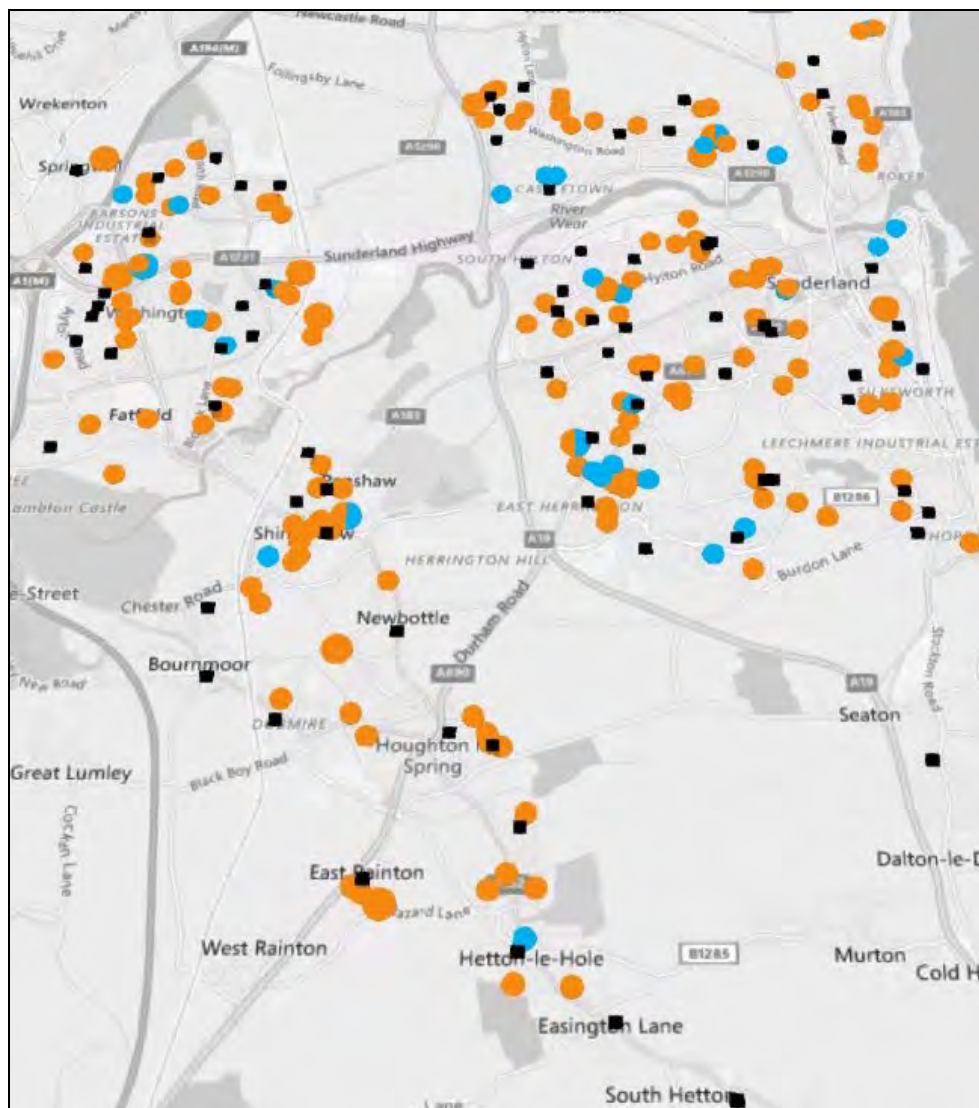
## Nursery/Reception

| Key |                |
|-----|----------------|
| ■   | School/Nursery |
| ●   | SEN Support    |
| ●   | EHCP/Statement |

| Ward                 | SEN        | EHCP/St   |
|----------------------|------------|-----------|
| Barnes               | 6          | -         |
| Castletown           | 9          | 1         |
| Copt Hill            | 6          | -         |
| Doxford              | 3          | -         |
| Fulwell              | 3          | -         |
| Hendon               | 10         | 1         |
| Hetton               | 4          | -         |
| Houghton             | 6          | 2         |
| Millfield            | 3          | 1         |
| Pallion              | 7          | -         |
| Redhill              | 6          | 1         |
| Ryhope               | 6          | -         |
| Sandhill             | 5          | -         |
| Shiney Row           | 9          | -         |
| Silksworth           | 2          | 1         |
| Southwick            | 2          | -         |
| St Anne's            | 8          | -         |
| St Chad's            | 7          | 1         |
| St Michael's         | 1          | -         |
| St Peter's           | 5          | -         |
| Washington Central   | 8          | 2         |
| Washington East      | 8          | 1         |
| Washington North     | 9          | 1         |
| Washington South     | 5          | -         |
| Washington West      | 4          | 1         |
| Non-Sunderland Wards | 3          | -         |
| <b>Total</b>         | <b>145</b> | <b>13</b> |

Map 2: Geographical representation of children with a diagnosis of ASD aged 3-5 years based on home postcode in Sunderland. The schools and nurseries shown above are attended by EYFS pupils.



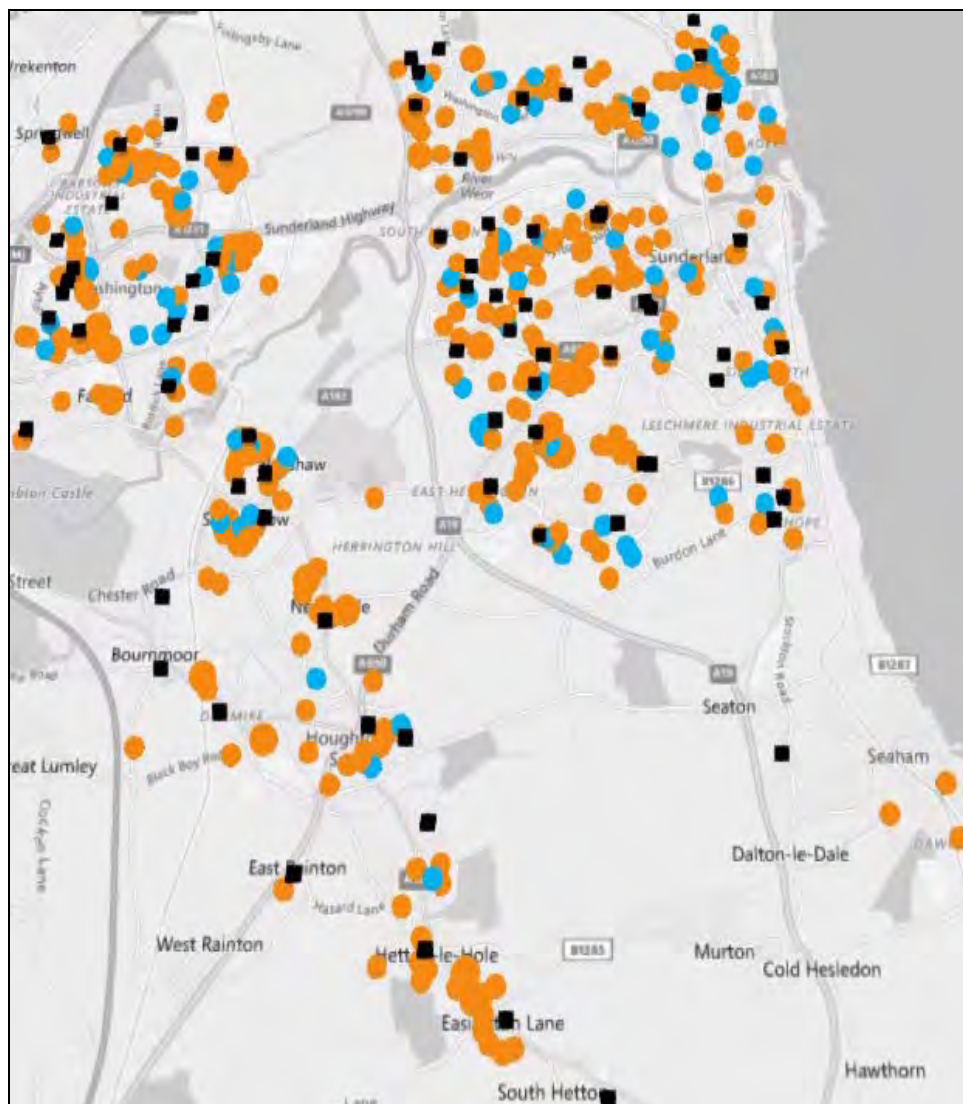


## Key Stage 1

| Key |                |
|-----|----------------|
| ■   | School/Nursery |
| ●   | SEN Support    |
| ●   | EHCP/Statement |

| Ward                 | SEN        | EHCP/St   |
|----------------------|------------|-----------|
| Barnes               | 4          | -         |
| Castletown           | 8          | 3         |
| Copt Hill            | 7          | -         |
| Doxford              | 3          | 2         |
| Fulwell              | 6          | 1         |
| Hendon               | 5          | 3         |
| Hetton               | 8          | 1         |
| Houghton             | 7          | -         |
| Millfield            | 6          | 1         |
| Pallion              | 5          | 1         |
| Redhill              | 8          | -         |
| Ryhope               | 3          | -         |
| Sandhill             | 6          | 2         |
| Shiney Row           | 11         | 2         |
| Silksworth           | 7          | -         |
| Southwick            | 5          | 3         |
| St Anne's            | 6          | 1         |
| St Chad's            | 7          | 4         |
| St Michael's         | 4          | -         |
| St Peter's           | 3          | -         |
| Washington Central   | 5          | 2         |
| Washington East      | 12         | 1         |
| Washington North     | 7          | 1         |
| Washington South     | 6          | -         |
| Washington West      | 10         | 3         |
| Non-Sunderland Wards | 1          | -         |
| <b>Total</b>         | <b>160</b> | <b>31</b> |

Map 3: Geographical representation of children with a diagnosis of ASD aged 5-7 years based on home postcode in Sunderland. The schools shown above are attended by KS1 pupils.



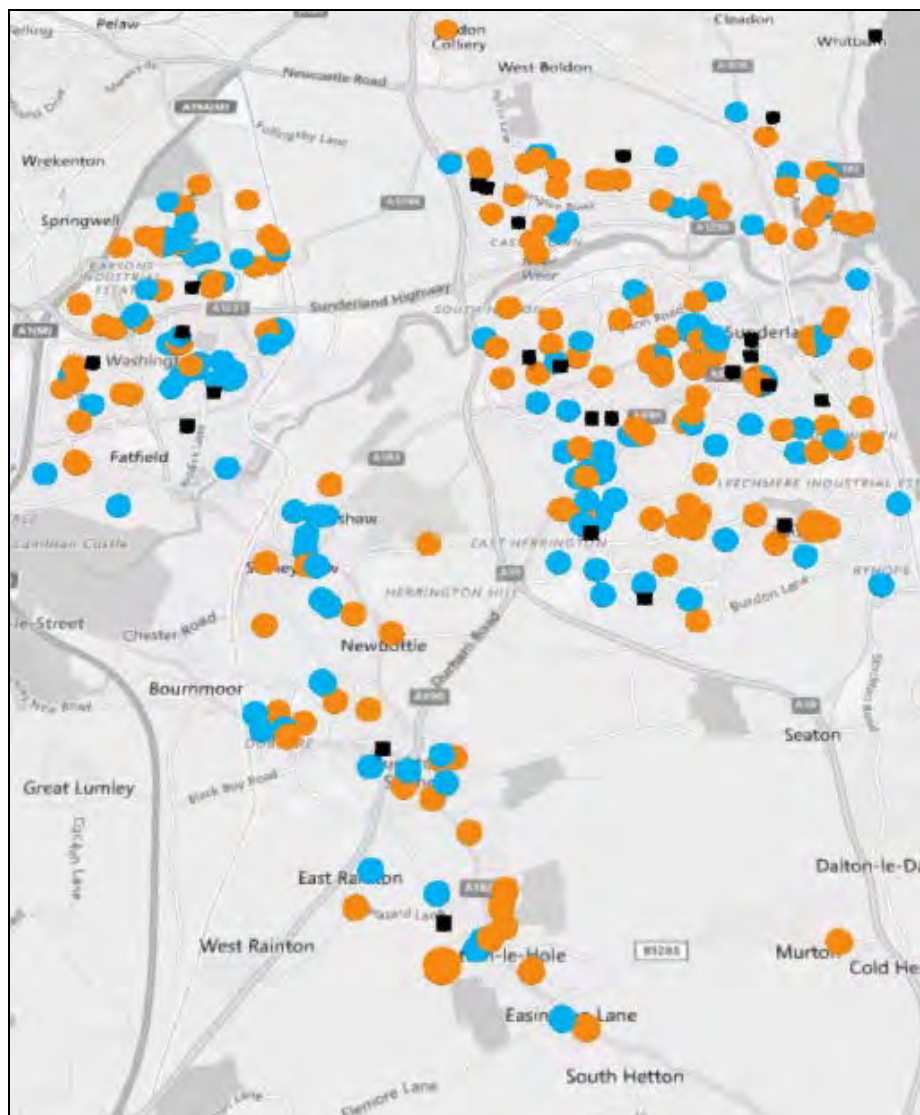
## Key Stage 2

| Key |                |
|-----|----------------|
| ■   | School/Nursery |
| ●   | SEN Support    |
| ●   | EHCP/Statement |

| Ward                 | SEN        | EHCP/St   |
|----------------------|------------|-----------|
| Barnes               | 10         | -         |
| Castletown           | 18         | 1         |
| Copt Hill            | 17         | 3         |
| Doxford              | 8          | 6         |
| Fulwell              | 9          | 6         |
| Hendon               | 11         | 2         |
| Hetton               | 19         | -         |
| Houghton             | 15         | 1         |
| Millfield            | 10         | 2         |
| Pallion              | 15         | 3         |
| Redhill              | 11         | 6         |
| Ryhope               | 9          | 1         |
| Sandhill             | 18         | 7         |
| Shiney Row           | 24         | 6         |
| Silksworth           | 15         | 1         |
| Southwick            | 12         | 4         |
| St Anne's            | 17         | 3         |
| St Chad's            | 15         | 2         |
| St Michael's         | 5          | 5         |
| St Peter's           | 8          | 4         |
| Washington Central   | 8          | 6         |
| Washington East      | 19         | 4         |
| Washington North     | 27         | 5         |
| Washington South     | 13         | 3         |
| Washington West      | 10         | 2         |
| Non-Sunderland Wards | 6          | -         |
| <b>Total</b>         | <b>349</b> | <b>83</b> |

Map 4: Geographical representation of children with a diagnosis of ASD aged 7-11 years based on home postcode in Sunderland. The schools shown above are attended by KS2 pupils.



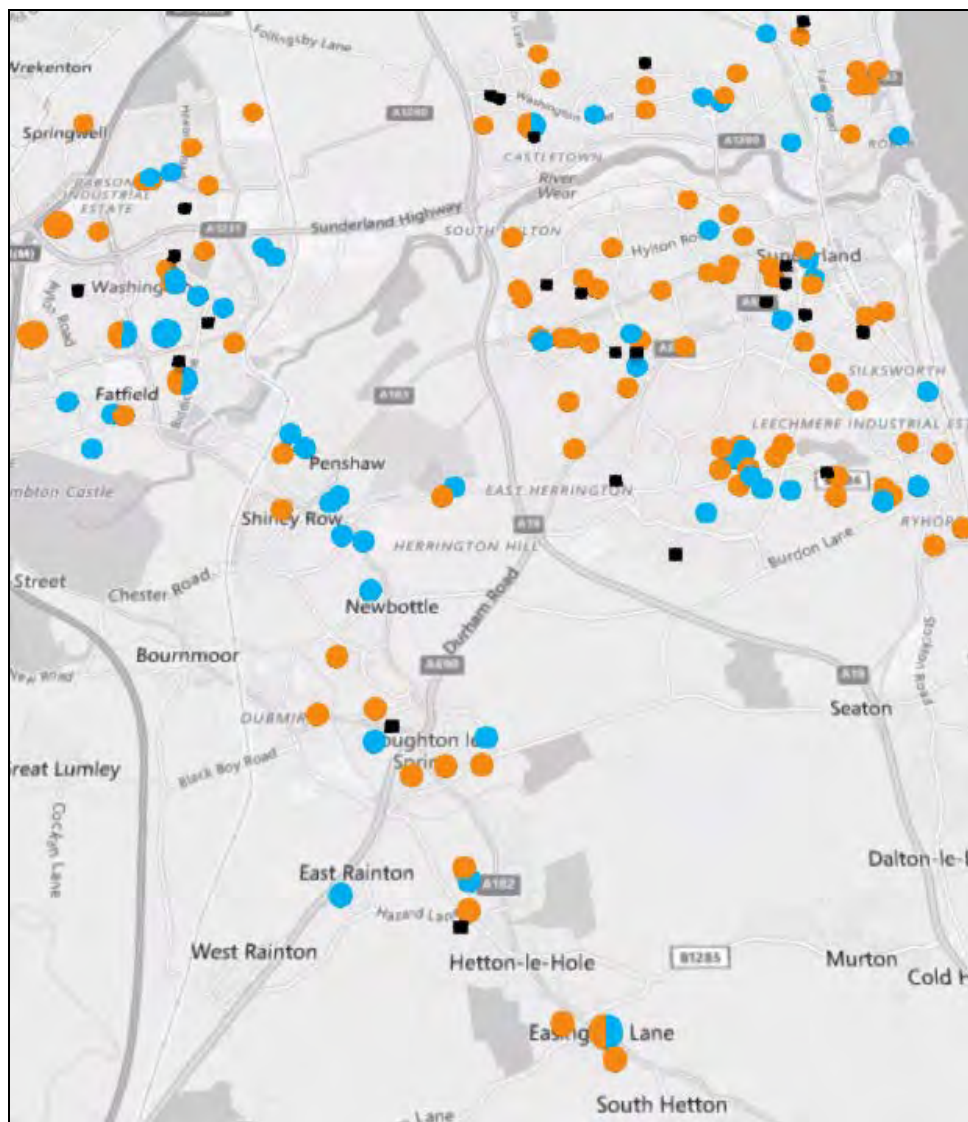


### Key Stage 3

| Key |                |
|-----|----------------|
| ■   | School         |
| ●   | SEN Support    |
| ●   | EHCP/Statement |

| Ward                 | SEN        | EHCP/St    |
|----------------------|------------|------------|
| Barnes               | 11         | 5          |
| Castletown           | 8          | 3          |
| Copt Hill            | 6          | 5          |
| Doxford              | 5          | 4          |
| Fulwell              | 3          | 2          |
| Hendon               | 6          | 2          |
| Hetton               | 9          | 5          |
| Houghton             | 6          | 6          |
| Millfield            | 1          | 3          |
| Pallion              | 5          | 1          |
| Redhill              | 7          | 3          |
| Ryhope               | 2          | 3          |
| Sandhill             | 3          | 7          |
| Shiney Row           | 5          | 6          |
| Silksworth           | 9          | 4          |
| Southwick            | 4          | 3          |
| St Anne's            | 7          | 3          |
| St Chad's            | 3          | 5          |
| St Michael's         | 5          | 5          |
| St Peter's           | 7          | 3          |
| Washington Central   | 5          | 10         |
| Washington East      | 2          | 3          |
| Washington North     | 11         | 9          |
| Washington South     | 6          | 4          |
| Washington West      | 8          | 4          |
| Non-Sunderland Wards | 3          | 2          |
| <b>Total</b>         | <b>147</b> | <b>110</b> |

Map 5: Geographical representation of children with a diagnosis of ASD aged 11-14 years based on home postcode in Sunderland. The schools shown above are attended by KS3 pupils.



#### Key Stage 4

| Key |                |
|-----|----------------|
| ■   | School         |
| ●   | SEN Support    |
| ●   | EHCP/Statement |

| Ward                 | SEN       | EHCP/St   |
|----------------------|-----------|-----------|
| Barnes               | 6         | -         |
| Castletown           | 2         | 1         |
| Copt Hill            | 3         | 4         |
| Doxford              | 2         | 2         |
| Fulwell              | 3         | 2         |
| Hendon               | 2         | -         |
| Hetton               | 5         | 3         |
| Houghton             | 3         | 1         |
| Millfield            | 4         | 1         |
| Pallion              | 2         | -         |
| Redhill              | 4         | 1         |
| Ryhope               | 6         | 3         |
| Sandhill             | 6         | 3         |
| Shiny Row            | 3         | 5         |
| Silksworth           | 8         | 5         |
| Southwick            | 2         | 3         |
| St Anne's            | 5         | -         |
| St Chad's            | 1         | -         |
| St Michael's         | 6         | 3         |
| St Peter's           | 3         | 2         |
| Washington Central   | 4         | 7         |
| Washington East      | 3         | 4         |
| Washington North     | 3         | 2         |
| Washington South     | 2         | 2         |
| Washington West      | 6         | -         |
| Non-Sunderland Wards | 1         | -         |
| <b>Total</b>         | <b>95</b> | <b>54</b> |

Map 6: Geographical representation of children with a diagnosis of ASD aged 14-16 years based on home postcode in Sunderland. The schools shown above are attended by KS4 pupils.

In addition to the data mapping exercise, we received data from the Council (February 2017) that indicated the following:

- The Autism Outreach Team (AOT) receives approximately 6 new ASD diagnosis confirmations per week from medics.
- The AOT receives approximately 15 new referrals per week requesting support from educational provisions.
- The AOT has 396 active pupils on the caseload.

As was discussed under previous themes presented in this report, Sunderland has a particularly high rate ASD diagnosis, when compared to national statistics. The mapping exercise has enabled us to break down the diagnoses rates further, by indicating the age phases at which diagnosis is occurring more frequently.

Upon analysis of the postcode data, we were able to identify specific streets in which multiple children with a diagnosis live, with this accounting for more than 16% of the postcodes represented within the study sample. We were unable to identify whether these children are siblings or related in any way.

### **Main Findings: Early Years**

- Currently, in the EYFS, there are 155 children with a diagnosis of ASD. Of these 155, 13 have an EHC plan and 142 are on SEN Support.
- When examining where these children live, it is evident that the ward with the greatest number of resident children with a diagnosis is Hendon. Conversely, there is only 1 child in St Michael's and 2 children in Southwick.

## **Main Findings: Key Stages 1-4**

- The maps indicated that there is a particularly high prevalence of diagnosis within KS2 in Sunderland, there are 426 children out of 1187 in this age phase.
- The data indicates that higher numbers of children are in the lower key stages and the Early Years Foundation Stage which will have implications for future planning provision and training.
- The lowest number of children with ASD are currently in Key Stage 4; this could suggest there are some undiagnosed young people in this age phase. However, given that Sunderland has a higher diagnosis rate compared to national statistics the rates in KS4 may be accurate.
- In Washington district there appear to be a large number of children and young people with a diagnosis of Autism. This is particularly apparent in Washington North which has 75 children. This is closely followed by Shiney Row with 71.
- The lowest prevalence rate is in Millfield with 32 children, 33 in Ryhope and 34 children in St Michael's Ward.
- It is not possible to determine from the data if there is a link between social deprivation or elevated economic status and prevalence rates by postcode (Larsson et al., 2005; Rai et al., 2012).

**Recommendation 26:** For the Council to take note of the high prevalence rate of ASD diagnoses in children currently in KS2, to provision plan as they progress through education into KS3. This will require an audit of teachers' knowledge and understanding of the indicators and evidence based practice related to approaches to learning in meeting the needs of children identified with ASD.

**Recommendation 27:** For the Council to conduct additional analysis into where there needs to be additional provision particularly in terms of nursery and school placements and where the children and young people reside, this should inform capacity building within the Autism Outreach Team. The local offer needs to be reviewed to ensure it effectively signposts families to support and services.

## 12.8 Theme 8: Analysis of high needs funding

It is evident from discussions with the stakeholders that Sunderland City Council has a robust banding system in place that is transparent and related to costed provision planning. Within Sunderland City Council there are systems in place to target provision for pupils with SEND and the following recommendations will support further strategic review and planning. At this point in time the Council are aware of their high needs allocation; however it is unclear what future funding allocations will be, as a result of insufficient clarification from Government.

Discussions with the commissioner of this report have suggested that a proactive approach to supporting children with their mental health may be worth close consideration, especially in light of the rising prevalence of SEMH in Sunderland. The City Council currently commission £500,000 of additional CAMHS services to support children and young people with Social, Emotional and Mental Health difficulties.

**Recommendation 28:** For the Council to develop a strategic SEND Provision map for the next five years in line with guidance (DfE, 2016a). This map will support optimal allocation of funding, resources and provision for SEND across Sunderland. The data contained in this report will support this process.

**Recommendation 29:** For the Council to analyse whether some children taught in specialist/alternative provision could have their needs met in an inclusive mainstream environment through effective early identification and assessment of need and staff training.

**Recommendation 30:** For the Council to support educational settings in gaining 'The Inclusion Quality Mark: a framework for evaluation of evidence based inclusive practice.'

## **12.9 Theme 9: Analysis of the primary need of children missing from education in Sunderland**

Unfortunately, the City Council was not able to provide any data for this theme. In light of this the recommendations are based on national data and research.

**Recommendation 31:** Ofsted (2013) encourage effective multi-agency working to avoid any unlawful forms of exclusion. Refresh school leaders understanding of statutory duties relating to children missing from education to ensure that they are fulfilling their role.

**Recommendation 32:** For the Council to appoint a senior officer responsible for obtaining and collating data on children missing from education to ensure they are meeting their statutory obligations (Ofsted, 2013).

## **12.10 Theme 10: Analysis of the primary need of children and young people in a Pupil Referral Unit (PRU)**

Table 19 (overleaf) was provided by City of Sunderland Council and shows that in the Pupil Referral Units they have identified:

- 86% of children and young people are identified as SEMH as their primary need with 101 children on SEN Support and 1 with an EHC plan (also for SEMH).
- 7% of the children and young people are identified as SEN Support for cognition and learning as their primary need.
- 5% of the children and young people have communication and interaction as their primary need.
- 2% (1 pupil) are classified as having other difficulty/disability.

Table 19

*The number of children and young adults attending PRUs in Sunderland (5 -16 years) (2017).*

| Broad Areas of Need                             | EHC plan / Statements | SEN Support |
|-------------------------------------------------|-----------------------|-------------|
| <b>Beacon of Light School</b>                   | -                     | <b>3</b>    |
| Cognition and Learning                          | -                     | 1           |
| Communication and Interaction                   | -                     | 1           |
| Other Difficulty/Disability                     | -                     | -           |
| Social Emotional Mental Health                  | -                     | 1           |
| <b>KS1 Pupil Referral Unit</b>                  | -                     | <b>21</b>   |
| Cognition and Learning                          | -                     | 2           |
| Communication and Interaction                   | -                     | 2           |
| Other Difficulty/Disability                     | -                     | 1           |
| Social Emotional Mental Health                  | -                     | 16          |
| <b>School Returners - Young Mum's Provision</b> | -                     | <b>12</b>   |
| Cognition and Learning                          | -                     | -           |
| Communication and Interaction                   | -                     | 1           |
| Other Difficulty/Disability                     | -                     | -           |
| Social Emotional Mental Health                  | -                     | 11          |
| <b>The Link School - Pallion</b>                | <b>1</b>              | <b>32</b>   |
| Cognition and Learning                          | -                     | 3           |
| Communication and Interaction                   | -                     | 1           |
| Other Difficulty/Disability                     | -                     | -           |
| Social Emotional Mental Health                  | 1                     | 28          |
| <b>The Link School - Tudor Grove</b>            | -                     | <b>33</b>   |
| Cognition and Learning                          | -                     | 1           |
| Communication and Interaction                   | -                     | 1           |
| Other Difficulty/Disability                     | -                     | -           |
| Social Emotional Mental Health                  | -                     | 31          |
| <b>Total</b>                                    | <b>1</b>              | <b>101</b>  |
| <i>Source: School Census</i>                    |                       |             |



**Recommendation 33:** For the Council to expand their data set from broad area of need to primary and additional needs for the children and young people in a PRU. This should also include a chronology of each child and young person in terms of their particular difficulties and strategies used to support their SEMH needs and a reintegration to mainstream package(s). The City Council should consider the viability of the educational psychology service providing a psychological service across all PRU provision to facilitate effective integration into mainstream through person centred approaches (Lawrence, 2011).

**Recommendation 34:** For the Council to commission further research into effective alternative provision models that support children and young people in achieving good outcomes in terms of education and to examine good practice approaches in meeting social, emotional and mental health needs. A similar review was carried out by Newcastle City Council in September 2016.

**Recommendation 35:** For the Council to collate data on which educational contexts are excluding children and young people on fixed or permanent basis to carry out a debrief with these schools to analyse the factors leading to the exclusions. This would allow the Council to target training to support schools in addressing early signs of behavioural difficulties which lead to SEMH difficulties.



### 13 Concluding remarks

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It is evident that there is a deep level of commitment from health and education services that have been involved in this research to improve outcomes for children identified with SEND. The process of referrals from Health Visitors and GPS to Consultant Paediatricians often results in early identification, intervention and clear support pathways for many children and young people. Constant comparative analysis of interviews with both the National Health Service (NHS) and Clinical Commission Group (CCG) highlighted areas of good practice in collaboration, particularly across health and education. However, a key recommendation to emerge from this research is for stakeholders to examine ways of collaborating to ensure that the care sector becomes an effective agency in contributing to and sharing the particular needs of children and young people with special educational needs and disabilities in Sunderland.

To further promote effective multi-agency working, the role of the Designated Medical Officer in Sunderland requires review. This will support the CCG in meeting its statutory responsibilities for children identified with SEND. If the role is to remain shared, clear role descriptors and responsibility allocation needs to be made explicit.

Following classification analysis of children and young people with SEND, it appears that there remain a significant number of children and young people whose needs require converting from a Statement of SEN to an Education, Health and Care plan by April 2018. This should be prioritised so that these children and families can have the advantages of the person-centred approach advocated by the new system (DfE, 2015a).

It is advised that the City Council use the recommendations of this study to plan future provision, practice and Continuing Professional Development (CPD) in light of prevalence findings in relation to specific primary needs of children with SEND. There has been a particular development need identified at SENCo level, due to the suspected over/under identification of a number of primary needs. SENCos within the Local Authority need to be supported to attend high quality training, which they then cascade and monitor the impact of with all staff members in their educational contexts. It is vital that Teachers and Teaching Assistants also need to be supported to meet the needs of children identified with SEND. It is imperative that all services know a child's holistic needs, not simply their primary need.

The key priority areas for CPD, as identified in the main report are associated with identification and assessment of the following primary needs:

- Autism Spectrum Disorders
- Social, Emotional and Mental Health
- Specific Learning Difficulties
- Moderate Learning Difficulties
- Speech, Language and Communication Needs (EYFS and Primary phase)

There is currently an under identification of Specific Learning Difficulties in schools, when compared to national averages. Across all age phases there needs to be further investigation into the classification of Moderate Learning Difficulties (MLD), as this is the most prevalent need in school-age children and is high in children in Reception. Social, Emotional and Mental Health Difficulties (SEMH) are also rising and are particularly prevalent from Year 5 onwards, peaking in Year 11. The factors contributing to this need to be further explored to ensure that early support is provided and sustained. Within the early years, and into Year 2, Speech, Language and Communication Needs (SLCN) is also a primary need with high prevalence.

It is considered by the research team and those interviewed that the SEN panel needs to become more efficient. This could be supported by the development of training materials and exemplars to promote consistency and compliance through a locally agreed EHC plan format, which reflects the principles, set out in Chapter 1 of the SEND Code of Practice (DfE, 2015a).

### 13.1 Further research opportunities

- To examine effective alternative provision models that support children and young people in other Local Authorities in achieving good educational and social outcomes
- To examine knowledge and understanding of school leaders and staff of the meaning and indicators of Moderate Learning Difficulties and Specific Learning Difficulties.
- To examine why there is a steady increase in SEMH diagnoses as children move through school. It is recommended that a mapping exercise is carried out to explore service provision and the effectiveness in meeting the range of needs associated with SEMH. This should explore the value for money in the commissioning of mental health services to children and young people.
- To analyse the range and effectiveness of educational pathways, including dual placements, taken by children and young people educated in both PRUs, young offenders' institutions and those missing from education. This will identify the additional support that children need to access or have accessed and will highlight good practice examples of early identification in need and support. As reported by DfE (2016h) Sunderland had the highest number of permanent exclusions in primary schools in 2016, at 10.
- To pilot an ethical approach to data sharing through NHS digital, CCG, City Council and educational providers, with the aim of engendering effective multi-agency working through accurate and timely information sharing of the health needs of children and young people.
- A strategic SEND Provision map for the next five years should be developed, in line with guidance (DfE, 2016a). This map will support optimal allocation of funding, resources and provision for SEND across Sunderland. The data contained in this report will support this process.

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## **15 Appendices**

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### **15.1 Appendix 1: Interview questions for CCG**

#### **The commissioning of Services**

1. How do you ensure there is sufficient capacity to meet the range of need? How do you monitor/record this and is this shared with the LA?
2. How far in advance do you plan for the commissioning of services for children and young people with SEND?
3. Have you seen an increase in any disabilities over the last few years, why do you think this is?
4. Do you have any suggestions/concerns regarding any trends in types of needs being identified?

#### **Effectiveness of multi-agency involvement**

4. Which of these agencies is it easiest to access and collaborate with, why do you think this is?
5. Where multi agency working is less effective, why is this? What are the barriers?

### **Joint commissioning – provision**

6. How do you strategically plan for the commission of services or placements for children with high level needs? What information is used? Where does the come from? What is the process of gathering this information and sharing? Whose role is this?
7. How is the Local Authority involved in the decision making processes for the placement of children with education as well as health needs?
8. How much control does the LA have for commissioning services, is there a particular type of need where this is more difficult to achieve?

### **Data sharing protocols to inform strategic decision across the local area**

9. What is the process for communicating confidential information from the CCG to outside agencies? Is it effective? How could it be improved?

### **Possibility of joint data base to inform decision making**

10. How could you see data being shared more effectively on the needs of children given the NHS protocols and current systems used by the different agencies?
11. Are you aware of any areas of best practice?
12. Is there anything else you would like to add which we have not discussed?

## **15.2 Appendix 2: Interview questions for NHS**

### **Theme (a) Criteria and pathways – diagnosis**

1. How do you provide early identification of physical disabilities in neonatal screening programmes? How is this information used/shared?
2. Who is usually the first person to notify the other professionals/LA once an SEN/D is identified? How effective is this process?
3. How well does the current system allow for effective planning for all provision (Health, education and social care?) based on the identified need?
4. What increases in prevalence of any particular primary need in children 0-16 years? For example ASD, PMLD have you identified? What trends (if any) have you noticed?

### **Theme (b) Effectiveness of multi-agency involvement**

5. Which agencies across education, health and care is it easiest to access and collaborate with about the needs of children, why do you think this is?
6. Where multi agency working is less effective, why is this? What are the barriers?
7. How able do you and your team feel in advising and train education staff in schools for meeting the needs of children with SEND (for example managing epilepsies and diabetes?)
8. What are the barriers to this or aspects of good practice you can identify? What is the current capacity for liaising with education?

### **Theme (c) Joint commissioning – provision**

9. What is the process by which local health services (including primary and secondary care) are able to inform them of children, including those under compulsory school age who are identified as having an SEN and/or disability. How effective is this and how could it be improved?

### **Theme (d) Data sharing protocols to inform strategic decision across the local area**

10. What is the process for communicating confidential information from the NHS to outside agencies?

11. How are under 3s flagged up from health visitors to consultants and how is this shared with the Local Authority for planning purposes and early years providers?

12. What increases in prevalence of SEMH issues have you identified? Are mental health services able to manage the level of need? How can these be improved? What additional funding is available based on recent Government pledges? Who targets funding? How are decisions made? What funding is still available for TAMHS (Targeted Adolescent Mental Health)?

### **Theme (e) Possibility of joint data base to inform decision making**

13. How could you see data being shared more effectively given the NHS protocols? Would co-location of services make this more effective?

14. To what extent is there a shared understanding across the agencies of 'disability?' How does this impact on decision making and provision planning?

### **15.3 Appendix 3: Codes to emerge from interview transcripts**

#### **NHS Interview**

Early identification of physical disabilities:

- Clear pathways for each identified condition (structured approach to treatment from newborn)
- Early identification is effective for pre-term/high risk children.
- Universal screening at set times such as the Newborn Hearing Screening programme which has been effective.
- Respondent reviewing drafts of guidance from NICE (shows that the Council is involved in shaping policy changes/new guidance)
- New guidance insists that children born prematurely will have to have a cognitive formal test at age of 4, and the guidance will split out support given for children born at levels of prematurity (more evidence of early intervention)
- Advocating standardised testing of children's health.
- Evidence of strong multi-agency working. Neonatalists contact respondent to go into the neonatal unit and meet the families- 'smooth transition of care and continuity of care right from the outset.' Also parental consent to share information is gained early so that SENCos in educational settings can be made aware of needs early and GPs can inform SENCos of when to get Ed Psych involved
- Open and honest communication is important- acknowledges that schools and GPs can have different agendas and this can mean conflicting priorities, but open and honest communication can get around those
- 'very clear pathway about who gets picked up and when'
- Paediatrician/Health Visitor usually the first to identify SEND

### Relationships between Education, Health and Care:

- Health and Education work very well together
- Social Care different- they have a much higher threshold for which children and families they will support- usually safeguarding/severe learning disability. Difficult for joined up working across the piece.
- Families defensive about having a Social Worker involved (stigma towards involvement of social care)
- Sunderland has a Specialist Health Visitor, Carer Centre and Parent Carer Network. These help with signposting and joined up working with families
- Operational meetings once a month that involve representatives from Health and Social Care. 'everybody knows on a Friday afternoon once a month where to find everybody so we can problem solve together, communicate about any issues and iron out any issues.'

### Changes in need prevalence:

- Complexity of need is increasing
- Increase in Autism diagnoses in ages up to teenage years. These are due to failures previously. A third and a half of the referrals are for Autism.
- Complexity of need is hidden by the primary need heading, ASD often overlaps with other needs.
- Increase in technology dependent young people

### Approach to meeting needs

- Sunderland have improved their approach to care by taking into consideration young people's rights and pastoral management of needs.
- A move to 'proactive management' rather than 'passive monitoring'
- Nurses are now based in Sunderland's special schools to make sure that their complex medical needs are met, enabling their education



- Examples of using specialist nurses to provide training and teaching to schools about specific conditions e.g. epilepsy, diabetes
- Respondent calls for more Autism training in schools and a real need to 'make sure that the workforce is disability aware and disability welcoming, have got can do attitudes and problem solve.' Also call for training on what 'reasonable adjustments' are in mainstream, could use Disability Matters for this.
- Training Teaching Assistants crucial to meeting needs
- 'Specialist Support Team' go into schools and trouble shoot, do risk assessments, provide support, look at ICT solutions for children with physical disabilities- innovative ways of problem solving
- Not a huge amount of migration in Sunderland- means there aren't often barriers to notifying people or communication with relevant teams once initial assessment has been done. Paediatricians automatically notify the LA.

#### Under 3 identification of need:

- Under 3 children with SEN identified through the Healthy Child Programme
- Specialist Health Visitor flag children not yet in education but with a need.
- Good communication to meet the needs of the under 3s- there is a two year pathway- pro-active in Sunderland to get commissioned early Nursery places for children with extra needs.

#### Barriers to effective multi-agency working:

- Potential difficulties with appointments in Social Work teams- meaning difficult to build familiarity with health and education
- Safeguarding seems better connected- 'robust inter-agency meetings and networking going across agencies.'
- 25% cut in paediatric team- staff aren't being replaced when colleagues move on
- Health isn't represented at every Education and Health Care Planning meeting- not the staffing - Health are able to SEND reports due to effective inter-agency working.

- CAMHS pressure is increasing- lots of reorganisation and shifts in personnel- problems with waiting times
- Respondent has 'special reserve new patient slots'- can get advice and make sure the child is seen early, even if big waiting lists for treatment. CYPS doesn't have this
- Finding a significant number of children under the Youth Offending Team who have undiagnosed learning disabilities. These children are often educated in a number of different schools/educational institutions and passed between them. Data systems are not robust enough to know where children are and how their needs are being met so can easily drop off the radar
- Children are referred at the end of the 12 week period whilst in a PRU – why aren't they seen at the start?
- Difficulty in meeting the needs of very young children (under 6), who present with behavioural needs- often a pressure for SENCOs to exclude. CYPS don't take the children, CAMHS not assessing because of social work involvement etc.
- SEN Panel isn't running as efficiently as it should be- no set templates for SENCOs to fill in which is resulting in disparate levels of information given, particularly about what they're spending on meeting the needs of a child and the impact it's having
- General recommendation that all processes should be person-focused rather than process-focused
- Problem with using common and agreed criterion for identifying children that would benefit from specialist provision

#### Social, Emotional and Mental Health Needs

- Not enough capacity in the system to assess the young children presenting with mental health difficulties effectively- there needs to be a timely assessment
- Paediatricians getting a lot of younger children coming directly to them, rather than CYPS. Respondent asks for CYPS to be a bit more responsive and pick them up quicker, so that assessments can be done concurrently with health assessments and needs better identified.
- Respondent has no additional funding for SEMH- all goes to CYPS and respondent has no say over what the funding is spent on

- DMO role shared between respondent and CCG- not clear who is doing what.

#### Sharing of data:

- LA need to work out the governance around sharing data. CCG currently do not share data from Neonatal screening with the LA – (it would be useful if they did so)
- Respondent suggests that data from NHS Digital be SEND to the CCG- CCG decide how data can be safely triangulated with LA data from school census etc.

#### Understandings of disability:

- All organisations use WHO's International Classification and Functioning Disability of Health' model of disability.
- There seem to be a vast number of different groups/meetings between individuals that are designed to meet the needs of children identified with SEND. It seems convoluted and superfluous- maybe a recommendation to review all groups that meet regularly and identify cross-overs to maximise efficiency?

#### **CCG Interview**

#### Codes to emerge from data:

- Undertake assessments every year for every acute service- analyse data to monitor staffing, resourcing and working with providers
- Run 3 acute services in Sunderland- SALT, physiotherapy and hearing service.
- Services that are additional to the 3 acute services are commissioned via a 'special requests.' These could be additional hours or short breaks.
- Increases in ASD and Diabetes prevalence- predominantly in primary for Diabetes. Increased numbers of child obesity and child mental health figures have continued to rise.

- CCG supports third sector organisations working to support children with ASD
- CCG respondent identified good working relationships with the LA (through regular meetings to discuss EHC plans and LAC) and City Hospital Sunderland (because CCG are a direct commissioner of them).
- CCG respondent identified poorer working relationships with the care industry because 'we're a bit more arm's length to the actual care home or foster care provision.'
- No current opportunity for all stakeholders interested in early intervention to meet.
- Difficulties in multi-agency working where a child has health needs because health is always the lead partner, so have to make sure that you complement the existing health services in place.
- Respondent acknowledges that there should be a server that hold shared data about children's needs, but that the complexities of having the permissions make it a difficult task.
- Respondent identifies lack of clarity with DMO role- feels that part of the role should be about helping to co-ordinate some of the issues that have been discussed.

#### 15.4 Appendix 4: Ward Map of Sunderland (2015)



## 15.5 Appendix 5: SEND Staff Training Audit

### SEND Staff Training Audit

(Adapted from Cheminais, 2015, p. 84)

Name

Date

From the list of topics below, choose three and number in order of priority (1-3).

- Identifying SEN
- Meeting pupils' SEMH needs
- Meeting pupils' communication and interaction needs
- Meeting pupils' cognition and learning needs
- Making reasonable adjustments to meet the needs of pupils with physical/sensory impairments
- Differentiating the curriculum
- Assessment for learning
- Target setting for pupils with SEND
- Working productively with parents and carers or pupils with SEND
- Making the best use of technology to enhance access to learning
- Effective deployment of support staff
- Meeting Ofsted inspection requirements for SEN
- Person Centred Planning and Supporting SEND pupils in reviewing their own progress and provision
- Any other SEND topic

Please indicate your preferred method for accessing the training identified:

External Course

Online Resources

SENCo drop in

Workshops in-house

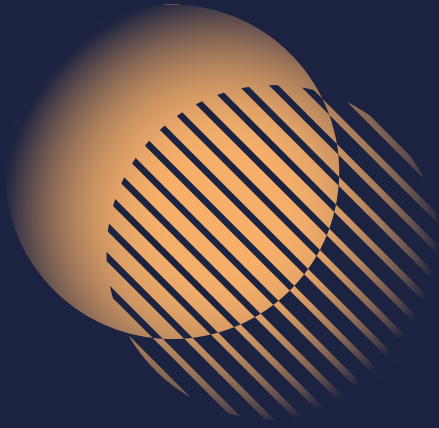
Printed information

Teaching School CPD

School INSET

1:1 Coaching/mentoring





# **An investigation into the perceived enablers and barriers to mainstream schooling: The voices of children excluded from school, their caregivers and professionals**

Principal Investigator and Author: Sarah Martin-Denham  
University of Sunderland, School of Education  
Commissioned by Together for Children, Sunderland

March 2020



**University of  
Sunderland**





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## Executive summary

The University of Sunderland was approached by Together for Children in Autumn 2018 to 'investigate the factors that impact upon social and emotional wellbeing of children and young people, from 3-16 years in Sunderland City, which may lead to exclusion from school'. The purpose was to provide a research-informed review of mainstream schooling in the City, through a detailed examination of the personal lived experiences of children and their caregivers who experienced exclusion from school. The research also elicited the perceptions and experiences of other stakeholders across health, education and support services on the enablers and barriers to mainstream education for children vulnerable to school exclusion.

In total, 174 participants were interviewed for this research. This included: 55 children, 41 of their caregivers, 69 education professionals including head teachers from nursery to secondary age phase and 14 Special Educational Needs Coordinators (SENCOs) and class teachers. The sample also included nine health and support professionals and three separate advisory groups, consisting of 12 children, five professionals from health/support services and five education professionals.

This is the most substantial piece of primary research carried out to date on the enablers and barriers to mainstream schooling for those at risk of school exclusion in England. It would not have been possible without the commission from Together for Children (TfC), who must be commended for their ambition to improve the lives and schooling experiences of children across the City.

What is evident from this research is that when the caregivers sent their child to school, they did not foresee the difficulties that lay ahead. The reality is that for some of the children in this study, the mainstream model of schooling didn't work. They reported barriers to accessing the curriculum and participating in learning due to a multitude of factors outside of their control, including academic expectations and curriculum, large class sizes and unidentified

learning and health needs. They also shared experiences of failed relationships with teachers and a need for more holistic support than was available. Some participants suggested that inflexible behaviour sanctions, including being placed in isolation booths, where predominantly, no teaching or learning occurred, were a barrier to mainstream school.

## The overarching aim

To investigate the factors that impact upon social and emotional wellbeing of children and young people from 3-16 years in Sunderland Local Authority, which may lead to exclusion from school.

## Objectives

- To elicit the perceptions and experiences of excluded children, their caregivers and professionals, around the barriers and enablers to mainstream schooling
- To determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream-school
- To evaluate the effectiveness of national policy in supporting children to remain in mainstream school
- To produce a report with supporting evidence to inform provision planning and training for education professionals within the local area of Sunderland

## Recommendations

The recommendations in this report are intended to enable the local area to develop expertise and capacity in schools to allow children to thrive emotionally and socially. Implementing these recommendations will require a shared

**Recommendation 1:** We think isolation booths should be removed from all schools as they do not work and do not improve behaviour but make it worse.

**Recommendation 2:** We need smaller class sizes in mainstream schools, 30 in a class is too noisy, there is too much distraction and teachers cannot give us the help we need, this will help us learn.

**The following recommendations are from the interviews, conversations and advisory group comments.**

**Recommendation 3:** Governing bodies must work with senior leaders and SENCOs to embed alternative approaches to isolation booths that are based on child-centred approaches. This needs to include training, so there is a clear understanding of the need to apply the graduated approach of: assess, plan, do and review (DfE, 2015a) to identify, understand and respond to children's needs through evidence-based practices.

**Recommendation 4:** Schools should access training to reinforce their reasonable adjustment duties as legally required by the Equality Act 2010 and obligations within the Children and Families Act 2014. These need to be made explicit in school policies such as SEND, safeguarding, equality, behaviour/discipline, positive handling, mental health and looked after and previously looked after children.

**Recommendation 5:** Schools should access training on alternative and child-centred approaches to restraining children. For example, Studio 3's Managing Challenging Behaviour course (MCB), accredited by the British Institute of Learning Disabilities. This needs to include the impact of traumatic Adverse Childhood Experiences (ACEs) on children's mental health and wellbeing.

**Recommendation 6:** For stakeholders in key stage 2, secondary education and TfC to explore the adoption of a vocational education and training model for children who have aspirations outside of academic routes and/or who find the current curriculum stressful and unmanageable. With agreement from the caregiver and child, there should be consideration of continuing the primary education model into years 7 and 8 for those children who have been identified as needing an alternative route within secondary mainstream education.

**Recommendation 7:** Review of health services pathways, including the introduction of a health and support services triage service in Sunderland for children across the child and adolescent years. This would ensure that a health professional decided which pathway is most suitable for the child or young person (paediatric disability service, community CAMHS or CYPS), or other support services. This will need to include a review of the procedures for responding to caregiver concerns at the two-year progress check.

**Recommendation 8:** To immediately revoke the child and adolescent mental health service CAMHS special circumstances list so that all children can access timely support.

**Recommendation 9:** Children on the edge of or allocated a fixed-period or permanent exclusion should be referred to health services to determine any underlying genetic, learning disabilities or neurodiversity causes.

**Recommendation 10:** To provide training to health visitors to ensure there is consistency in how the teams recognise and respond to the caregiver's voice when they share concerns about their child's development and/or behaviours.

**Recommendation 11:** To create a crisis response team as part of the CYPS service, to be available to schools from 8 am until 5 pm to allow for issues arising before, during and after school.

**Recommendation 12:** Further consideration to be given across the health services of the consequences when a child fails to attend an appointment, or is unable to communicate during the meeting. The paediatric disability consultants should lead this, as they were commended for their procedures and practices.

**National recommendation:** Department for Education (DfE) must take steps to address the use of isolation booths in schools. They should review guidance on the use of this method of sanction and commission case studies of alternative child-centred approaches.

I am grateful to all the participants who took part in this research and openly shared their experiences. Thank you for your time and your stories you have been honest and sincere, and this will allow the local area to move forward with research-informed evidence. I would particularly like to thank the children and caregivers; being able to hear from you directly has been fundamental to this research. You are all brave and inspirational, and I wholeheartedly wish you the best life.

**Sarah Martin-Denham**  
March 2020



## Sarah Martin-Denham: Principal Investigator, Project Director and Author



Sarah is a Senior Fellow of the Higher Education Academy, a Vice-Chancellor Teaching Fellow, Chair of an independent SENCO network and a Convenor of an Interdisciplinary Research Network for developing knowledge, understanding and approaches for supporting children who are experiencing adverse childhood experiences. She has extensive knowledge of learning and teaching in the North East of England, in a variety of settings, from Early Years to Higher Education. Sarah has successfully developed and led four programmes and research projects in the School of Education at the University of Sunderland, and is the Programme Leader for the National Award for Special Educational Needs Coordination. Through her work with children and families over the last twenty years and her neurodiverse abilities, she has developed a particular interest in Special Educational Needs and disabilities.

### Recent Publications:

Martin-Denham, S. and Donaghue, J. (written for submission) 'The impact and measure of Adverse Childhood Experiences: Reflections of undergraduates and graduates in England.'

Martin-Denham, S. (2020) 'A review of school exclusion on the mental health, well-being of children and young people in the City of Sunderland.' Sunderland: University of Sunderland.

Martin-Denham, S. (2020) 'The enablers and barriers to successful managed moves: The voice of children, caregivers and professionals.' Sunderland: University of Sunderland.

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# Glossary of acronyms

|                                                                         |                                                                    |
|-------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>ACE</b> Adverse Childhood Experience                                 | <b>DfE</b> Department for Education                                |
| <b>ADHD</b> Attention Deficit Hyperactivity Disorder                    | <b>DoH</b> Department of Health                                    |
| <b>AP</b> Alternative Provision                                         | <b>DSM-5</b> Diagnostic and Statistical Manual of Mental Disorders |
| <b>APVA</b> Adolescent to Parent Violence and Abuse                     | <b>EHCP</b> Education, Health and Care plan                        |
| <b>ASD</b> Autism Spectrum Disorder                                     | <b>EYFS</b> Early Years Foundation Stage                           |
| <b>BERA</b> British Educational Research Association                    | <b>GDPR</b> General Data Protection Regulation                     |
| <b>BILD</b> British Institute of Learning Disabilities                  | <b>GP</b> General Practitioner                                     |
| <b>CAMHS</b> Child and Adolescent Mental Health Services                | <b>HIV</b> Human Immunodeficiency Virus                            |
| <b>CAPBS</b> Centre for the Advancement of Positive Behaviour Support   | <b>IPSEA</b> Independent Parental Special Education Advice         |
| <b>CCG</b> Clinical Commissioning Group                                 | <b>ITE</b> Initial Teacher Education                               |
| <b>CCVAB</b> Children with Challenging, Violent or Aggressive Behaviour | <b>LA</b> Local Authority                                          |
| <b>CPV</b> Child to Parent Violence                                     | <b>MLD</b> Moderate Learning Difficulty                            |
| <b>CVAB</b> Challenging, Violent and Aggressive Behaviour(s)            | <b>NC</b> National Curriculum                                      |
| <b>CYPS</b> Children and Young People’s Services                        | <b>NCTL</b> National College for Teaching and Leadership           |
|                                                                         | <b>NEET</b> Not in Education, Employment or Training               |

|                                                                    |                                                                                |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>NHS</b> National Health Service                                 | <b>SENCO</b> Special Educational Needs Coordinator                             |
| <b>OCD</b> Obsessive-Compulsive Disorder                           | <b>SEND</b> Special Educational Needs and/or Disability                        |
| <b>OECD</b> Organisation for Economic Co-operation and Development | <b>SEP</b> Special Educational Provision                                       |
| <b>Ofsted</b> Office for Standards in Education                    | <b>SLCN</b> Speech, Language and Communication Needs                           |
| <b>PTSD</b> Post-Traumatic Stress Disorder                         | <b>UNESCO</b> United Nations Educational, Scientific and Cultural Organization |
| <b>SEN</b> Special Educational Needs                               |                                                                                |

## Glossary of terms

**Alternative provision:** For children of compulsory school age who do not attend mainstream or special schools

**Annual review:** The review of an EHC plan, which the Local Authority must make every 12 months as a minimum

**Care pathway:** The route a person takes through healthcare services

**Depression:** Where an individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy, leading to increased fatigability and diminished activity

**Designated teachers:** Champion the educational attainment of looked-after and permanently placed children

**Diagnosis:** The process of identifying an illness by carrying out tests or by studying the symptoms

**Early years foundation stage:** The framework for the learning, development and care of children from birth to five years

**Education health and care plan:** Details the education, health and social care support to be provided to a child with SEN and/or disabilities

**Graduated response:** A model of action and intervention to support children who have SEN

**Local authority:** Leading integration arrangements for children with SEND

**Maintained school:** Schools that are maintained by a Local Authority

**Methodology:** Describes how research is carried out, including how information is collected and analysed, and why a particular method or methods have been chosen

**National curriculum:** Statutory entitlement to learning for all children from 5-16 years

**NHS England:** An independent body that aims to to improve health outcomes for people in England

**Official exclusions:** These are recorded with central or local government and include temporary fixed period exclusions or permanent exclusions

**Ofsted:** Responsible for the inspection of all schools in England

**Prevalence:** How common a type of exceptionality is within a population, either at a point in time or over a given period of time

**Prognosis:** The medical assessment of the future course and probable outcome of an illness

**Pupil referral unit:** Provides education for children who would otherwise not receive suitable education because of illness, exclusion or any other reason

**Schizophrenia:** A severe mental health disorder, characterised by a loss of reality

**SEN support:** Extra or different support provided in addition to the school's usual curriculum

**Social care:** All forms of personal care and other practical assistance for children who need extra support

**Special educational needs:** A child has an SEN if they have a learning difficulty or disability which calls for special educational provision to be made

**Special Educational Needs Coordinator:** A qualified teacher in a school or maintained nursery school who has responsibility for coordinating SEN provision

**Special educational provision:** Provision that is different from, or additional to, that which is normally available to children with SEN, to enable them to access and participate in learning

**Stakeholder:** An organisation/individual with an interest in a topic, including public sector providers and commissioners of care or services

**Statutory duty:** A duty that must be complied with

**Unofficial exclusions:** These are not recorded as exclusions in the national data and include managed moves to a different school; a move into some form of alternative provision offsite; or illegal exclusions

**Young person:** A person over compulsory school age (the end of the academic year in which they turn 16 to the age of 25)

For ease of reading:

- 'Children' will be used to refer to children and young people
- 'Caregiver' for all of those with guardianship of children
- 'School' will be used to refer to any educational establishment
- 'Code' will be used for reference to the special educational needs and disability code of practice (DfE, 2015a)
- 'Mainstream school' relates to the following schools: maintained, academies, free and faith schools

# 1. Introduction

# 1. Introduction

## 1.1. Rationale for the report

Together for Children (TfC) commissioned this research in response to the Martin-Denham et al. (2017) report, which highlighted higher than the national prevalence of particular primary types of special educational needs (SEN). It reported that in 2016, the number of children with an education, health and care plan (EHCP) with social, emotional and mental health (SEMH) as their primary type of need was 14.03% higher than the national rate. TfC wanted to find out the factors that may have led to this rise, with a particular focus on those children who received fixed and/or permanent exclusions from school. The findings and recommendations will be used by TfC and Sunderland City Council to inform the strategic plan for the next five years. They want to use research as a tool to progress and reform how services are commissioned and to reconfigure inclusion for children with special educational needs and disabilities (SEND).

## 1.2. Context: Sunderland

The City of Sunderland, lies on the North East coast of England, and has a long and illustrious history of shipbuilding, heavy engineering and glass-making (Short and Fundinsland-Tetlow, 2012). Sunderland lies at the mouth of the River Wear, one of the principal waterways in the region's second largest City. The south of the river is the most populated area of Sunderland (Dodds, 2011).

Over time, Sunderland has grown from being a small trading port into a large industrial City due to rural-urban migration within the region, high birth rates and historic immigration from Ireland and Scotland (Cookson, 2015). The 2011 census (Nomis, 2019) states that the total number of residents in Sunderland was 275, 506, with 39.9% of households having no adults currently in employment.

## 1.3. Research question

What are the enablers and barriers to mainstream schooling for children at risk of school exclusion in the City of Sunderland?

## 1.4. Aims and objectives

The project had the following aim and objectives:

### Aim

To investigate the factors that impact on social and emotional wellbeing of children and young people, from 3-16 years in Sunderland Local Authority, which may lead to exclusion from school.

### Objectives

- To elicit the perceptions and experiences of excluded children, their caregivers and professionals, of the barriers and enablers to mainstream schooling
- To determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream school
- To evaluate the effectiveness of national policy in supporting children to remain in mainstream school
- To produce a report, with supporting evidence, to inform provision planning and training for education professionals within the local area of Sunderland

## 2. Literature Review

## 2. Literature review

The literature review explores key themes that relate to the rights of children with SEND. This begins with setting the context in terms of legislation and policy. It then discusses different aspects that impact negatively on some children's ability to access school due to the barriers to learning some children experience.

The Children and Families Act (CAFA) (2014) part 3 provides the current legislation for children with SEND from 0-25 years in England. It sets out a legal duty for health, education and care to work collaboratively as a joined-up approach for the benefit of families and children; it is legally binding, so schools and Local Authorities (LAs) must comply with their duties. The SEND regulations (DfE, 2014a) are the main set of regulations that underpin this legislation. The following principles in the CAFA (2014) are of paramount importance:

- Taking into account the views of children and their caregivers
- The child and their caregivers participating as fully as possible in decisions and in being provided with the information and support needed to enable them to participate
- The need to support the child and their caregivers, to facilitate their development to achieve the best possible educational and other outcomes, preparing them adequately for adulthood
- To identify the needs of children and to provide high-quality provision
- To focus on inclusive practice and removing barriers to learning.

Inclusion is inextricably linked to legislation and policy, and where the child is placed. This forms part of the discussion for this study, as it explores whether it is possible for children with SEN to feel and be included while attending mainstream school (Martin-Denham and Watts, 2019). It is widely accepted that

the notion of inclusion and what constitutes inclusive practice is the most controversial issue regarding education of children with SEND (Farrell, 2010; Hornby, 2015; Glazzard, 2015). One complexity is due to the many varying definitions of the term 'inclusion', which incorporates the difference between inclusion and integration (Norwich, 2012). The term 'integration' was introduced by Warnock (Department of Education and Science, 1978), referring to accommodating children with SEN into a common educational framework. The Education Act 1981 created an expectation that a child would be placed in an 'ordinary' school when it did not negatively affect the education of other children, was cost-efficient and accorded with parental preference. It also signalled a move away from the presumption that certain needs would be provided for in specialist schools. This new inclusive model was intended to promote placing a greater number of children within mainstream schools (Lauchlan and Grieg, 2015). At this point, the terminology began to change from 'integration' to 'inclusion' following the United Nations Educational Scientific and Cultural Organisation's (UNESCO) Salamanca Declaration (1994). This statement called on all countries to embed the principle of inclusion into their education policies and practices so that all children could access mainstream school. A widely shared definition from the National Association of Special Educational Needs (NASEN, 1998) is as follows:

**'...inclusion is not a simple concept, restricted to issues of placement. Its definition has to encompass broad notions of educational access and recognise the importance of catering for diverse needs. Increasing mainstream access is an important goal. However, it will not develop spontaneously and needs to be actively planned for and promoted'.**

Norwich (2017) clarified that the term inclusion was intended to be used to focus on what specific provision the child needed to develop and learn, such as teaching, facilities, materials and support; not the difficulties the child experienced. In 2007, a Conservative Party sponsored commission stated that inclusion was a failed ideology and advocated the use of



separate and specialist provisions, despite many being closed as part of Government policy. A change in Government in 2010 resulted in the Conservative Party endorsing special school provision, giving caregivers a greater choice over choosing schools (DfE, 2011a).

Warnock (2005) has rejected the idea of educating children ‘all under one roof’ instead she supports the importance of children being engaged in a common education experience to learn and develop to the best of their abilities prioritising this over the placement. This was more recently endorsed in the DfE (2015a) Code, which states:

**‘Special schools in the maintained, academy, non-maintained and independent sectors, special post-16 institutions and specialist colleges all have an important role in providing for children and young people with SEN and in working collaboratively with mainstream and special settings to develop and share expertise and approaches’** (DfE, 2015a, p. 28)

The DfE (2015a) Code makes little reference to inclusion. However, the National Curriculum (NC) (DfE, 2014b, 4.1) states that ‘a wide range of pupils have special educational needs, many of whom also have disabilities. Lessons should be planned to ensure that there are no barriers to every pupil achieving. In many cases, such planning will mean that these pupils will be able to study the full national curriculum’ (DfE, 2013a, p.8).

Inclusion is seen as a multi-dimensional concept that celebrates and values difference and diversity with consideration of human rights, social justice and equity; it holds a focus on both a child’s entitlement and access to education (Loreman et al., 2011; Topping, 2012). It is a problematic concept as it is used in different ways; either in reference to inclusive schools or inclusive societies, or from a policy level, more children in mainstream schools (Terzi, 2010). The notion of ‘full inclusion’ education in these schools is impossible to achieve as the provision is not the right environment for all children (Hansen, 2012; Kauffman and Badar, 2014). This creates tension between a child’s fundamental

right to be educated alongside their mainstream peers (Hornby, 2015) and their human right that it is not, for some, morally the best option (Terzi, 2010).

## 2.1. What are special educational needs (SEN)?

A SEN is defined as:

- A child or young person who has a learning difficulty or disability which calls for special educational provision to be made for him or her.
- A child of compulsory school age or a young person has a learning difficulty or disability if he or she:
- has significantly greater difficulty in learning than the majority of others of the same age

or

- has a disability that prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions (DfE, 2015a).

The reality is that there are issues with the term SEN, including variability in how it is identified, interpreted and assessed, due to varying interpretations of its meaning (Ellis and Tod, 2012; Martin-Denham and Watts, 2019). This will inevitably lead to inconsistencies in levels of support received across education provisions within local authorities and across the country.

## 2.2. Numbers of children in England with special education needs and disabilities

The National Audit Office (NAO) (2019) reports that 1.3 million pupils in England were identified as having SEND at the end of January 2019. They clarify that these children have diverse needs of different levels of severity and they may have more than one type of difficulty. The most commonly identified primary SEND nationally are: Speech, Language and Communication Needs (SLCN) (21.7% of pupils with SEND at January 2019) and Moderate Learning

Difficulties (MLD) (20.4%). Significantly more boys than girls are identified as having SEND – 20.2% of boys aged 5 to 17 in state-funded schools in January 2019, compared with 10.7% of girls.

There are fewer children with SEN attending mainstream provision nationally, with 83.9% attending mainstream education in 2015/16, decreasing to 82.9% in 2017/18. This meant that in 2017/18, approximately 10.3% of children designated with SEN were enrolled in alternative provision and maintained or non-maintained special schools; representing an increase of 0.6% from 2015/16.

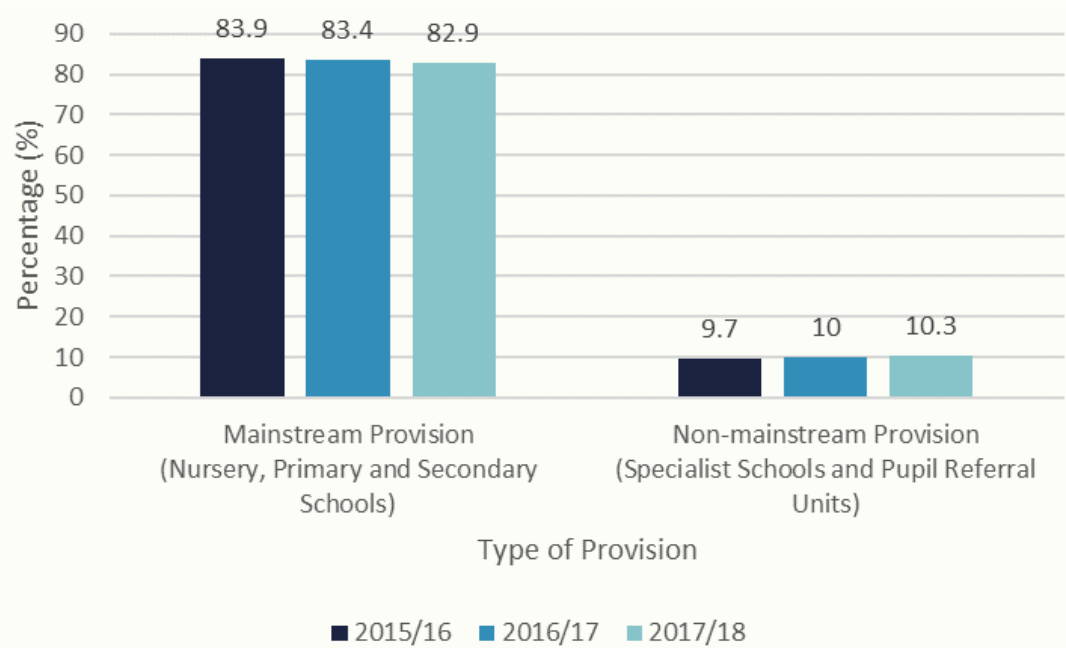


**Figure: 1.** Percentage of children designated as SEN in mainstream and non-mainstream provision (2015/16 - 2017/18).

## 2.3. What is a disability?

The Code (DfE, 2015a) shares a definition of disability that draws upon the Equality Act (2010). This explains that children have a disability if they present with ‘a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities’ (p. 16). This definition provides a relatively low threshold for disability and includes more children than many realise: ‘long-term’ is defined as ‘a year or more’ and ‘substantial’ is defined as ‘more than minor or trivial’ (Martin-Denham and Watts, 2019). The following needs are automatically treated as a disability under the Equality Act (2010): cancer, HIV, multiple sclerosis, severe disfigurement and and certified blind or having severe vision challenges as confirmed by a consultant ophthalmologist. For other physical and mental health conditions, it depends on the effect on daily life and includes:

- Sight or hearing
- Heart disease and asthma
- Learning disabilities
- Learning differences such as dyslexia and dyspraxia
- Autism
- Depression, schizophrenia, bipolar affective disorders, eating disorders, obsessive-compulsive disorders.
- Difficulties due to brain injury

If a child with a disability also requires special educational provision (SEP), they will also be covered by the SEN definition.

## 2.4. Special educational needs support and education health and care plans

The National Audit Office (NAO) (2019) note that nationally, on January 2019, 20.6% of children had legally enforceable entitlements to packages of support, which were set out in EHC plans. Almost half of these (47.9%) attended mainstream schools. Likewise, 79.4% of children with SEND did not have an EHC plan but were identified as accessing additional support (SEN support), most of these (91.6%) attended mainstream schools.

## 2.5. Outcomes for children with special educational needs and disabilities

Underlying issues identified by Ofsted (2018) are that many EHC plans are not successfully implemented, so gaps in outcomes between those with and without an EHC plan continue to widen. They also report that identification of SEN is weak and those who do not meet the threshold for an EHC plan are more likely to have negative outcomes. The report also emphasised that in 30 local area inspections, children on SEN support did not benefit as consistently as those with an education, health and care plan (EHCP). DfE (2018) agreed, reporting that outcomes for young people with SEND are often poor. In 2016/17, the Progress 8 score for those on SEN support was -0.43 and for those with a statement or EHC plan, it was -1.04. Fewer 16-17-year-olds with SEN (87%) than without (92%) are in education or training (DfE, 2018). Figure 2 shows that children attending local authority maintained schools have an average attainment eight score of 46.5, the third highest behind converter academies (50.2) and free schools (48.9).

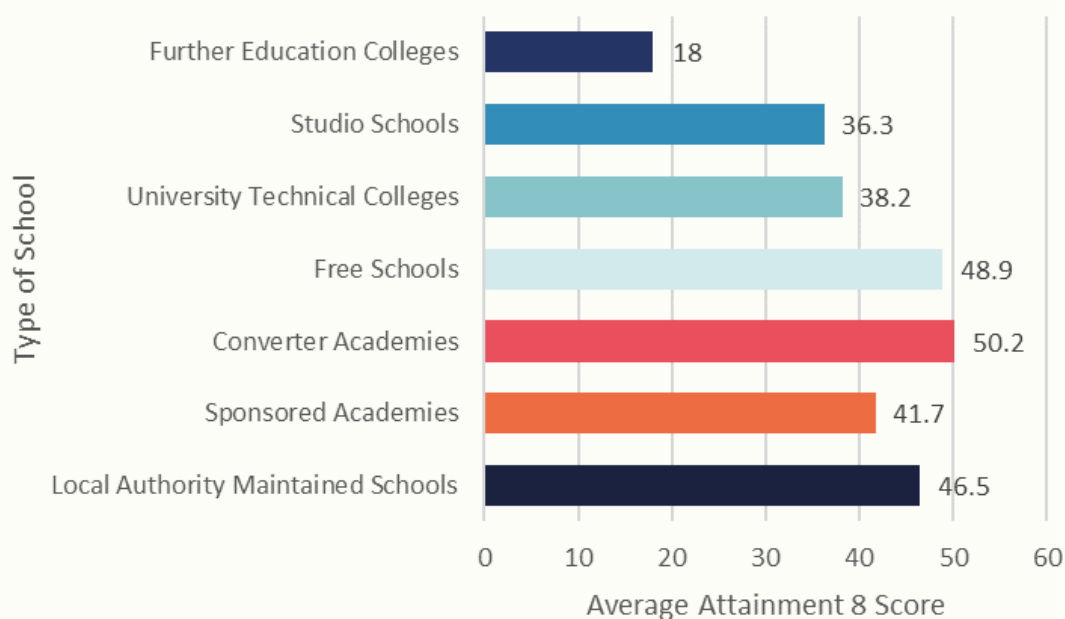


**Figure: 2.** Average Attainment 8 score across different types of school

## 2.6. Funding for children with special educational needs and disabilities

An estimated £3.8 billion of ‘schools block’ funding was explicitly spent to support children with SEND in mainstream schools (NAO, 2019). This was not ring-fenced but the expectation was that schools would use this money to cover the first £6,000 of support per pupil with SEND (Martin-Denham and Watts, 2019). In addition, £5.6 billion of ‘high needs block’ funding pays for places in specialist and alternative provision, and gives top-up funding for mainstream schools for the costs above the £6,000 per-pupil threshold. High needs funding has fallen in real terms due to a 10% increase in the number of children in specialist provision (NAO, 2019).

## 2.7. Special Educational Needs Coordinators (SENCOs)

Maher and MacBeath (2014) suggest that one outcome of the commitment to the UNESCO (1994) inclusive education policy was to increase the number of children with SEN being taught in mainstream schools, which made SENCOs increasingly part of the

school culture. The Code requires governing bodies of maintained mainstream schools and proprietors of academies and free schools to ensure there is a qualified teacher designated as SENCO (DfE, 2015a). Their role should be strategic, overseeing the day to day operation of the SEND policy, coordinating provision, supporting colleagues with professional guidance, advocating for caregivers and children, and being a point of contact for external agencies (DfE, 2015a). In a 2018 survey, 74% of coordinators reported that they did not have enough time to ensure those on SEN support could access the support they needed, and 70% did not feel they had enough time allocated to the role (NASEN, 2018). One of the challenges of being a SENCO is that the Code does not dictate that they must be part of the school leadership team (Martin-Denham and Watts, 2019). This creates barriers to the development of inclusive learning environments and resources allocation due to a lack of authority in school hierarchies (Wedell, 2004; Maher and Macbeth, 2014).

## 2.8. Teacher training

DfE (2011b) stated in the statutory teachers' standards that teachers must have a clear understanding of the needs of all pupils, including those with special educational needs. In 2014, the Secretary of State for Education asked Sir Andrew Carter to carry out an independent review to identify which core elements of high-quality Initial Teacher Training across phases and subject disciplines are key to equipping trainees with the required skills and knowledge to become outstanding teachers (DfE, 2015b). This and other research has shown that some teachers lack the skills to manage the mental health and wellbeing needs of children (Lebeer et al., 2012; Carter, 2015). The impact of this has been outlined by NAO (2019) who shared caregivers' concerns that mainstream schools were not meeting children's needs and were unable to cope with children's behaviour. In some cases, this led to school exclusion or caregivers withdrawing their child because of concerns about their mental health. The recommendations following the Carter Review were that teacher training providers should ensure trainees understand the SEND Code (DfE, 2015a) and are confident working with the four broad areas of need, including adapting teaching strategies to ensure all children can access the curriculum (DfE, 2016). In light of the issues raised, Ofsted (2018) is focusing on an initial teacher education (ITE) inspection framework with an expectation that it will ensure trainee teachers are well prepared to provide support to all children in education.

In addition, the National Institute of Clinical Excellence (NICE) (2017) produced guidelines for early years, primary and secondary education to promote social and emotional wellbeing. This included planning and delivering programmes and activities to support schools in identifying signs of anxiety or social and emotional problems and how to address them. This guidance also includes recommendations of comprehensive, universal and targeted approaches for use in schools that rely upon teachers and practitioners being trained to identify and assess where a specialist should be involved with a child.

## 2.9. Barriers to mainstream schooling

The debate about how to support children with diverse abilities to enable them to remain in a mainstream context is ongoing internationally and it is suggested that many variables in school can affect children's ability to learn, including class size, dynamics and the availability of additional adults (Blatchford and Webster, 2018). Evidence presented by Johnson et al. (2017) found that the barriers to providing effective support were resource issues, namely the availability of external professionals. Concerns were also identified with the quality of lessons for children with SEN and the ability of staff to meet their needs. These themes and others will be further explored in this section.

### 2.9.1. Accountability

The current accountability structures in England were introduced following the Education Reform Act (DES, 1988). Brown and Carr (2019) argue that the introduction of mandatory national Standardised Assessment Tests (SATs), following the Education Reform Act 1988, was intended to measure the variable achievements of children in the core subjects. Schools are still adjusting to systemic changes that reconstructed education as outcomes-oriented and where external judgements of schools are made based on their outcomes (Ball, 2003; Martin-Denham and Watts, 2019). House of Commons (2018b) rightly reports that the education system has been subject to significant change, to qualifications at both primary and secondary phases and with the push for academisation across the country. School budgets are much tighter; the school system has fragmented yet further and is now a national system in name only, as there are seven types of secondary schools in England and Wales (Coffield, 2018). Local Authorities are starved of resources, with budgets effectively cut by around a quarter since 2010 (Smith et al., 2016). Cash welfare benefits have been cut, capped and frozen, with many claimants waiting weeks for payment since the introduction of universal credit (NAO, 2018; Patrick, 2017). Some claimants were sanctioned by halting their payments (Patrick, 2017). All of these

factors are believed to have caused the re-emergence of child poverty and homelessness, which has risen by over 50% since 2010 (Yeung, 2016). Food bank use has grown hugely, with the Trussell Trust providing 1,084,604 food parcels in 2014-15 compared to 40,898 in 2009-10 (Garthwaite, 2016).

Research for the National Union of Teachers (Hutchings, 2015, p. 2) emphasised that the accountability agenda in England has changed the nature of education in wide-ranging and harmful ways. Teaching standard 5 (DfE, 2011b, p.11) states that teachers must adapt teaching to respond to the strengths and needs of all children, and must be able to use and evaluate distinctive teaching approaches to engage and support them. Hutchings (2015) reports findings that teacher workloads are excessive, resulting in increased stress due to the pressure to meet targets for children's attainment. She conveyed children's views that there is a reduction in teacher-pupil interaction, loss of flexibility and lack of time for teachers to respond to children as individuals with increasing pressure for them to do things before they are ready. Wyness and Lang (2016) add that changes to teacher workloads have had significant implications for schools as a social and emotional space, where children can develop as learners, democratic citizens and as emotionally and socially centred individuals.

As illustrated below, responsibility and accountability for the development and progress of children with SEND lie with teachers, not SENCO or support staff.

#### **The Code adds that teachers:**

- Are responsible and accountable for the progress and development of the children in their class, including where children access support from support staff or specialist staff
- Should remain responsible for working with the child on a daily basis, even when interventions involve group or one-to-one teaching away from the main class or subject teacher
- Should work closely with any teaching assistants or specialist staff involved, to

plan and assess the impact of support and interventions and how they can be linked to classroom teaching

- Working with the SENCO should revise the support in light of the child's progress and development, deciding on any changes to the support and outcomes in consultation with the caregiver and child

(DfE, 2015a, p. 99, 101, 102).

### **2.9.2. The testing regime**

The National Curriculum (NC) was introduced in 1988 as an assessment-driven system with tests for children from year one to year eleven. Since their introduction account has not been taken of how to assess children with SEN (Norwich, 2017). This is evidenced by the Government taking 13 years to introduce a modified NC for children with learning difficulties through the introduction of P scale assessment for children attaining below level 1 of the NC scale (Martin-Denham, 2015).

The National Teachers' Union Report (2015, p. 5) concluded that 'children and young people are suffering from increasingly high levels of school-related anxiety and stress, disaffection and mental health problems.' ChildLine (2014; 2015) expressed the same views, reporting that school and exam pressures were one of the biggest causes of stress and anxiety among children and young people, noting a 200 per cent increase in counselling sessions related to exam stress between 2012-13 and 2013-14. Hutchings (2015) elaborates that there is increased pressure from tests and greater awareness at younger ages of their own failure due to the increased rigour and academic demands of the curriculum. ATL (2016) share findings that 82% of educators believed children were under more pressure now than ten years ago, with 89% agreeing that testing and exams are the most significant factor. Power and Taylor (2018) suggest that high stakes testing leads to disengagement of children who struggle academically. The House of Commons (2018b) agreed that high stakes exams were a source of pressure and that a reduction in creative and technical subjects meant fewer opportunities for children to express themselves. In comparison to other European countries,



11-16-year-olds in England feel more pressure to do their school work (WHO, 2012).

2.9.3. The vocational/academic divide

The divide between vocational and academic routes has been persistent in the UK education and training sector for a long time (Taylor, 2010; Chankseliani et al., 2016). The reason is that vocational routes are deemed to be inferior to academic pathways, as they attract a disproportionately high number of children from low-income families who may be excluded from mainstream education (Lewis, 1994; Pring et al., 2009; Cabinet Office, 2011). However, the Wolf Report (2011) acknowledged the importance of the vocational subjects in schools within a core curriculum for those aged 14-16 years. Since then, the intellectual and professional nature of vocational education is being recognised due

to the number of medium and high skilled jobs that are considered to be vocational (Clifton et al., 2014).

In Switzerland, vocational education is the preferred route, chosen by approximately two-thirds of a birth cohort (Basler and Kriesi, 2019). Their system is highly stratified and differentiated into a series of routes or tracks which differ based on the level of academic requirement (Buchmann et al., 2016) and links to the labour market (Sacchi et al., 2016). The tracks shown in Fig. 3 begin at age 12 or 13 with different academic requirements. The model is mostly based in business, with trainees spending three to four days a week with a training organisation and two days in vocational school. It offers around 230 training occupations, which are applied for age 14 or 15 (Basler and Kriesi, 2019).

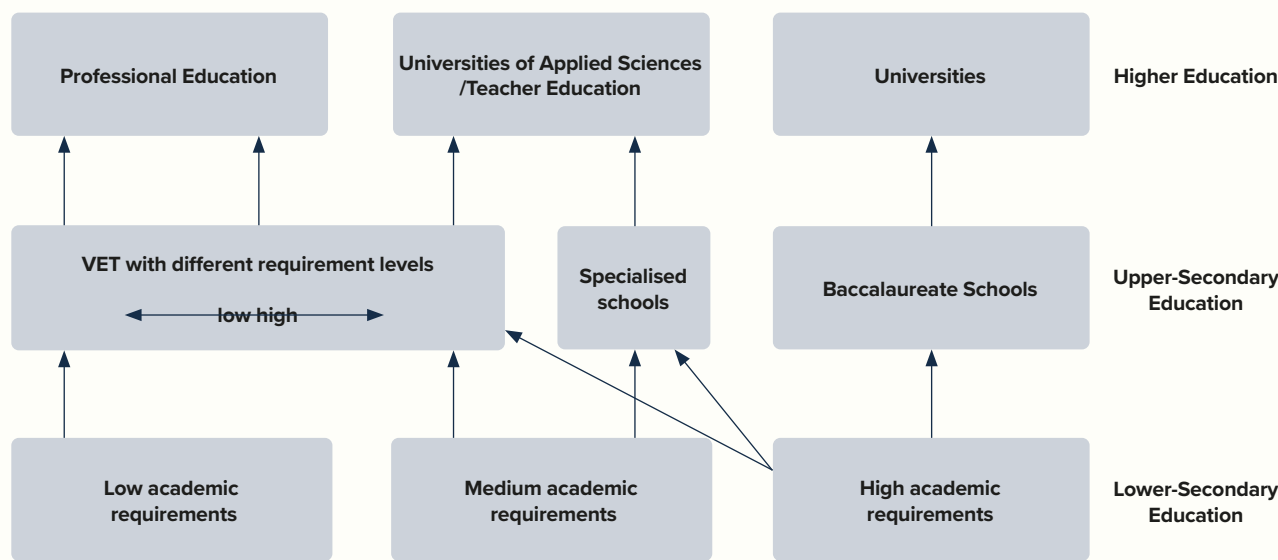


Figure 3. The Swiss education system: The pathways between secondary and higher education (Basler and Kriesi, 2019).

#### 2.9.4 Alternative school models

Duffield (2018) proposes that alternative school models are one way to meet the needs of children who have not succeeded in the traditional school format. Aron (2006) discusses the concept of alternative programming as an approach to support children with multiple and varied needs, such as social and emotional and behavioural difficulties. The characteristics of this approach are small class sizes, teachers with experience in alternative education, a highly structured and collaborative environment and integrated classes (Vann et al., 2000), and links with outside support agencies including mental health providers (Weir, 1996).

#### 2.9.5. Adverse Childhood Experiences (ACEs)

The World Health Organisation (2018a) defines adverse childhood experiences (ACEs) as ‘some of the most intensive and frequently occurring sources of stress that children may suffer in early life. Such experiences include multiple types of abuse; neglect; violence between parents and caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence’. Following exposure to stress, the body’s natural response is to stimulate the sympathetic nervous system, increasing the levels of stress hormones, such as cortisol, and other responses, such as an increase in respiration, heart rate and blood pressure (Dusek and Benson, 2009). When the stressor has been removed, in most cases, this is followed by the activation of the parasympathetic nervous system, acting as a counterbalance (Skonkoff et al., 2011) to return the body to ‘normal’ (Franke, 2014). Prolonged, permanent or extreme exposure to stress can lead to prolonged stress hormone activation, which cumulatively leads to ‘wear and tear’ on organs including the brain (Johnson et al., 2013). This is known as toxic stress and in the absence of supporting adults acting as a buffer, has been linked to physiological changes that can lead to developing poor health outcomes in later life and adolescence.

These include depression, anxiety, sleep disorders, low self-esteem, substance misuse and risky health behaviours (Dunn et al., 2013; Vachon et al., 2015; McKelvey et al., 2017; Thorley and Coates, 2018).

Cooper and Mackie (2016) share that resilience is a positive and adaptive response, which can transform ‘toxic stress’ into ‘tolerable stress’. They also provide evidence from research that one stable and committed relationship from either a supportive caregiver or another adult or peer can reduce stress. An additional protective factor described by Schofield et al. (2018) is community cohesion, which can reduce the impact of ACEs across generations.

#### 2.9.6. Challenging, violent and aggressive behaviour(s) (CVAB)

Thorley and Coates (2018) introduced the term CVAB to encompass a range of previous acronyms used to define children’s behaviour, these included CPV (Child to Parent Violence), APVA (Adolescent to Parent Violence and Abuse), and VCB (Violent Challenging Behaviour). In schools and at home, children can display behaviour that is viewed as challenging, aggressive or violent by those who observe it. Knowing how best to support children with unpredictable behaviours is complex. However, such support is crucial for the health and wellbeing of all concerned (Martin-Denham and Watts, 2019). They discuss that behaviours may arise due to trauma, adverse childhood experiences, bereavement or identified/unidentified special educational needs or learning/physical disabilities. Staff need to be enabled, through training, to understand and manage these behaviours or they will continue or escalate, ultimately leading to both the teacher and the child becoming increasingly distressed.

It is widely understood that children with autism may experience intense anxiety due to difficulties with communication and interaction with teachers and peers. Many factors can lead to increased anxiety, such as being over- and/or under-stimulated, or undiagnosed due to



changes to school timetables or classroom routines or staffing (Martin-Denham and Watts, 2019). They add that if a child is in crisis or there has been an incident involving CVAB, there should be a debrief to see how this could be prevented. However, attempting to debrief with children at the point of the behaviour is unrealistic. It is therefore important to **relate** before any attempt is made to **regulate**. It is important to note that when a child reaches the point of crisis, it means school processes have failed; a need has not been met and this needs to be explored through debriefing systems to plan to prevent future occurrences.

### 2.9.7. Zero tolerance and non-flexible behaviour policies

As Booth and Ainscow (2011) discuss, developing inclusion involves reducing exclusionary pressures. They use the term 'disciplinary exclusion' to refer to the temporary or permanent removal of a child for breaches of school rules. What needs to be understood is that some children have ongoing pressures that prevent them from participating in school life including: dealing with previous or current trauma, or learning challenges, including specific learning difficulties or ongoing unmet needs (Martin-Denham and Watts, 2019). The DfE (2018) reported the evidence from the Timpson Review highlighted a rise in 'zero tolerance' behaviour policies which create school environments where children are punished and excluded for incidents that could have and should have been managed within the mainstream school.

During adolescence, there are 'rapid cognitive, biological and social changes that may increase misbehaviour' (Amemiya et al., 2019, p. 3). Gregory and Cornell (2009) and Kupchik and Catlaw, (2015) concur that internationally, discipline policies in schools don't consider or allow normative adolescent behaviours. As part of this developmental stage, children need to establish autonomy from adults, which may involve stepping outside of boundaries (Eccles and Roser, 2013; Bryan et al., 2016). A driver for children in using low-level behaviours can be to gain acceptance from peers and to achieve autonomy (Shulman et al., 2016).

In recent years there has been a rise in punitive discipline for low-level behaviours such as making jokes, uniform breaches and laughing (Okonofua et al., 2016). The issue of conformity to school rules is nationally published, with children being excluded from schools in England for reasons such as: not wearing the right uniform or wearing too much makeup (Horton, 2017). Munn and Lloyd (2005) express that children behave differently in different classrooms and that a critical influence on their behaviour is the teachers own self-concept and sense of self-esteem, they can label children based on reputation.

The American Psychological Association (APA, 2008) reviewed the evidence on the effectiveness of zero-tolerance behaviour policies and found they negatively impact:

1. The relationship between schools and the criminal justice system
2. Child development (adolescents who receive severe consequences due to poor judgement even though their brains are still developmentally immature)

The House of Commons (2018, p. 13) view is that 'it would be reasonable for schools to take a zero-tolerance approach to drugs or weapons. A school culture which is intolerant of minor infractions of school policies, haircuts or uniforms, will create an environment where pupils are punished needlessly where there should be a degree of flexibility and a degree of discretion'. This correlates with the views found in research that adolescents may react to discipline for minor infractions by re-establishing their autonomy through defiant behaviour (Brehm, 1966; Bryan et al., 2016, Okonofua et al., 2016). Munn and Lloyd (2005) advocated active pupil participation in school and classroom decision making about rules, rewards and sanctions. This would not necessarily eradicate disruption, but it could minimise it and enhance pupil-teacher relationships. The remaining sections of chapter 1 focus on key issues that impact on children's ability to participate and learn in schools.

### 2.9.8. Class sizes

In 2017, English primary school class sizes were deemed to be the third-largest among the 37 Organisation for Economic Co-operation and Development (OECD) countries (2019), and secondary education classes the 14th largest. They remark that England is unique in that numbers per class decrease between primary and secondary (averaging 27 at primary and 23 at lower secondary). It is widely accepted that classroom engagement decreases in larger classes and this is particularly evident for lower attaining children at secondary school age (Smith and Glass, 1990; Blatchford et al., 2011; Sanders et al., 1997). An alternative view was previously given by Sanders et al. (1997) that it is not the class size that makes the difference to learning but the quality of the teachers. The recently held view is that teachers who have large class sizes cannot be expected to effectively and consistently provide individualised educational support (Webster and Blatchford, 2017). Hart et al. (2011) reported that children with attention deficit hyperactivity disorder (ADHD) would be more 'on task' during small-group instruction than both whole-class teaching and independent activities. They suggest that for best results, small class sizes should be introduced immediately following school entry (Blatchford et al., 2003) as these enable teachers to individualise teaching and to differentiate the curriculum (Graue et al., 2008). However, Blatchford et al. (2011) note that what is considered to be a 'small class size' is of ongoing debate due to a lack of research in this area.

### 2.10. Enablers to mainstream schooling

Cosma and Soni (2019) argue that children feel their educational provision is not appropriate for their needs, and that pressures are too high and levels of support are too low. These findings have been reported in other research, identifying that the reason they have negative behavioural responses is justified because teachers don't meet their learning needs even when they are asking for help (Nind et al., 2012). Michael and Frederickson (2013) and Tellis-James and Fox (2016) carried out research with children

with SEMH needs who, when asked, said they needed a personalised curriculum that took into account their strengths, and emotional and behavioural difficulties.

The Code (DfE, 2015a) shares a definition of disability that draws upon the Equality Act (2010). This explains that children have a disability if they present with '... a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities' (p. 135). This definition provides a relatively low threshold for disability and includes more children than many realise. 'Long-term' is defined as 'a year or more', and 'substantial' is defined as 'more than minor or trivial'. The following needs are automatically treated as a disability under the Equality Act (2010). The DfE (2014c) guidance, 'The Equality Act 2010 and schools', is explicit that the overriding principle of the equality legislation is that schools may be required to treat those with disabilities differently by making reasonable adjustments. The duty to make reasonable adjustments applies only to children with disabilities. For schools, the duty is summarised as follows:

- Where something a school does places a disabled pupil at a disadvantage compared to other pupils, then the school must take reasonable steps to try and avoid that disadvantage.
- Schools will be expected to provide an auxiliary aid or service for a disabled pupil when it would be reasonable to do so and if such an aid would alleviate any substantial disadvantage that the pupil faces in comparison to non-disabled pupils (DfE, 2014c).

### 2.10.1. Relationships

Positive teacher-student relationships are believed to have an energising function that supports positive academic-related outcomes (Furrer et al., 2014). The higher the quality of this relationship, the more likely the child is to participate in and enjoy school (Martin and Collie, 2019). Ruzek et al. (2016) highlighted that where classrooms had emotionally supportive teachers, the children experienced more autonomy, resulting in positive outcomes. This correlates with research that has identified that positive relationships with staff contributes to a more positive schooling experience for children (Sellman, 2009; Nind et al., 2012; Jalali and Morgan, 2018). Meehan et al. (2003) and Martin and Dowson (2009) agree, adding that positive teacher-pupil relationships are a protective factor which can help children manage in school despite their difficulties.

Previous research identifies how children feel negatively perceived by teachers due to their past behaviours and experiences within education (Nind et al., 2012; Michael and Fredrickson, 2013; Sheffield and Morgan, 2017), and how children believe teachers focus on the negative aspects of their behaviour (O'Connor et al., 2011). Negative teacher-student relationships are considered to have a cumulative and chronic effects on children's outcomes (Wentzel, 2009; Hughes et al., 2012). Cosma and Soni (2019) agree that past negative relationships with teachers are a key contributor to behavioural responses and subsequent school exclusion. NICE (2017) advocate training and development to ensure teachers have the knowledge, understanding and skills to build successful relationships with children and to deliver the curriculum effectively. This should include activities to support children in developing social and emotional skills and wellbeing to prevent behavioural difficulties in all areas of school life.

### 2.10.2. No contact policies

Research on the importance of touch for children dates back to the 1940s, with studies by Spitz (1945, 1946, 1951) and Harlow (1959, 1963) highlighting the importance of touch and physical proximity for healthy physical, mental and social development. The need for children to have physical contact to develop and feel good continues to be documented (Andersen, 2008; Underdown et al., 2010, 2013; Johansson, 2013). The benefits of touch are: reduced stress and a positive impact on well-being (Field, 2002). The DfE (2019, p. 29) 'Keeping children safe in education' guidance states that 'the adoption of a 'no contact' policy at a school or college can leave staff unable to support and protect their pupils and students fully. It encourages headteachers, principals, governing bodies and proprietors to adopt sensible policies, which allow and support their staff to make appropriate physical contact'. This guidance supports the use of physical contact with children where there is a need and a want. As Piper and Smith (2003) and McWilliam and Jones (2005) suggest, consideration needs to be given to who may touch the children and when and how it should take place. Physically touching children in education continues to be a difficult subject and one which requires respect for the child's body (Ohman, 2016). The reasons why touch does not happen is due primarily to the fear of being vulnerable to suspicion of abuse and paedophilia (Munk et al., 2013). This is the case for both men and women working with children, who worry it will create suspicion and distrust (Piper et al., 2012). In summary, the literature over the last eighty years states that what is harmful to children is not too much but too little touch (Piper et al., 2012).

### 2.10.3. Noise

Noise has been defined as ‘unpleasant sounds which distract the human being physically and physiologically’ (Melnick, 1979, p. 72). Sensory processing is the way the central and peripheral nervous systems manage incoming sensory information from the sensory organs, namely visual, auditory, tactile, taste, smell, proprioception and vestibular (Fernandez-Andres et al., 2015, p. 203). Sensory processing difficulties have been reported as highly prevalent in the case of children with autism spectrum disorders (ASD) (Baranek et al., 2006; Costa and Lampreia, 2012) and children with other aspects of neurodiversity (Cheung and Sui, 2009; O’Brien et al., 2009; Wiggins et al., 2009). For children with ASD, 70% are believed to have hypersensitivity to auditory stimuli (Bromley et al., 2004). This can include unexpected sounds such as fire alarms, toilets flushing, children’s voices, clapping and acoustics (Dickie et al., 2009). It has been shown that noise can have a negative effect on health and physiological and psychological outcomes (Atmaca et al., 2005). Suter (1989) shared that the physiological effects can interfere with performance in tasks, startle response, increase muscle tension and increase aggressive behaviour. Atmaca et al. (2005) add that psychological effects include irritation, anxiety, anger, restlessness and lack of concentration. When children are distracted by noise, it decreases attention (Shield et al., 2010). Noise can be felt from teachers, the classroom environment, external to the school, heating, ventilation and air conditioning (Woolner and Hall, 2010). The literature on the detrimental effects of noise on children’s mental health shows that for those with sensitivities, there needs to be consideration of noise buffering in classrooms (Kanakri et al., 2017).

### 2.10.4. Belonging

Osterman (2000) carried out a comprehensive review of school connection and found that having a sense of belonging is associated with a healthy child and adolescent development. To achieve this, children need to feel related to the school environment and to have positive attitudes towards classwork, teachers and their peers. This view has recently been supported by Nind et al. (2012) and Tellis-James and Fox (2016), who shared that positive educational experiences are achieved through children securing a sense of belonging, through in-school and extra-curricular activities (Bouchard and Berg, 2017). Mann and Lloyd (2005) propose that routine practices in school can promote, or not, a sense of belonging through how interested teachers are in children’s lives and the mutual respect between them and children. The impact of not being connected is associated with negative behaviours in the classroom, low engagement in lessons and lower achievement (Osterman, 2000). A sense of belonging is more likely in primary school but less evident for some children in secondary education, who felt a lack of connectedness, due to feelings of inadequacy and academic failure (Jalali and Morgan, 2018).

## 2.11. Access to health services

Multi-agency working has been at the core of child mental health policy in recent years, with the aim of providing comprehensive and seamless services for children, young people and their families, particularly those with complex difficulties (O’Reilly et al., 2013, p. 7). The Department of Health and NHS England’s Task Force on Children and Young People’s Mental Health and Wellbeing recognised there was fragmentation and a ‘lack of cohesion’ leading to children falling between the gaps in service provision (2015a, p. 3). The Future in Mind report, 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’ (Department of Health and NHS England 2015b, p. 57).

### 2.11.1. Definitions and prevalence of mental health

The World Health Organisation (2018b) defines mental health as ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to the community’. Within the Code (DfE, 2015a), social-emotional and mental health (SEMH) difficulties are one of the four broad areas of need. The Mental Health Taskforce (2016) advises that certain groups of children are more susceptible to develop mental health difficulties, including those who are looked after, previously looked after, have disabilities, have long term health needs or are in the criminal justice system. NHS digital (2018) identifies that mental health difficulties develop early and that between the ages of five and 15, one in nine children will have a diagnosable mental health need. This is an increase from the 1 in 10 figure reported by NHS England in 2017. It is also understood that half of all mental health challenges become established by the time the child is 14 (Kessler et al., 2005).

Martin-Denham and Watts (2019) remark that difficulties with mental health can vary in intensity, duration and the impact they have on the child, their needs and their behaviours, and the extent to which they impact on their ability to participate and learn in school. NHS (2015a) report that mental health needs can vary from short spells of depression to severe and persistent conditions that can disrupt, isolate and frighten those who are experiencing them. They are likely to coexist with other health and learning needs. Furthermore, mental health needs may lapse, return or remain throughout childhood into adulthood if not addressed early, increasing the likelihood of school exclusion, school refusal, teenage pregnancy and criminality (Beecham, 2014).

### 2.11.2. Health services

In 2017, the NHS set out an ambition to support clinical commissioning groups (CCGs) to work with partners to build effective, evidence-based, outcome focussed child and adolescent mental health services (CAMHS). NHS England’s guidance to CCGs was that they are expected to commission complementary provision for children who do not meet the minimum thresholds for specialist CAMHS support (Children’s Commissioner Office, 2018b). In Sunderland, children who do not reach the minimum threshold of Tier 1 (see below) are referred to partner organisations and/or voluntary organisations (Sunderland CCG, 2019).

**Tier 1:** services for children, young people and their families with mild, early-stage problems delivered by non-specialist primary care workers, including teachers, school nurses and health visitors

**Tier 2:** services for children, young people and their families with moderate levels of mental health need to be delivered by specialised Primary Mental Health Workers

**Tier 3:** services for children, young people and their families with complex, severe or persistent levels of mental health provided by specialist multidisciplinary teams

**Tier 4:** services for children, young people and families with highly complex, severe or persistent levels of mental health need often delivered in a specialised day and in-patient settings



In addition to this and, particular to Sunderland, children who are identified as having ‘special circumstances’, that is, who belong to an ‘at-risk group’, who are more likely to develop mental health problems will not be seen by CAMHS but are instead referred to CYPS. Special circumstances include those who have:

1. Learning disabilities
2. Been looked after or accommodated, including those who have been adopted
3. Been neglected or abused, or are part of a child protection plan
4. Learning or physical disability
5. A chronic, enduring or life-limiting illness
6. Substance misuse issues
7. Risk of, or have been involved in offending
8. A status of homeless or who are from families who are homeless
9. Parents who have problems including domestic violence, illness, dependency or addiction
10. Been placed out of the area
11. Been placed in a secure placement
12. Parents in prison
13. Identified as being a minority ethnic or minority cultural background including travellers
14. Not been involved in education, employment or training.

(Sunderland CCG, 2019)

This special circumstances list would mean that many children are unable to be assessed by CAMHS and would then join the waiting list for Children and Young People’s Services (CYPS). This is a single service that is provided for children who are presenting with mental health difficulties. In most NHS Trusts, the age range for referrals is 0-18 years. In Sunderland, they provide tier 2 targeted services for children in the above special circumstances and Tier 3 mental health assessment and intervention.

In 2018, a report by The National Association of Headteachers described how 45% of school leaders encountered difficulties commissioning mental health support for children in their care. They claimed that not knowing what support was available was a barrier to providing effective mental health support. A lack of

information available to service users is widely acknowledged in research, in particular not knowing where a service is, the pathways, or how to make an appointment to seek mental health support (Boyd et al., 2011; McCann and Lubman, 2012). Caregivers have also cited not knowing where to go as a barrier to seeking support for their children (Iskra et al., 2015). Anderson et al. (2017) believe this is a common issue due to services not being well publicised. Hence, caregivers have to ask around to find where to request support. This is a particular issue for those with language barriers (Williams et al., 2013).

Crenna-Jennings and Hutchinson (2018) examined how many children were referred to mental health support and how many weren’t accepted. Their findings were:

- Over the last five years, the number of referrals to CAMHS has increased by 26%
- Approximately 55,800 children were not deemed appropriate for support
- Self-harm did not always trigger specialist services
- The average waiting time to be seen in 2017-18 was 34 days for assessment and 60 days for treatment

It has been identified by Bone et al. (2015) that there has been investment on and growth of CAMHS services in recent years but that the service varies across local areas and it is failing to fully meet demands (Rao et al., 2010). Multiple studies have identified that long wait times are the most commonly cited barrier to engaging with mental health services from service users (Golding, 2010; Vohra et al., 2014; Iskra et al., 2015; Anderson et al., 2017). There is also a suggestion that adolescents find long wait times frustrating, making them feel their issues are not considered severe enough to be heard. This deters some from persevering with gaining an appointment (McCann and Lubman, 2012). Overall, the evidence suggests that long waiting lists have a negative impact on family engagement with services for mental health support as there is a link between delays

in appointments being scheduled, the length of time between referral and appointment, and the likelihood of the service user attending the initial consultation (Gallucci et al., 2005; Westin et al., 2014).

A further barrier to ensuring children attend mental health appointments is complex administration procedures, such as having to make numerous 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). An additional frustration for caregivers is having to make multiple referrals to get to the right service, only to be referred to another service and then joining another long waiting list (Iskra et al., 2015). Reid et al. (2011) highlight that caregivers have to find different health professionals for a range of issues. Historically, it has been reported that to overcome administrative barriers to CAMHS, you have to be demanding, persistent, vocal, pushy, complain and write letters (Boydell et al., 2006). Barwick et al. (2013) suggest that providing community walk-in clinics has been shown to improve access to care for those disengaged by complicated referral procedures and long waiting lists. Service users were seen quicker and subsequently needed fewer appointments. Phone-based interventions and video conferencing have been shown to increase intake and uptake of future appointments (Calvaleri et al., 2010; Boydell et al., 2014). Similar positive results have been found in mental health services through online forums and advertising in places where services can be seen by children (Anderson et al., 2017).

### 2.11.3. Funding for health services for children

The NHS reports that funding has fared better for the organisation compared to other public services, but funding per person will reduce in 2018/19 and 2019/20 (2019a) as capital investment has been limited over recent years (Office for Budget Responsibility, 2016). NHS funding, like other public services, is reliant on a well-performing UK economy. Due to the

recession in 2008, NHS funding growth has been slower than historical trends (IFS, 2016). The Children's Commissioner Office (2018a) states that health spending in England is poorly measured and that many children's health services tend not to be for acute health problems, so are more vulnerable to cuts.

## 2.12. School exclusion

'Fixed-period' and 'permanent' exclusions were introduced in 1986 in the UK as a last resort to remove a child from school when they were deemed to be persistently or severely deviating from the school's behaviour policy (Education Act, 1986). The 2011 Education Act is the main statute that sets out duties when excluding a child. Independent Provider of Special Education Advice IPSEA (2017) confirms that there are two lawful types of exclusion; permanent and fixed-period. Only the headteacher of a school (or the teacher in charge of a pupil referral unit or the principal of an academy) can exclude a child. The legal stance is that a child is either in school full time or excluded, so informal or unofficial exclusions, such as sending a child home for the afternoon following an incident are unlawful (Martin-Denham and Watts, 2019). They add that if a caregiver is asked to keep their child off school, it is an exclusion, whether it is leaving early, at lunchtime or being part-time. All exclusions must be recorded in school and reported to the Local Authority (LA).

Unlike other nations within the UK, permanent exclusions in England have risen significantly in recent years (Power and Taylor, 2018). Data presented in Table 1 shows that England had the highest rates of both fixed and permanent exclusions in the UK, with thousands excluded between 2015/16 compared to only five in Scotland.

**Table 1:** Rates of fixed-period and permanent exclusion across the UK in 2015/16

| Nation           | School Population | Fixed Period Exclusions | %   | Permanent Exclusions | %        |
|------------------|-------------------|-------------------------|-----|----------------------|----------|
| England          | 8,559,540         | 339,360                 | 4.0 | 6,685                | 0.08     |
| Scotland         | 680,007           | 18,430                  | 2.7 | 5                    | 0.02     |
| Wales            | 466,555           | 15,051                  | 3.2 | 109                  | 0.000007 |
| Northern Ireland | 339,785           | 4,147                   | 1.2 | 19                   | 0.0006   |

It has been suggested by Parsons (2005) that the reason for markedly different profiles between the countries is due to differing reform agendas of the four nations in the UK and in particular the negative consequences of education policies in England. The ‘marketisation’ of education in England has created pressures for schools to exclude children who will negatively affect performance data and league tables (Booth et al., 1997). The introduction of academy schools, which remain outside of the Local Authority (LA) system, has resulted in academies having a lower number of children with SEN compared to those forced to convert due to low attainment (Norwich, 2017). This view has been supported by Gazeley (2010), who reported findings in one LA that schools have difficulty reconciling the need to meet academic targets and to do well in Ofsted inspections with inclusive approaches to managing behaviour. Academies and free schools, which are growing in number, are more likely to exclude than any other type of school, as they operate outside of LA control (West and Bailey, 2013; Gorard, 2014).

2.13. Internal exclusion

The Department for Children Schools and Families (DCSF) (2008) signalled the way for ‘internal exclusion’ or ‘remove rooms’ in their now archived guidance to schools on good practice. These are described as an internal process within the school to remove the pupil from class, not from the school site, for disciplinary reasons. The guidance goes on to clarify that the child should receive an appropriately supervised education for the shortest period possible and be allowed to reflect on their behaviour. Ofsted (2018) confirm that schools can place children in isolation for a limited period; this should be made clear in

behaviour policies and be lawful, reasonable and proportionate. The key issue in England is that the Department of Education appears to be delegating ethical responsibility for its use to the schools themselves and there is no clarification of the meaning of what is meant by ‘for a limited period’ (DfE, 2016). It is also of concern that it is for schools to decide how long a child should be kept in isolation and for staff to determine what they may and may not do during the time they are in there. This ‘advice’ gives schools free rein to do as they see fit with no accountability or monitoring of the frequency or impact on the child’s holistic development.

Barker et al. (2010) suggested that in the UK the introduction of school based-internal exclusion, now commonly known as ‘isolation’ was a response to political pressure on schools to raise standards, reduce school exclusions and to remove ‘undesirable’ children from public spaces during school hours. The House of Commons (2018) shared their evidence that children had been put in isolation in mainstream school for large parts of the academic year; some for behaviour and some for self-protection from bullying. The children’s responses in this evidence included ‘they would give you a book to copy from; there would be no real learning’. Furthermore, one of the most important social factors predicting healthy behaviours and development in adolescents is having peers (Umberson et al., 2010). There is evidence that isolating children may increase risks of ill health, substance misuse, self- medication, anxiety and loneliness (Hall-Lande et al., 2007; Osgood et al., 2014) and anti-social activities (Kreager, 2004). These findings are at odds with the DfE requirement (2016) that schools must ensure the health and welfare of the child during their time in isolation.



The option to isolate children has led to schools having less inclusive approaches to behaviour management. With local authorities having increasing numbers of academies beyond their control, they are powerless to intervene (Gazeley 2010; West and Bailey, 2013; Gorard, 2014). Power and Taylor (2018) theorise that if definitions of school exclusion were to be expanded to include the range of practices that schools use to remove children from the mainstream classroom, while keeping them on the school roll, the rate of exclusion would be higher than official data. Currently, this casts doubt on how useful official exclusion data is in indicating how inclusive a school is.

The Human Rights Act 1998 provides the fundamental rights and freedoms that apply to everyone in Britain. They incorporate the rights from the European Convention on Human Rights (ECHR) into domestic law (Ofsted, 2018). The following rights are relevant to the use of isolation and restraint:

- Article 3- Prohibition of torture: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
- Article 5- Everyone has the right to liberty and security of person
- Article 8 - The right to respect for private and family life
- Article 14 - Prohibition of discrimination

(Council of Europe, ud)

A report by the Centre for the Advancement of Positive Behaviour Support (CAPBS) (2015) suggests that the use of seclusion in schools could breach Article 5 of the Human Rights Act:

- Outside of an emergency situation where staff need to exercise the duty of care to prevent harm, seclusion is not acceptable and is likely to be a breach of Human Rights and criminal law, i.e. false imprisonment

- Any emergency use of seclusion should trigger a review
- Any Deprivation of liberty needs legal authorisation (outside of lawful detainment)
- Seclusion is not therapeutic and is likely to cause psychological harm
- Schools should issue clear guidance to staff on the use of isolation and punitive responses to children with special needs, and review blanket policies
- ‘Time out’ is a psychological intervention. It should not be used as a matter of course. Staff should be clear about the difference between ‘time out’ and the use of ‘time away’ as a proactive strategy.

The attitude of the Department of Education is in stark contrast to the guidelines issued by the Department of Health (2014) regarding the use of restrictive practices: restrictive practices should never be used as punishment. The Mental Health Code of Practice states unequivocally that ‘seclusion can be a traumatic experience for any individual but can have particularly adverse implications on the emotional development of a child or young person’ (Centre for the Advancement of Positive Behaviour Support (CAPBS, 2015). Yet, here we have children being systematically subject to seclusion. This correlates with historical research by Miller (1986), one of the few researchers to have examined the use of exclusion on children by drawing images of the experience. Their descriptions conveyed punishment, fear and abandonment. The Department of Health (2014, para 87) defines seclusion as ‘the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving’. This looks remarkably similar to the use of isolation within English schools.

## 2.14. Restraint

The use of 'restraint' in English schools is set out in the document, Use of Reasonable Force: Advice for headteachers, staff and governors (DfE, 2013), which clarifies that 'reasonable force' cannot be used as a punishment. The Keeping children safe in education guidance document (DfE, 2019, p. 29) clarifies:

**'The term 'reasonable force' covers the broad range of actions used by staff that involve a degree of physical contact to control or restrain children. This can range from guiding a child to safety by the arm to more extreme circumstances such as breaking up a fight or where a young person needs to be restrained to prevent violence or injury. 'Reasonable' in these circumstances means 'using no more force than is needed'. The use of force may involve either passive physical contact, such as standing between pupils or blocking a pupil's path, or active physical contact such as leading a pupil by the arm out of the classroom'.**

However, recent research has found that in some schools, physical restraint had been used as a form of punishment (McCluskey et al., 2015). 'Restraint means to hold back physically or to bring a pupil under control, and is typically used in more extreme circumstances, for example when two pupils are fighting and refuse to separate without physical intervention' (DfE, 2013, p 4). Restraint is permissible in education to keep children or staff safe; there is no legal duty to record or report incidents when restraint has been used (Ofsted, 2018). They add that the expectation is that adults must be skilled and confident in finding the best way to keep children safe in ways that promote their rights, respect their dignity and equip them for the future. Isolation and seclusion in school are classified as a restriction on children's lives, and include locking doors, leaving a child alone and time out. The Equality and Human Rights Commission (2020) has launched an inquiry into how schools in England and Wales are monitoring and recording the use of restraint and restrictive practices. This has arisen due to concerns about the lack of data available on these approaches.

The Physical Control in Care Medical Panel (2008, as cited in DfE, 2013, p.6) outlined how the following restraint techniques pose an 'unacceptable risk when used on children and young people', they are:

- The 'seated double embrace' where two members of staff force a child into a sitting position and lean them forward, while a third member of staff monitors breathing
- The 'double basket-hold' which involves a member of staff holding a child's arms across their chest and;
- The 'nose distraction technique' which involves a sharp upward jab under the child's nose.

The DfE guidance (2019, p. 29) is clear that in response to risks presented by children with SEN, disabilities or medical conditions that:

**'Schools and colleges should in considering the risks carefully recognise the additional vulnerability of these groups. They should also consider their duties under the Equality Act 2010 in relation to making reasonable adjustments, non-discrimination and their Public Sector Equality Duty.<sup>41</sup> By planning positive and proactive behaviour support, for instance through drawing up individual behaviour plans for more vulnerable children and agreeing on them with parents and carers, schools and colleges can reduce the occurrence of challenging behaviour and the need to use reasonable force'.**

A Freedom of Information request in 2017 by the BBC to local authorities in England, Scotland and Wales revealed that there were 13,000 physical restraints in the past three years, resulting in 731 injuries. However, the majority of LAs did not respond with figures, arguing that they did not keep such data (Harte, 2017). This suggests that the use of restraint, including harmful restraint, is much more widespread in British schools. For a child facing a potential or actual restraint, their body becomes hyper-aroused because they sense danger and perceive it as abuse. As they struggle, there is potential for injury and death through resisting the restraint or the sheer force of those carrying out the restraint (Mohr and Mohr, 2000).

Ofsted (2018, p.3) clarify that staff should work positively and confidently with children and find the least intrusive way possible to support, empower and keep children safe. This should include:

- building relationships of trust and understanding
- understanding triggers and finding solutions
- if incidents occur, defusing the situation and/or distracting the child wherever possible

All restrictive practices within health and social care are subject to clear ethical principles and guidelines, found in Positive and Proactive Care: reducing the need for restrictive interventions (DoH, 2014) and the Mental Health Code of Practice (DoH, 2015). Restrictive practices are highly contentious in health and social care settings and are circumscribed by strict ethical guidelines following the Winterbourne Scandal (2011). The spectrum of restriction ranges from isolation and seclusion to long term segregation, from chemical, mechanical and physical restraint. These latter techniques are used to control extreme and out of control behaviour of individuals. However, in practice, as at Winterbourne, they can be used as facilitating tools for an aggressive and uncontrolled regime based on cruel and malevolent intent. The Department of Health guidance for the use of restrictive

interventions (2014) provides six fundamental principles:

- Compliance with the relevant rights in the European Convention on Human Rights at all times
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced
- Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable, and subject to the person's wishes and confidentiality obligations
- People must be treated with compassion, dignity and kindness
- Health and social care services must support people to balance safety from harm and freedom of choice
- Positive relationships between the people who deliver services and the people they support must be protected and preserved

Within health, there is a requirement for all services who use restrictive interventions to have in place 'restrictive intervention reduction programmes' to use less detrimental alternatives to restraint (DoH, 2014). They also provide post-incident reviews, which are a recommendation of this research

The American Psychiatric Association (2003) suggest alternatives to the restraint of children, to enable trying to determine the underlying message conveyed by the child's behaviour(s), so that the cause can be identified and the child supported. This is also advocated within the DfE (2015a) Code. Other recognised strategies are: positive reinforcement by spending more time with the child, with a focus on good behaviours, rather than negative reinforcement of secluding them in the hope this will modify behaviour. This approach saw a 97% reduction in seclusion episodes in two months (Irwin, 1987). Some training courses promote person-centred approaches to crisis management to negate the

need for physical intervention, such as studio 3's three-day 'managing challenging behaviour' programme, accredited by British Institute of Learning Disabilities (BILD).

## 2.15. Outdoor learning and physical activity

Internationally, an all-encompassing definition of outdoor education is scarcely possible due to the range of different meanings, understandings and practices in research, countries and cultures (Allison, 2016). Waite et al. (2015) examined the context of regular outdoor education within the school curriculum, comparing Danish and English approaches, and focusing on aims, pedagogy, content, outcomes and barriers. They found that both methods seem to support children in social, academic, physiological and psychological wellbeing. This was echoed in a systematic review by Becker et al. (2017), who shared that regular curriculum-based outdoor learning advances physical and psychological learning, and social dimensions. The barriers to outdoor learning include: cost of transportation, travel time, extra teacher and qualifications (Waite et al., 2015).

The Good Childhood Report (2018, p.40) says that over a third of children (38%) said they had been physically active on five or more days in the past week. It adds that children with low life satisfaction and those with more serious emotional and behavioural difficulties and depressive symptoms were less likely to be physically active than other children. In research shared by Fix et al. (2019), teachers were convinced of the positive effect of physical activity and sport for children's social development. This supports other findings by Bailey (2005), and Donaldson and Ronan (2006), who also found the benefit of sport on both social and emotional development. Though it needs to be noted that for some children, sport can negatively impact on their self-esteem if they perceive they have lower-level skills than their peers (Fraser-Thomas and Côté, 2009). Overall, the literature suggests that sports may be useful for at-risk children when there is a positive peer group climate and good relationships with teachers (Sandford, 2006; Bruner et al., 2011).

The next section describes the methodological approaches employed to answer the following research aims and objectives:

### Research aim

To investigate the factors that impact upon social and emotional wellbeing of children and young people from 3-16 years in Sunderland Local Authority, which may lead to exclusion from school

### Research objectives

To elicit the perceptions and experiences of excluded children, their caregivers, and professionals, of the barriers and enablers to mainstream schooling

- To determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream school.
- To evaluate the effectiveness of national policy in supporting children to remain in mainstream school

To produce a report, with supporting evidence, to inform provision planning and training for education professionals within the local area of Sunderland

## 3. Methods

### 3. Methods

The method section presents the approaches adopted and procedures used when carrying out the research. Overall, the section will share the researcher's philosophical perspective, the data collection methods used, participant demographics and how they were recruited, data analysis and research ethics.

#### 3.1. Paradigm

The term paradigm is used to describe a researcher's philosophical perspective when carrying out research (Guba and Lincoln, 1986; Mackenzie and Kipe, 2006). Four main components make up a paradigm; epistemology, ontology, methodology and axiology. While detailed descriptions of these components are beyond the scope of this report, overall, they link the research philosophy to practice (Newby, 2014). When carrying out research that involves a level of interpretation, it is essential to disclose the researcher's underlying philosophical perspective as it directly influences the data collection methods, analysis and any final interpretation (Kivunja and Kuini, 2017).

The objectives of the research were to elicit and determine the enablers and barriers to mainstream schooling from the perspective of children excluded from school, their caregivers, headteachers and SENCOs. Therefore, an interpretive perspective was chosen for this research. This is summarised by the assumption that reality differs from person to person and is consequently subjective (Guba and Lincoln, 1994). Interpretivism predominantly uses qualitative data collection methods (Silverman, 2000; Willis, 2007; Nind and Todd, 2011), which are shown below.

#### 3.2. Methodology

As the aim of the research was to provide a detailed examination of participants' personal lived experiences, the qualitative approach chosen was interpretative phenomenological analysis (IPA) (Smith and Osborn, 2015). The

assumptions of IPA are that individuals make choices but are limited by their present conditions; this is known as situated freedom (Webb and Welsh, 2019). The research aimed to understand the participants' experiences and to develop a phenomenological interpretation as a whole, characterised by:

- An emphasis on the phenomenon
- A focus on the philosophical supposition;
- The use of interviews to collect data;
- Typically qualitative data analysis
- The culmination of a rich description of the phenomenon (Cresswell and Cresswell, 2013).

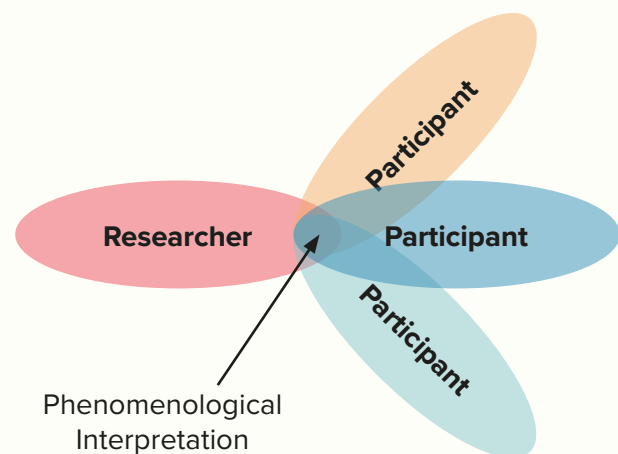


**Figure 4:** Phenomenological interpretation

Figure 5 below presents the steps that informed the research procedure for this study.

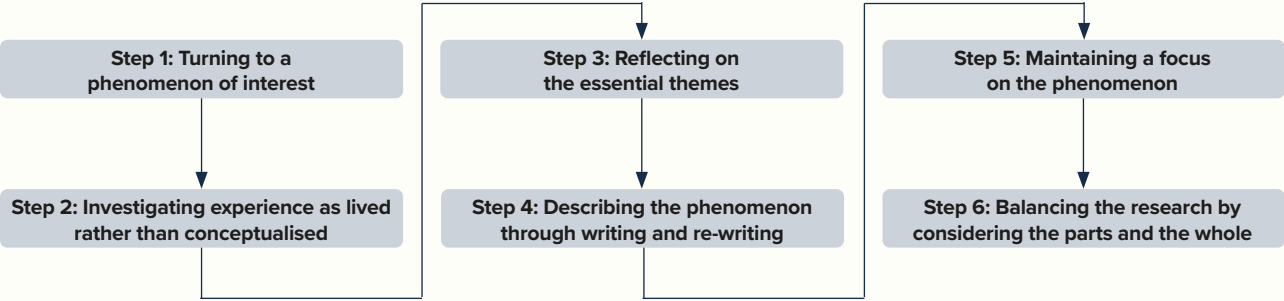


**Figure 5:** Phenomenological inquiry steps (adapted from van Manen, 1997)

**3.3. Methods**

The data collection methods used for this research were a combination of one-to-one and group semi-structured interviews. Semi-structured interviews use set questions, but also use an adaptable style to allow for relevant experiences or views to be explored (O’Leary, 2004). When interviewing children and young people, the term ‘conversation’ was used instead of ‘interview’. All interviews were recorded using a Dictaphone and transcribed verbatim, excluding any identifiable information.

**3.4. Participants**

There were 174 participants interviewed. The sample included 55 children, 41 of their caregivers, and 69 education professionals including head teachers from nursery to secondary age phase and 14 Special Educational Needs Co-ordinators (SENCOs) and class teachers. Nine health and support professionals were interviewed and there were an additional three advisory groups consisting of 12 children, five professionals from health/support services and five education professionals.



**Table 2:** Participant sample and subgroups

| Group             | Number    | Group                            | Number    |
|-------------------|-----------|----------------------------------|-----------|
| <b>Children</b>   | <b>55</b> | <b>Professionals</b>             | <b>78</b> |
| KS1               | 20        | Nursery headteachers             | 4         |
| KS2/3             | 15        | Primary headteachers             | 28        |
| KS4               | 20        | Secondary headteachers           | 9         |
| <b>Caregivers</b> | <b>41</b> | Specialist headteachers          | 4         |
| KS1               | 4         | ARP/AP headteachers              | 10        |
| KS2-3             | 16        | SENCO                            | 14        |
| KS4               | 21        | Health and support professionals | 9         |

3.5. Participant recruitment

Participants were recruited using purposeful sampling, which is described as the identification and ‘selection of individuals that are experienced in or are knowledgeable of the subject of interest’ (Cresswell and Plano Clark, 2011, p173). The principal investigator liaised with gatekeepers, who could brief school staff on the purpose of the research and in turn, relay this to the child and adult participants. Letters were sent home to caregivers to explain the study, to provide information sheets containing details about ethical considerations such as their right to withdraw and confidentiality, were sent home to caregivers to explain the study. These were followed up with telephone calls from the school or the research director. All children and caregivers in both provisions were given the opportunity to take part. They were told of the need for voluntary consent and their right to withdraw within six months of the interview taking place (British Educational Research Association, 2019).

Children were recruited from alternative provisions in Sunderland following gatekeepers’ permission. The children ranged in age from 5-16 and all apart from key stage one had been permanently excluded. Many had also received fixed-period exclusions. Two key stage one children had permanent exclusions and the remaining children were identified as being at risk of school exclusion by their school. None of the children had an education, health and care (EHC) plan and no caregiver reported their child as being on the SEN register. However, at the

time of the research, with children in alternative provision, some were on the SEN register, with a diagnosis of ASD, ADHD and SEMH.

Caregivers of children were recruited from the same provisions as children. Headteachers and SENCOs were invited to participate by the funder and the University Research team. Controls were put into place to recruit staff from schools with high and low exclusion rates, and a range of Ofsted rated schools were included as part of the sample. Where schools did not consent to take part in the research, replacement schools were sought and recruited.

3.6. Ethical procedures and compliance

The project was submitted to and approved by the University of Sunderland Ethics Committee in March 2018. The following section outlines the process that was adhered to when gaining voluntary and informed consent in accordance with the BERA (2018) and the five principles from the NSPCC (2018).



### 3.6.1. Caregivers' voluntary and informed consent

BERA (2018) clarifies that it is fundamental research practice to obtain voluntary informed consent prior to any research.

1. The information sheet and consent form was shared with the caregiver by the gatekeeper or member of the school team alongside a verbal explanation of the purposes of the research and to explain that participation was voluntary. This was to ensure that they understood the purpose of the project. At this stage, the caregivers gave consent to be interviewed and for their child to participate. For early years and key stage one, the research team visited the provision to meet caregivers to have casual conversations and to build trust (Gibson, 2012).
2. At the interview, consent was checked both in terms of signed/verbal consent prior to any recording on the Dictaphone.
3. At the end of the interview, the caregivers were asked if they would consent to their children taking part. This included sharing the questions the children would be asked with the caregivers, so they could make an informed decision. They also had the option of being present for the conversation, making them feel more comfortable with the researcher and strengthening cooperation (Greene and Hill, 2005). For any children who were designated as 'looked after', consent was gained from their social worker and foster carer, as appropriate.
4. All of the caregivers who were interviewed were invited to the University of Sunderland to be on the advisory group; none of the caregivers were able to take part.

### 3.6.2. Children's voluntary and informed consent

The challenge in this research was ensuring the children and young people had accessible (age and developmentally appropriate) information to make an informed choice about whether or not to take part. The school staff shared the research overview with all children and to gain initial consent. Because participation was not based on a one-off decision, consent was also obtained prior to the conversation with the researcher (NSPCC, 2018). On the day of the conversation, a comic strip was used to remind the children of the research (and to check they were fully informed) and to provide an opportunity to ask questions. Information that was reiterated included: how their views were confidential; that the conversation would last 20 - 30 minutes; how the children can say 'stop' at any time; and that they did not have to answer any questions they found difficult to talk about. The informed consent process for the children was as follows:

1. Once gatekeeper and caregiver consent were received, the school staff then explained the purpose of the research to the children. A list of those who wished to take part was created and kept within the school, so the participants were self-selected. If the caregivers consented to their child taking part but the child did not, the child did not take part in the research.
2. The venue was agreed.
3. On the day of the interviews, the researcher explained the purpose of the research to the child and gained formal consent using a comic strip and emoji faces with Yes/No next to them. This was to allow the children to indicate consent by circling their choice (the words were important should they not be able to identify with emotions on emojis). All children were given the opportunity to ask questions about the research and the process and structure of the conversation. Any children who did not consent (to either the caregiver or researcher) did not take part. This was important as it gave the children

time to reflect on whether or not they wanted to take part between being told about the research from the gatekeeper and the day of the conversations. For the children in early years and key stage one, the school team, represented by a safe and familiar adult, led the conversations with the children.

4. The date and time of interviews were flexible and were scheduled so that children would not miss favourite lessons or activities. Gibson (2012) suggests that the researcher engages in activities with children to promote the enjoyment of the process and create a partnership that builds trust and thereby decreases the power differential. In light of this, these activities took place with the children in key stage 2 before the conversation began. This is crucial in adult dominated places where children have even less control (Punch 2002). Given the themes within the interviews, there was a focus on building relationships with participants to obtain valid and reliable data.
5. All of the children who were interviewed were invited to the University of Sunderland to be on the advisory group. This was to discuss key themes from the headteachers' interviews for them to give a response. Twelve children from two alternative provisions attended and verbal consent was given to check they were still happy to participate in the research project (NSPCC, 2018).

### 3.6.3. Recording, transfer and storage of 'interviews' and 'conversations'

All individuals have the right to be informed about the collection and use of their personal data; it is an essential transparency requirement under GDPR. As part of this duty, participants in research must be provided with information including the purposes for processing their personal data, retention periods and who the data will be shared with - this is known as privacy information (Information Commissioner's Office, 2019). All participants were told where and how the audio recordings would be stored, how they would be anonymised and that the original recordings would be deleted when the

reports were published. They were also made aware that the data would be retained in the form of anonymised transcripts and used in future publications. The right to withdraw with time frames in accordance with BERA (2018) was also made explicit.

### 3.7. Specific ethical considerations for the conversations with children

Careful and informed thought was given to how children could be safely included in this research project. Avoiding personal and social harm to participants and researchers is the principal aim of ethical principles and guidelines (NSPCC, 2018). However, the NSPCC acknowledges that causing harm or upset can never be fully mitigated. In liaison with the schools, 'aftercare' was discussed and processes were put in place for any child needing specific support. The main risks identified for the children were that:

- Traumatic memories or feelings about school exclusion could be reawakened
- The questions asked could potentially uncover suppressed or new feelings
- There could be a disclosure relating to child protection
- The children could worry about what they had said following the conversation

It was felt that understanding the child’s perspective was crucial for integrating the opinion of this neglected social group into the exclusion debate. To ensure the children felt safe and to negate the risks, the following processes were adhered to:

- Conversations with children were attended by either a caregiver or an adult familiar to the child, such as the designated officer for safeguarding within the school.
- Clear arrangements were in place with the host schools and researchers should there be any disclosure of child protection concerns or other safeguarding issues related to adults in the study (NSPCC, 2018).

Discussions were held prior to the ‘conversations’ about which protocols to use if the child became distressed. If the questions are appropriate for the research and the distress is not excessive, it can be considered ethical to ask them to continue if they agree (NSPCC, 2018).

- Aftercare arrangements for children and caregivers following the interviews were in place with the schools, including asking how they were feeling and asking if they had any support needs.

3.7.1. The ‘conversations’ with children

One challenge was: which age ranges should be engaged in the ‘conversations’. Following discussions with the gatekeepers, it was agreed that children in key stages 2/3 and 4 would be suited to an informal conversation. But for those in early years and key stage 1, their voice would be captured by alternative means, by the school staff, as the younger children would be more likely to be wary of strangers (Gray et al., 2004). It was important that applicable methods and questions were suited to the children’s developmental abilities and to their understanding and communication competences (Gibson 2012).

This process ensured that the children freely agreed to take part, following both caregiver and gatekeeper consent. Two children changed their minds on the day and were not interviewed. One child decided, following consent, that he did not want to have his voice recorded on the Dictaphone; he chose to draw a picture instead of what he enjoys about his new school (alternative provision). The participants all maintained the right to withdraw by June 1st 2019 without giving a reason. This was explained in all interview consent forms and information sheets. No requests to withdraw were received. The conversations were structured in such a way that the more sensitive questions on ‘school exclusion’ were in the middle, with a positive discussion about achievements and aspirations to close.

3.7.2. Upholding children’s rights

In addition to planning the research, following BERA (2018), the principal investigator also ensured the responsibilities within Articles 3 and 12 of the United Nations Convention on the Rights of the Child (UNCRC) (1989) were adhered to for the conversations with those under the age of 18 (see Fig. 6).

Article 3

The best interest of the child must be top priority in all decisions and actions that affect children.

Article 12

Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously.

Figure: 6. Articles 3 and 12 from the United Nations Convention on the Rights of the Child

### 3.7.3. Withdrawing consent

Processes were put into place for any participant who wished to withdraw consent. It was made clear that they could withdraw consent up until June 1st 2019 when the data was analysed in preparation for the draft report. They were advised verbally and on the consent form of contact details and that they do not need to give a reason why. It was agreed the school staff would advise the principal director directly if any child decided to withdraw consent (BERA, 2019). No participants withdrew consent following the interviews.

### 3.7.4. Ethical dilemmas

The other dimension of ethics is how it is applied in a practical sense in the field of research. This concerns ethical dilemmas that are not predictable and which compel the researcher to make decisions at any stage of the research (Kutrovátz, 2017). Kutrovátz describes these situations as 'ethically important moments', or 'micro-ethics' (ibid). In this research, ethical dilemmas refer to situations during the 'conversations' with children when their body language changes (head down, eyes to the floor) or verbal language changes ('mmm', or inability to form sentences), as described by Phelan and Kisella (2013). This occurred in two interviews when the researcher began to ask about experiences of school exclusion; one child froze and another just looked away. In these two cases, it was immediately decided it was not in the best interests of the child to continue. Instead, child-led conversations took place outside of the research themes one around Christmas and another around the newly acquired school therapy dog. This highlights that formal ethical approval is not enough for managing unpredictable situations; it is the child's, the researcher's and the safe adult's decision not to proceed regardless of gatekeeper, caregiver and child consent. A combination of the two approaches (formal procedures and ethics in practice) and the continuous reflexivity of the researcher are required if research is to be carried out in an ethical manner (Christensen and Prout 2002). The notion of reflexivity is

essential: Guillemim and Gillam (2004) extend its application to ethical practices when they suggest that 'Adopting a reflexive research process means a continuous process of critical scrutiny and interpretation; not just in relation to the research methods and the data, but also to the researcher, participants and the research context' (p. 275).

### 3.7.5. Disseminating research findings

Consideration was given to how to disseminate the findings in the most relevant and useful way to the different participant groups (BERA, 2018, p. 8). In discussion with the caregivers and children, it was decided that two other versions of the report would be produced by April 2020 and would be made available to all who took part.

### 3.7.6. General Data Protection Regulation (GDPR)

This piece of legislation is applicable only to Europe and replaced the Data Protection Act (1998). It concerns how data is acquired, held and used. This new legislation, which came into force on 25th May 2018, has brought with it increased expectations of how organisations process personal data. The key change from the DPA (1998) is around informed consent and transparency in relation to personal data usage. The intention of GDPR is not to impede research but to reflect good practice and to ensure the application of relevant safeguards (NHS, 2018). They add that organisations need to be lawful, fair and transparent when processing or controlling the processing of personal data.

Audio recordings were stored within a secure university server with access permitted to the research team only. This is in accordance with Opie and Brown (2019), who advise keeping research data in a separate storage area. The information sheets and consent forms provided for all participants are in accordance with GDPR in that they are:

- Concise, easy to understand and use clear and plain language
- Tailored to the needs of the audience
- Provided by appropriate means, for example, not everyone could access the written form, so a verbal agreement was sought.

NHS (2019)

### 3.8. Analysis strategy

All approaches to qualitative content analysis require a similar seven-step analytical process, including: formulating the research questions to be explored, selecting the sample to analyse, defining the categories to be applied, outlining the coding process and the coder training, implementing the coding process, determining trustworthiness, and analyzing the results of the coding process (Kaid, 1989). This section outlines the strategy to the data analysis with justification.

The approach to analysing the data began with ‘summative content analysis’, which involved the counting and comparisons of key themes followed by interpretation of the underlying content (Hsieh and Shannon, 2005). The author read all the data to immerse in the voices of the participants and to gain a sense of the key themes arising (Tesch, 1990). This is then used as a basis to derive codes when reading each verbatim transcript, organised by participant group (Miles and Huberman, 1994; Morgan, 1993; Morse and Field, 1995). The process was carried out using NVIVO Pro (qualitative analysis software), which was used to code excerpts before arranging them into developing themes. As codes emerge, they are continuously revised, merged and reviewed in preparation for analysis. The advantage

of this process was that the researcher gained information from the research data without imposing preconceived categories or theoretical perspectives (Hsieh and Shannon, 2005).

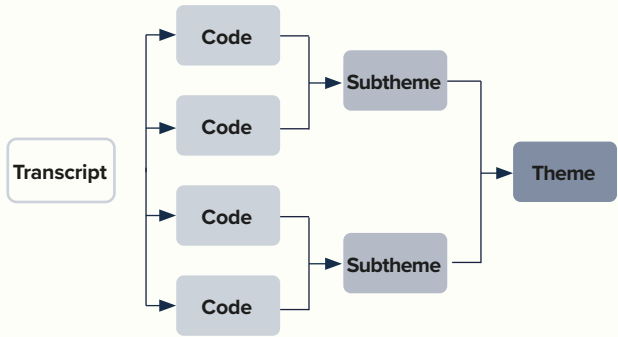


**Figure 7.** Iterative example of the coding process used in content analysis where codes emerge from the data.

The participant groups were coded sequentially using a coding list generated after the initial analysis of the first participant group. A coding list was used to limit the cognitive load when analysing the transcripts and to maintain reliability when analysing the large amounts of data (Morse and Richards, 2002). It should be noted that the approach was inductive, as codes were allowed to emerge from the data and were added to the expanding coding list. Examples of arising codes are given in the figure below.

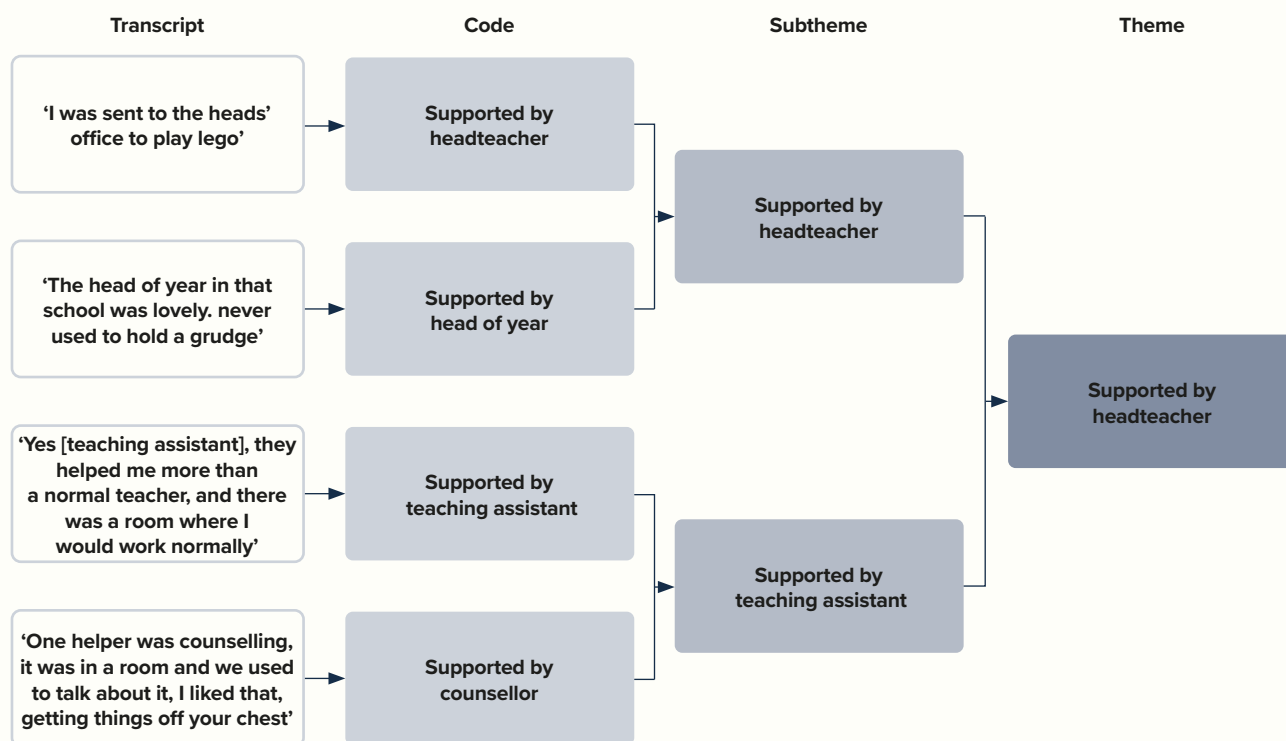


**Figure 8.** Example of the coding process with transcript excerpts, codes, subthemes and theme.

Usually, a limitation of this type of analysis is that there is a failure to develop a complete understanding of the context. This was overcome by the author carrying out over 50% of interviews following an approach advocated by Lincoln and Guba (1985) and Manning (1997), and debriefing from other members of the research team. Content analysis alone cannot be used to infer meaning but instead presents the usage of key terms which can be quantified (Kondracki and Wellman, 2002). The summative approach used allowed the researcher to go beyond mere word counts to include latent content analysis. This refers to the process of interpretation (Holsti, 1969), to focus on discovering the underlying meaning of the content (Babbie, 1992; Morse and Field, 1995).

### 3.9. Limitations

It is acknowledged that the researcher reflected on her own meaning-making in relation to the shared lived experiences of the participants. However, by adopting an inductive approach, themes were identified from the data using careful and structured means of analysis to keep descriptions as true to participants' own as possible. The research also carried out what is known as 'bracketing', where researchers acknowledge any preconceptions held throughout the research process to minimise its influence. Members of the research team were also involved in quality assuring their own and each others' transcripts, coding and analysis to avoid interpretation bias and to maintain accuracy. The questions asked to all participants were open-ended, to create the opportunity for them to share their experiences, and there were no time restrictions imposed on the length of any discussions.

Although this was a large study compared to other available research, it uses a relatively small purposive sample, based on availability and gatekeepers discretion. This means the findings cannot be generalised, as they represent the voices only of those who participated. The limitations of this research specifically include:

- The sample is not representative of children across the UK who have experienced exclusion from school
- It does not include a sample of children fully accessing mainstream education as a comparison of schooling experiences
- The views of those in the local area of Sunderland
- Only themes relating to barriers and enablers to mainstream schooling were included in this report.

## 4. Analysis



## 4. Analysis

In this section, children, caregivers and professionals reflect on the enablers and barriers to mainstream schooling.

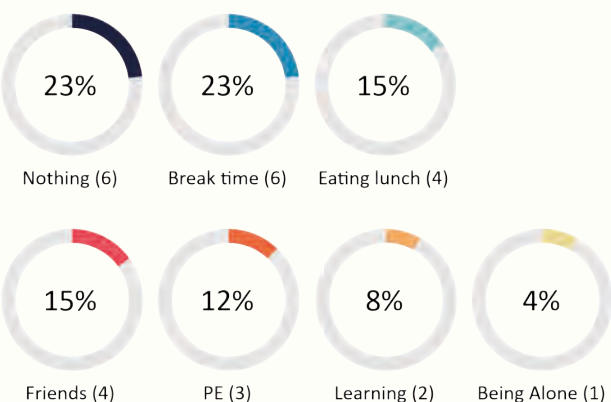
### 4.1. What the children enjoyed about mainstream school

Twenty-three children responded to this question:

- 20/20 children in key stage 1 (26 references)
- 3/35 children in key stages 2-4 (4 references)

#### 4.1.1. What the children enjoyed about mainstream school: Key stage 1 children

All 20 children in KS1 were able to articulate what they enjoyed about mainstream school, making 26 references to this theme.



The most prevalent responses as to what they enjoyed about mainstream schooling from KS1 children were **‘nothing’** and **‘break time’**, with children providing descriptions such as **‘I did not enjoy anything about that school, everyone was being mean to me’** and **‘I enjoy the bouncy ball – space hopper’**. The other responses included **‘eating lunch’**, **‘having good things to eat’** and their relationships with friends **‘I enjoyed playing with my friends’**. **‘Physical Education’** (PE) and **‘learning’** were cited as elements of mainstream school that they enjoyed **‘I enjoy doing phonics’** and one

child mostly enjoyed being alone **‘everyone out of the classroom. I liked the classroom empty’**. These findings suggest children liked opportunities for social interaction and physical activity. This could indicate that some are simply not ready for the formality of school where the focus is on achieving academic targets rather than on social and emotional development (WIES, 2012; Faulkner and Coates, 2013).

#### 4.1.2. What the children enjoyed about mainstream school: Key stage 2, 3 and 4 children

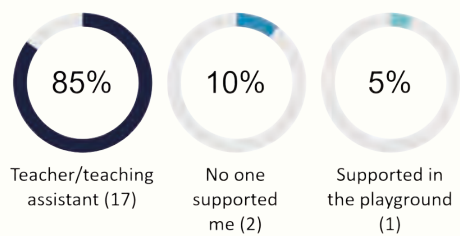
Unlike KS1, only 3 out of a possible 35 KS2-4 children were able to speak positively about any aspect of mainstream schooling. The first child, in KS2 reflected that he liked being with a non-teaching member of staff who let him ‘help with jobs around school and told jokes’. The same child also discussed enjoying playtime, particularly football, and stated that they like to be outside in the fresh air. The second child, a KS3 pupil, commented that they had enjoyed sport as they ‘could do PE, unlike English’. Finally, a child from KS4 responded that they enjoyed DT and art as they were a ‘calm lesson, something to do’. These comments suggest a positive impact of physical activity and sport on children’s emotional development. This could be due to their ability to be successful in these activities or because they are able to play alongside their peers as suggested by Sandford (2006) and Bruner et al (2011).

### 4.2. Children’s views of who supported them in mainstream school

In total, 32 children shared how they felt they were supported within mainstream school:

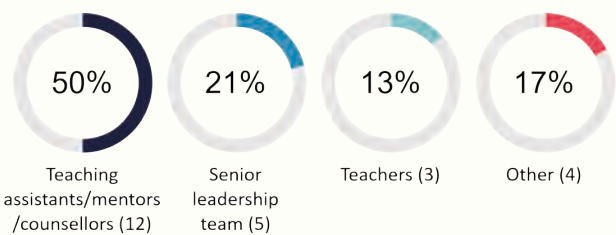
- 17/20 children in KS1 (20 references)
- 12/15 children in KS2-3 (24 references)
- 3/20 children in KS4 (6 references).

4.2.1. Children’s views of who supported them in mainstream school: Key stage 1



Of the 20 references generated by KS1 children, the most common way they recalled being supported, representing 85% of all comments, was by mainstream teachers and teaching assistants helping them with their school work. They stated that they valued the support and needed the help **‘I work best with the teacher; I only work with the teacher a little bit’** and **‘I need help in the classroom, a teacher helps me’**. This provides evidence that teachers can be a protective factor when there is a positive teacher-child relationship (Meehan et al., 2003; Martin and Dowson, 2009). Two of the children felt that no one supported them and one said they **‘sometimes get help in the playground’**.

4.2.2. Children’s views of who supported them in mainstream school: Key stage 2 and 3



There were 24 references to this question from KS2-3 children. Half said they were supported by teaching and support staff; fewer than reported by KS1 children **‘a teaching assistant from year 2, it was more help, but I still couldn’t cope’** (KS2 child) and **‘I had a member of staff just to work with me, just me. If I got upset or annoyed, she would take me out of the classroom. We had a bag of sensory toys I could play with, or we could go to the school library and read a book, so I could calm**

**down’** (KS3). These responses were similar to KS1 in that children identified they needed and received support to help them cope and learn in a mainstream school environment.

Senior leaders and heads of year were also cited as a positive source of support **‘I used to go to the head’s office, she had iPads. I went there when I got wrong and she would say ‘do you want to play with me Lego and calm down?’** (KS2) and **‘the head of year in that school was lovely, never used to hold a grudge’** (KS3). The remaining references were to three English teachers and the remaining four references were mixed but mentioned a supportive member of the wider school team **‘if I was being naughty he used to come and help. When I ran away, he got me to come back in his car. Without him, I’d be bored, kicking off more with nobody to calm us down’** (KS2), **‘being outside, friends and having a quiet space to work’**. While over a fifth of the KS2-3 children interviewed cited senior leaders as a source of support, the discussions suggested that at times children were unable to cope in mainstream classrooms and that support was needed for them to access schooling.

4.2.3. Children’s views on the level of support in mainstream school: Key stage 4

Only three KS4 children out of a possible 20 were able to describe how they were supported in mainstream school. All six comments referred to support from teachers, support staff and a SENCO **‘Yes, one good teacher. She was the head of year base. She was always the one who actually listened. She would sort out problems if you had one. None of the other teachers cared’** and **‘they got this lass in to help with my behaviour. Why give me that in Year 9? Or Year 8? When I needed it in Year 7?’** The children were able to articulate that they needed support but their views imply that it wasn’t always available in mainstream classrooms. A barrier to providing consistent support for these children could have been due to resource issues and the availability of external professionals to provide advice

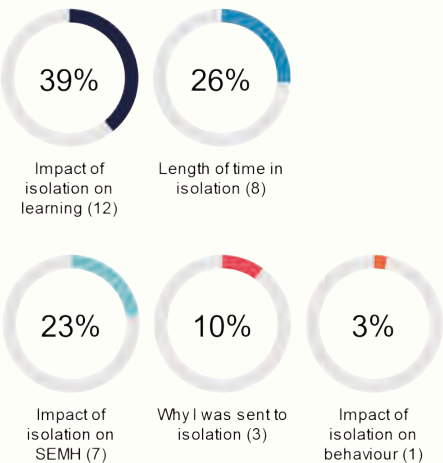
and guidance, as suggested by Johnson et al. (2017). The final comment does intimate a lack of timely intervention in the school as recommended by the Code (DfE, 2015a) as he recalls waiting two years for support.

4.3. Children’s views on the use of isolation booths in mainstream schooling

This section provides an analysis of the conversations with 27 children who shared their views of the use of isolation booths as a disciplinary sanction. This number includes an additional child, who contributed to this theme while attending a caregiver interview and consented to have his comments reported.

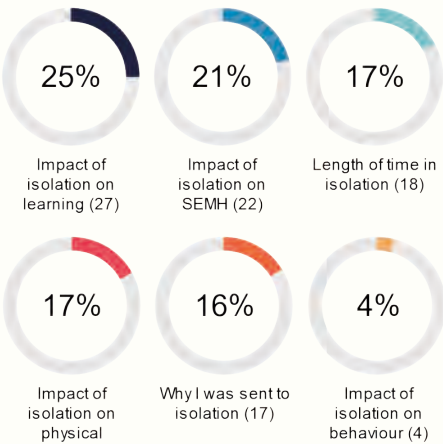
Overall, isolation booths were predominantly used in KS3 and KS4, with one child having a booth within a classroom in KS2. The number of children who spoke about isolation is given below:

- 8/15 children in KS2-3 (31 references)



Nineteen out of 20 children discussed their experiences of isolation in mainstream secondary schools.

- 19/21 children in KS4 (106 references)



Along with the 27 children who expressed their views, 19 of their caregivers participated in and discussed the impact of isolation on their child’s learning, mental health and wellbeing, and physical health.

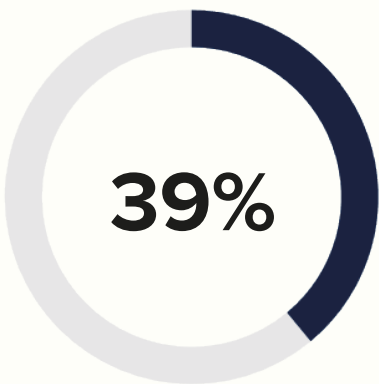
4.3.1. Children’s views on the impact of isolation booths on their learning

Overall, 27 children shared how isolation impacted on their learning:

- 8/15 children in KS2-3 (12 references)
- 19/20 children in KS4 (106 references)

4.3.1.1. Children’s views on the impact of isolation booths on their learning: Key stage 2 and 3

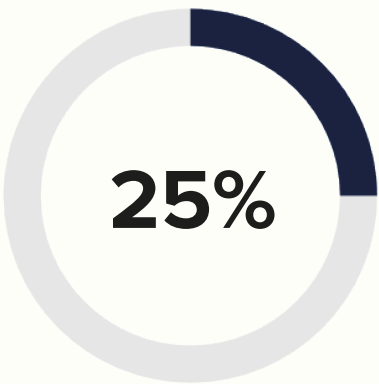
The most common theme in all of the responses relates to the perceived impact on learning due to being placed in an isolation booth. Within KS2, a child who said they were in an isolation booth within the primary classroom explained that they were faced away from the teacher during lessons **‘I couldn’t see the board or what we were learning so I had to turn around all of the time. I got sick of it’**. The other child in this age phase shared they were not in a booth but were frequently sent out of class **‘they would make me stand outside in the corridor’**. The remaining responses were all from children in KS3, with all six children recalling being placed in an isolation room with individual booths. They felt the implications for their learning were that they were ignored by staff, not taught or supported **‘not taught; they just gave you the textbook’** and **‘they just ignored you’**. There was only one child in the sample who could recall a small level of support **‘if I asked them but they wouldn’t help go through a question. They would do an example and then say they wouldn’t help anymore’**. The children’s perception was that they felt they were not supported; their learning needs were not met, even when they asked for help, supporting the findings of Nind et al. (2012) that children can feel negatively perceived by teachers.



Impact of isolation on learning (12)

4.3.1.2. Children’s views on the impact of isolation booths on their learning: Key stage 4

As with KS2 and KS3, not being taught or spoken to was a persistent issue raised by 17 KS4 children **‘they just told you to sit down and get on with your work, no teaching’** and **‘not taught, just worksheets; just had to figure that shit out for myself, but that’s life isn’t it’**. The premise of historic guidelines was that if children were placed in internal seclusion, they should have the opportunity to reflect on their behaviours (DCSF, 2008; DfE, 2015). These responses imply that some staff were not talking to children and if this was the case, it is hard to see how the cause of behaviours can be understood. During the conversations, the children were able to talk about what they learned **‘I didn’t do anything. So that is why I came to this school knowing nothing [alternative provision] knowing nothing, I was so behind on everything after two and a half years in isolation’** and **‘I couldn’t even read or write properly, because they used to kick me out of lessons’**. These views correlate with the findings of the House of Commons Education Committee (2018) that some children are left to self-teach, which contravenes advice from DfE (2016), that time spent in exclusion should be used as constructively as possible.



Impact of isolation on learning (27)

One child reported (later confirmed by the gatekeeper), that following isolation, there was an illegal exclusion **‘halfway through year 7, I got fixed-term excluded... I was only allowed in once a month; they brought me a computer home. I was home for two and a half years, mum and dad worked. I would just fall asleep’**. This would have clear implications for safeguarding the child if they were home alone from the age of 11 to 14 years. The outcome of not being taught is that children will fall behind in their learning, with severe implications for their transition to adulthood and life outcomes (Goldman-Mellor et al., 2016). This child went on to talk about how he thought the impact of not being in school explained why he could not read or write.

4.3.2. Length of time children recall spending in isolation booths

Children who responded to this question:

- 6/15 children in KS2-3 (8 references)
- 18/20 children in KS4 (19 references)

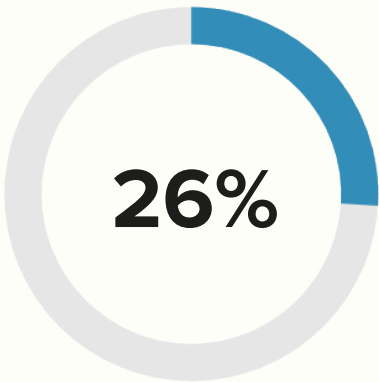
4.3.2.1. Length of time children recall spending in isolation booths: Key stage 2 and 3

The two children in KS2 reported being isolated daily **‘I have a booth in the corner of my classroom with my stuff on it’** and **‘that was my whole life really, getting sent out’**. All six KS3 children felt they could recall the length of time they were in isolation which was **‘once’** to **‘the whole day for two months’**.

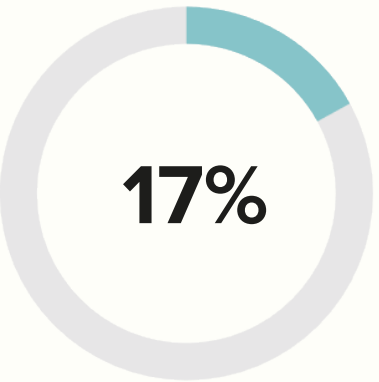
4.3.2.2. Length of time children recall spending in isolation booths: Key stage 4

What is clear from the analysis is that children in KS4 reported spending much longer periods of time in isolation compared to those in KS2 and 3 (Figure 7, below). Many described isolation booths being used as a continuous provision, with eight of the children recalling being placed in a booth every day for one to three years (Fig. 7). DfE advice (2016) allows schools to place children away from others for ‘a limited period’, which implies it is to be used for much shorter periods of time. Ofsted (2018) also clarified that children should only be in isolation for the shortest possible period. However, this was not the experience shared by some of the children in this study.

The conversations with the children insinuate that in some schools and age phases there is an over-reliance on the use of isolation booths and as a result, they feel there is limited or no education during the time they are isolated. In KS4, 19 children



Length of time in isolation (8)



Length of time in isolation (18)

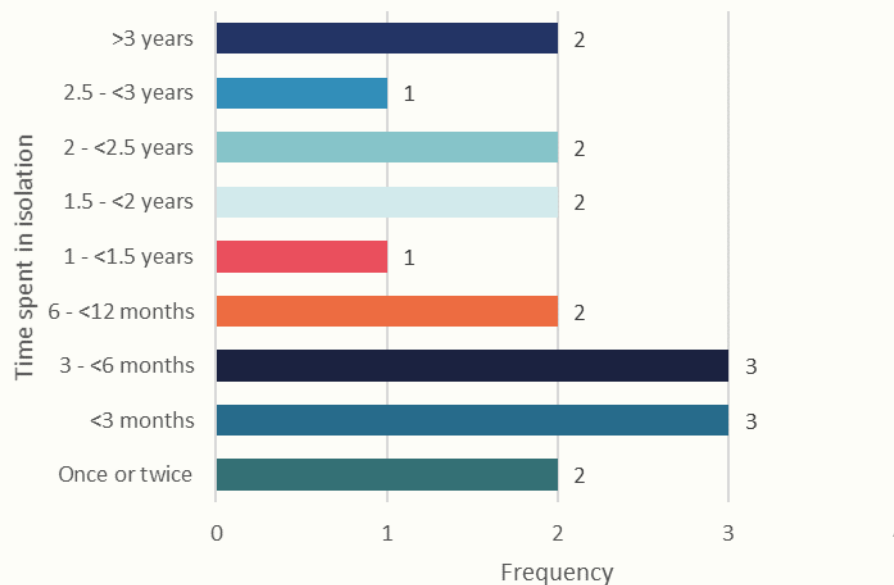


**Figure: 9.** Time children spent in isolation

discussed how long they were in isolation (Fig. 9) and their views imply that it is not being used as a one-off sanction but as an ongoing provision. Another child talked about being sent out of the area to another school, to be placed in an isolation booth **‘well the longest isolation that I had was like, two weeks, three weeks. So I had to go to this other school and sit in isolation. I had to go out of area, it was like one school linked with another school. Where they send different students over’**.

These findings suggest that isolating children results in less inclusive approaches to behaviour management, as they suggested they were in isolation from days to years (Gazeley 2010; West and Bailey, 2013; Gorard, 2014).

The evidence from this research suggests that for some children who are placed in isolation, they lose the right to be listened to and, in some cases, taught. This echoes findings of other research into the use of isolation booths (Sheffield and Morgan, 2017; Cosma and Soni, 2019). Given the children’s accounts, questions should be raised at a local and national level around how to manage this potential breach of the Human Rights Act 1998, in particular, article five: ‘everyone’s right to liberty’. This was clearly not the intention when ‘remove rooms’ were introduced by the DCSF in 2008; they were never intended to be used for statutory education.



4.3.3. Children’s views on the impact of isolation booths on their mental health

In total, 25 children shared how they felt isolation impacted their mental health:

- 7/15 children in KS2-3 (7 references)
- 18/20 children in KS4 (22 references)

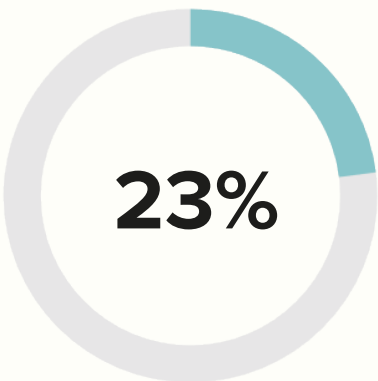
4.3.3.1. Children’s views on the impact of isolation booths on their mental health: Key stage 2 and 3

Seven children talked about their experience of being placed in isolation. Some described having restricted movement **‘not allowed out at break times, not allowed outside or to do PE (Physical Education)’** and **‘I had to face the wall’**. Two children recalled it not being too challenging an experience **‘there were three or four people with one teacher. It was actually okay’** (KS2 child) and **‘I got used to it after a while. When I first went in there I was bored’**.

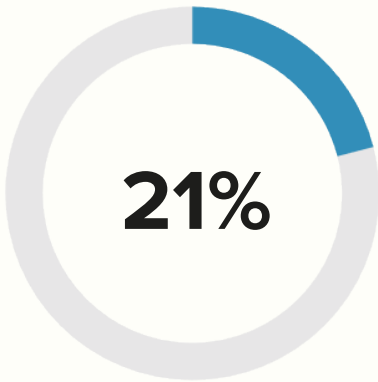
4.3.3.2. Children’s views on the impact of isolation booths on their mental health: Key stage 4

For children in KS4, their responses were similar to KS2 and 3 but the impact seemed to be more pronounced. Some reflected on the direct impact of isolation booths on their mental health using terms such as ‘depression’, ‘coping’ and ‘loneliness’ **‘it was depressing I felt alone’** and **‘I ended up quite lonely’**. This suggests that they made a link between being placed in isolation booths and their mental health, supporting existing literature by Hall-Lande et al. (2007) that suggests isolation can increase the risk of anxiety and loneliness. With current DfE (2016) guidance leaving the school to decide the duration, it seems that schools can continue to have a detrimental impact on current and future generations of children.

One child made reference to the effects of being in an isolation booth, which led to self-harming behaviours **‘I used to pull my hair out, scratch my face. I couldn’t cope with it at all. The teachers used to sit there and watch me cry’**. Another child reported that they **‘used to call it ‘the bridge’ because it made you want to just jump off a bridge’**. These comments could signify the detrimental impact of isolation booths on the mental health of children as outlined by CAPBS (2015), that seclusion can be a traumatic experience for children and can have adverse consequences on their emotional development. It also implies that the wellbeing of children is severely affected, despite a duty on schools to ensure the child’s welfare (DfE, 2016).



Impact of isolation on SEMH (7)



Impact of isolation on SEMH (22)

Similar to KS2 and 3, the children described restrictions on physical movement which they felt impacted negatively on their mental health **‘I wasn’t allowed out, no fresh air or anything’** and **‘someone kicks off, they get locked in’**. The DfE (2016) advice allows schools to prevent children from leaving isolation rooms in exceptional circumstances, although there is no legal duty to record when this occurs. The children’s comments across the key stages clearly corroborate other research, further evidencing that isolating children increases the risk of mental health difficulties such as anxiety, depression and loneliness (Hall-Lande et al., 2007; Osgood et al., 2014). There are clear indications that isolation booths and limited movement may have adverse implications for these young children. Questions need to be asked about why this continues to be a lawful approach to behaviour management across schools in England.

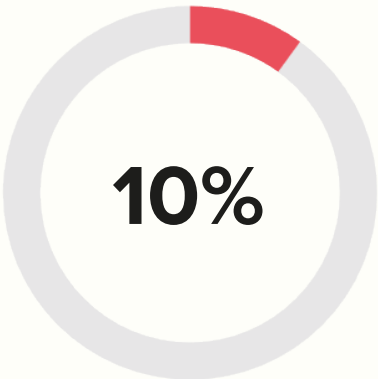
4.3.4. Children’s views on why they were sent to isolation

Overall, 20 children disclosed why they thought they were sent to isolation:

- 3/15 children in KS2-3 (3 references)
- 17/20 children in KS4 (17 references)

4.3.4.1. Children’s views on why they were sent to isolation: Key stage 2 and 3

For this age phase, there was a range of views from three respondents about why they were instructed to go to isolation. The reasons they gave included: being disruptive in class and being sent there as a last chance to remain in the school **‘isolation was if you are on your last chance in the school. It was a unit and you would go there’**. The other reason cited was **‘if you weren’t in the yard for 8.45 am, something stupid as that you get put in isolation’**. These comments suggest that there is variability in why a child would be excluded from classrooms.



Why I was sent to isolation (3)



4.3.4.2. Children’s views on why they were sent to isolation: Key stage 4

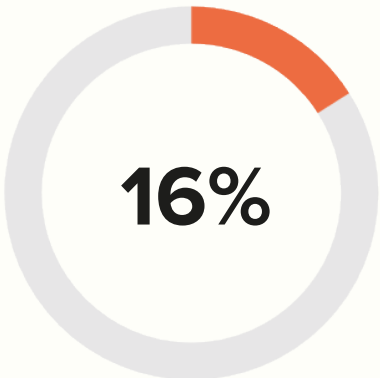
Seventeen children in KS4 talked about why they were sent to isolation. Of these, only four acknowledged that it was because of their negative behaviours **‘shouting, hitting pens off their heads. Hitting them with rulers’** and **‘it was more cheekiness and then carrying on; it got to the point where I was told ‘you are not coming into my lesson’**. The children also described how they were not asked the reason for their behaviours. Three felt they were stigmatised for previous behaviours **‘I was really naughty in Year 9, but then in Year 10, I started sorting myself out a bit. But by then the teachers just didn’t like me at all’**. This would suggest that once a child has been seen to behave negatively, they are unable to rebuild the relationship with teachers.

Several children commented that they felt they had been sent to isolation for reasons that they found hard to understand, such as **‘I had just arrived from a managed move’**, to wearing makeup, the wrong skirt, false tan, not wearing the correct shoes or being late for a lesson. Ofsted (2018) has clarified that these reasons would not justify placing a child in isolation as they would not constitute a reasonable nor a proportionate response.

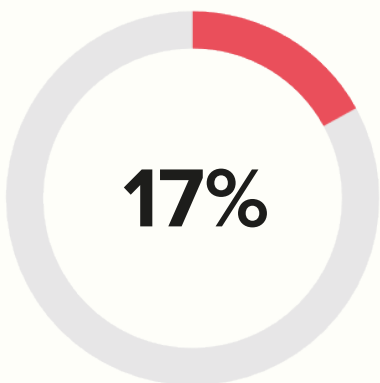
Two children described actively seeking isolation to escape what they perceived to be victimisation, to feel safe **‘I used to purposefully get myself put into what was their isolation, to avoid everyone. They used to wait outside of the classrooms for me. I used to beg my teachers to let me leave early’** and **‘I would wear the wrong skirt knowing that I would get put there. I would just do anything’**. These children felt that being in isolation was preferable to the stress of having older children waiting for them between lessons. This could indicate that procedures should be developed in these cases to support identifying the causes of underlying behaviours that children present with.

4.3.5. Children’s views on the impact of isolation on their physical health: Key stage 4

Unique to KS4 was participants reporting how isolation impacted on their physical health, with 18 out of 20 commenting. **‘I didn’t like it, it made me feel sick, they just told me to do my work’** and **‘it made me feel dizzy’**. As with KS3, it is evident that the children perceived that when they were in isolation, they were not allowed movement breaks during the school day and that movement within the isolation booths was also monitored and restricted **‘you weren’t allowed to cough or breathe loud’** and **‘you weren’t allowed to turn around or make any noises’**. The DfE (2016) advice for schools states that schools must ensure the health and welfare of children; these descriptions suggest this is



Why I was sent to isolation (17)



Impact of isolation on physical health (18)

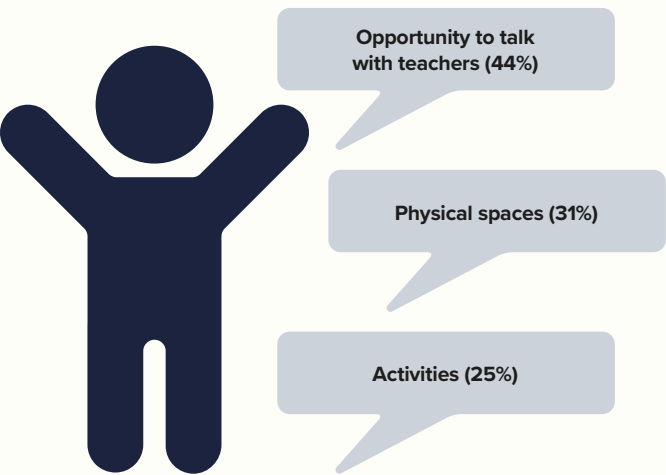
not the case. The impact on physical health due to social isolation is documented in the literature, with headaches and stomach aches reported by Lohre (2012).

Overall, the analysis of the data from children suggests that isolation for some can be a lonely and negative experience. Some felt isolation had consequences for their mental health, physical health and educational outcomes. It seems that the use of isolation booths has removed children’s sense of belonging to the school community and, due to their detrimental impact, alternative approaches need to be explored and implemented. Overall, the children’s reports imply their emotional needs were neglected (a child does not get the stimulation they need) and they were deliberately isolated and ignored. By these accounts from the children, the descriptions could be seen to fall under the definition of emotional abuse (NSPCC, 2019).

**4.3.6. Advisory group of children: Proposed alternatives to isolation booths**

The advisory group was held following the transcription, coding and analysis of the conversations and interviews in which emerging themes were identified. These were presented to the 12 children for discussion of their thoughts, views and suggestions of alternative approaches. All 12 children said that isolation booths do not modify or improve behaviour and in most cases, makes it worse. One child argued that some type of isolation system was needed because disruptive children should not be allowed in classrooms; the other children did not respond or agree with this view. The outcome of the discussion was that the children voted unanimously that the main change needed to improve mainstream education was the removal of all isolation booths, and this forms the basis of recommendation 1 in this report.

The comments below share the voice of the advisory group of children on what they believe would be beneficial alternatives to isolation booths in schools.



### Opportunity to talk with teachers (7 references)

- ‘Take a few minutes to talk to the staff.’
- ‘Make time for us, speak to us.’
- ‘Listen to our reasons for being sent out.’
- ‘Talk to the student and ask what happened and ask what they want to do.’
- ‘Take time and take help from teachers.’
- ‘Teachers need to speak and treat students the way they want to be treated.’
- ‘Don’t automatically take the teachers’ side.’

### Physical spaces (5 references)

- ‘Take you to a serene room.’
- ‘Be able to go to a calm room before being sent back to class.’
- ‘Do a calm room and more space in the isolation room.’
- ‘Let you calm down for a bit.’
- ‘Make time and places for all students.’

### Activities (4 references)

- ‘Do something with them they like, to calm down.’
- ‘Leave you for a bit to calm down.’
- ‘Play games to calm down.’
- ‘Do something you like to calm down.’

The advisory group comments show that the children were able to articulate what would help them stay in the classroom and access learning and teaching. They describe a need to be left to self-regulate and to calm down, to talk to staff and go to a space they enjoy. This suggests the importance of children being enabled to manage their stress in a way that meets their needs (Ryzin et al., 2009). The solutions the children suggest would also support schools in understanding the multifaceted needs of the children through the adoption of these child-centred approaches.

### 4.4. Caregiver’s views on the use of isolation booths in mainstream school

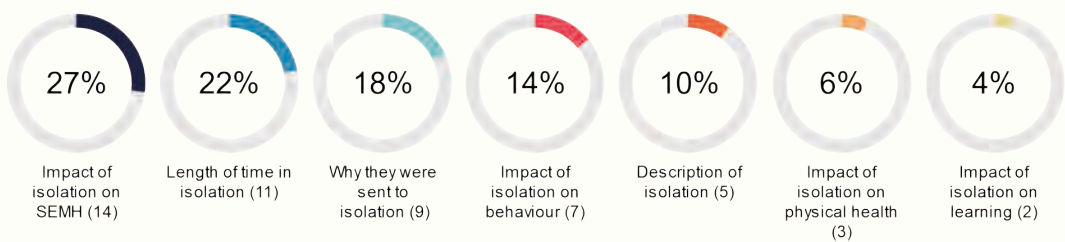
Overall, 19 caregivers shared their views on the use of isolation in mainstream school:

- 3/16 caregivers of children in KS2-3 (3 references)
- 16/21 caregivers of children in KS4 (51 references)

#### 4.4.1. Caregivers’ views on isolation booths: Key stage 2 and 3

The caregivers reflected on their perceptions of the impact of isolation on their child **‘the teachers never gave him the time of day that he needed. He was automatically ‘a naughty boy’. So he was in inclusion, isolation mainly. Being shoved in a room and not spoken to. That would be for a lot of the time’**. The remaining two comments related to the view that there was a negative impact of isolation on their child’s behaviour **‘if you’re going to lock him up in a room, well he’ll just be like a crazed animal’** and **‘a school we know uses the term ‘lockdown’ for isolation. ‘We’re putting you in lockdown’? Wow! It’s like, come on. What type of word is that? They’ve got no windows in the room where the child goes. Then they panic and just misbehaves again and gets another day added on’**. The caregiver’s views highlight their difficulty in conceptualising the use of isolation as an approved method of discipline in schools (DfE, 2016).

4.4.2. Caregivers views on isolation booths: Key stage 4



The majority of caregivers made comments about what they perceived to be the impact of isolation booths on their child’s health and wellbeing. The main concerns they raised were their child not being able to move out of the room where they are isolated (even at lunchtime) and losing their right to liberty, **‘no breaks and not being able to communicate with teachers or peers; they don’t get break times, they don’t get lunchtimes. A cold sandwich gets sent from the main school across. They have to have all their meals there. They are there from going in till finishing school. They get no engagement, nothing, no picking their own meals’**. They discussed the impact of sitting in complete silence **‘they had to sit in silence all day. I don’t agree with isolation, sitting in silence he would come home in a complete mood. Because obviously he had sat there for hours, not being able to speak’**. One caregiver reported that the use of isolation was used against the advice of an educational psychologist and could not understand how this would be allowed to happen **‘you will have to give him some sort of break because that is in his recommendations from the Ed Psychologist. He has to have**

**these breaks. You are basically torturing him. How can you expect him to work when he doesn’t have time to reset himself? When he doesn’t have a break from that room’**. The caregivers all identified that the children need alternative approaches and that removing a child from human contact is not improving but compounding their mental health difficulties and behaviours **‘it’s like a prison and they are locked in the room’**. They identified basic needs, such as nurture and stimulation, for their child’s healthy emotional development, a view supported by the NSPCC (2019). Their views imply that they thought seclusion through isolation booths was not the right approach for their children (2015).

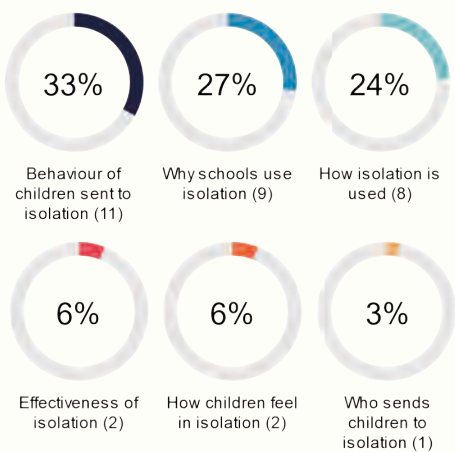
Two caregivers acknowledged their child had behaviours that, at times, were hard to support. However, they stated that isolation was an overzealous response to some behaviours **‘he threw a paper plane at his friend, he turned to speak to a friend’** and **‘for not handing his home work in, which is stupid’**. All caregivers were asked how long their child was in isolation for and their responses aligned with those of their children, whose interviews were held separately and in different weeks.

## 4.5. Professionals’ views on the use of isolation in mainstream school

For ease of reading the results in this section are presented by the participant group.

### 4.5.1. Secondary headteachers: Views on isolation booths

Of the nine secondary headteachers interviewed, all referred to isolation as a ‘behaviour management tool’, with a total of 33 references



Some secondary headteachers shared the view that behaviours of the children sent to isolation related to actions deemed to be too extreme to remain in the classroom **‘if children are not behaving to the standards we expect’** and **‘if it kicks off and they’re disrupting the learning of others and mental health problems for all concerned, we have to remove them from that until things calm down’**. The language used by a few of the secondary headteachers was **‘internal exclusion...we also have internal exclusions, where they are removed from the classroom because the teacher can’t teach’** and **‘say they have had an argument with the teacher or sworn at the teacher, then they would be in internal exclusion. Years ago you would have put somebody out for that’**. Some comments indicated that children could be removed for non-violent behaviours **‘if we find that a child is finding it hard to get through the door’** (come into school) and **‘so we’ll do**

**isolation with the head of years first if it’s not extremely violent’**. The comments from the headteachers indicate that there is a range of punitive measures used in secondary schools.

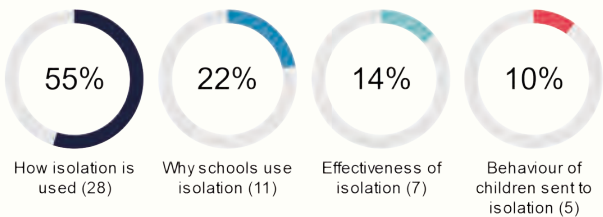
When asked why they use isolation, the secondary headteachers’ main response was to modify behaviours and to avoid fixed-period exclusions **‘they are isolated, or it’s a proper fixed term exclusion’**. Some commented that children could see exclusion as a reward as they get to stay at home **‘I swear at the teacher and I get two days out; they would almost see that as a reward’**. It appears that isolation booths are used for misdemeanours to prevent further behaviours ; they believed that when in isolation booths, the children would be reflecting on their behaviours, although the evidence from the children and caregivers was that it does not have this impact.

There were two references to the use of isolation booths and looked after children **‘we have isolation, if that doesn’t work we are supposed to send them home but my assistant head in charge of that area is a bit soft and will say ‘I don’t want to send him home’ or ‘he’s a looked after child’ so we sit him in the corridor outside, and say let’s contain him. But it doesn’t solve any problems’** and **‘we use isolation as an evidence-gathering tool, especially for young people with EHCPs. So they’re saying ‘we can’t manage’ so we’re saying ‘well prove you can’t manage’ and we know that our isolation room, it does have booths and we know that all the latest stuff is not to put our LAC children in there. I mean we don’t do that, but we’ve got to prove some way where they’re not coping’**. It is interesting that these secondary headteachers acknowledged that they should not place looked after children in isolation and that it is an ineffective approach. The evidence from the children and caregiver interviews suggests that isolation booths are not an appropriate environment for children and indeed are not a place where professionals would be able to gather an evidence base for a child’s strengths and needs. The premise of the Code is that professionals need to understand the reasons for children’s behaviour (DfE, 2015a).

There was an acknowledgement from some of the secondary headteachers that the isolation booths are not a comfortable environment for children to be placed **‘isolation is a small boothed room which is not very nice, where they are working quietly with school behavioural managers, some of whom are leaders. They might be in there for the rest of the lesson, the morning, or the day’** and **‘a lot of students hate being in there, so they will do anything to not be in there. It’s a quiet environment. You sit there on your own in silence; they generally don’t like being in there’**. Additionally, some secondary headteachers confirmed they do not gain parental consent to place their child in an isolation booth. These comments corroborate with children’s responses, that they have their freedoms limited in isolation, in terms of limiting comfort breaks **‘we don’t exclude you from breaks and lunchtimes, we are humane (laughs) please make sure that goes into the report. We do set toilet time and we still feed people. The parents are informed and there is no parental consent sought’**. Only two headteachers reflected that they felt isolation had a positive impact on behaviour, though they did accept that this was not the case for the majority of children placed there.

**4.5.2. Primary headteachers: Views on isolation booths - this was not the case for the majority of children placed there.**

Overall, 23 of the 28 primary headteachers made 51 references on the use of isolation in mainstream school.



In Sunderland, two primary schools reported using isolation as a behaviour management tool in response to extreme challenging violent and aggressive behaviours **‘the first one was**

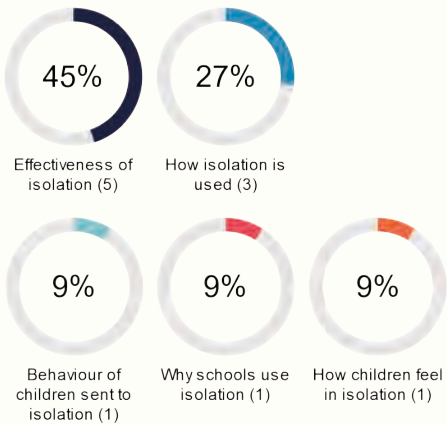
**absolutely horrendous aggression between themselves and staff, and the second one was that that child has been building up a pattern... I have never had a child scream and shout at staff in the way that he did. He had escalated until he pushed a member of staff’** and **‘there are times when a child has had to be removed out of the classroom because sometimes frustration can manifest itself in throwing chairs or whatever, and at that point, the safety supersedes everything’**. The justification for the use of isolation from the two primary headteachers was related to keeping the child, other children and teachers safe, when there were no other options. This differed from the responses from some of the secondary headteachers, who seemed to use isolation for low-level behaviour disruption as well as higher-level behaviours.

Most primary schools said they didn’t use isolation but other alternative approaches that were felt to support the children to become more regulated. The types of approaches included time out, being ‘sent’ to work in the headteacher’s office, given jobs to do, toilet breaks, speaking to the school counsellor, going into another classroom and nurture/ sensory rooms. For the schools that used isolation, it was when other approaches to managing behaviour had been tried and failed **‘once you’ve followed all of your normal routes and all of your normal consequences, that would be the next step’**. There was a sense from the interviews that primary headteachers understand that children need respite from classrooms and the benefits of providing short term intervention to calm children, so they are able to re-engage with learning.



4.5.3. Nursery headteachers: Views on isolation booths

All four nursery headteachers who were interviewed spoke about isolation, making eleven references.

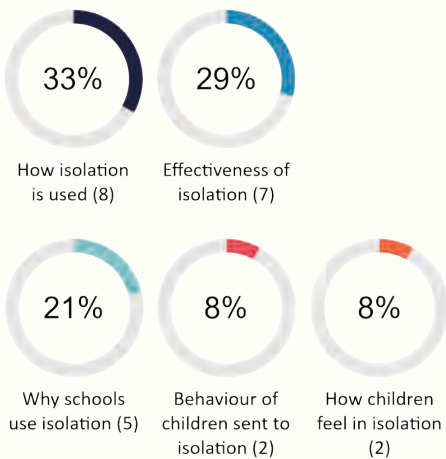


The views of nursery headteachers were similar to those of primary headteachers; that isolation was used when there was challenging, violent and aggressive behaviour **‘huge temper tantrums... scratching members of staff, biting, kicking, all sorts of things, for that child, it was appropriate to remove him’**. Similar to primary headteachers’ responses, nursery headteachers said they took children to safe spaces to calm down. In nursery schools, staff also provide comfort through physical contact **‘when a staff member could read that he was ready enough to come back then they would say ‘would you like a cuddle?’ and ‘we will come into my room and we’ll sit together and rock until she’s calmed down... At first, I did have to explain to the staff that this isn’t about us rewarding her behaviour; it’s about us supporting her to learn to regulate it. We’ve got that now’**. Nursery headteachers reported the importance of soothing, finding a comfortable place to comfort the child to show them how to emotionally regulate close to a trusted adult, an approach supported in research (Spitz, 1945, 1946, 1951; Andersen, 2008; Underdown et al., 2010, 2013; Johansson, 2013). The benefits of touch are reduced stress and a positive impact on wellbeing (Field, 2002). The importance of touch and time-in was clearly felt to be an effective and appropriate strategy provided by these nursery schools in

Sunderland. Such approaches are embedded in their policy of inclusion **‘for us, it’s very much about having an inclusion policy, not an exclusion policy. We never have time out; we always have time in because we look at children’s behaviour. If you’re excluded, you will never learn how to behave if you’re not part of the group’**.

4.5.4. Alternative provision and additionally resourced provision: Views on isolation

Alternative provision and additionally resourced provision headteachers were combined into one participant group to preserve anonymity. Nine out of ten participants shared their opinions on the use of isolation in schools creating 24 references in total. It is important to note that not all of these provisions have isolation booths in operation.



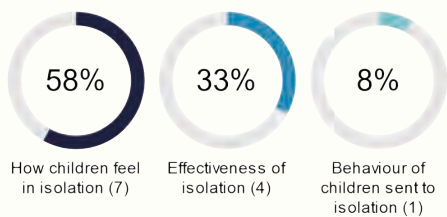
Similar to primary and nursery headteachers’ views, the alternative provision and additional resourced provisions used isolation when children were **‘having a meltdown’** and **‘hitting and kicking and screaming’**. The reasons isolation was used were: to prevent children from witnessing violent behaviours and to allow others to continue with learning. Some also said it was to ensure they knew there were boundaries in place in school **‘the last thing we want to do is take the child out; our bread and butter is around reinforcement and improving wellbeing but if we have to give warnings and consequences, we have to be quite firm and clear with that because sometimes that is**

what these children sometimes haven't had. Otherwise, they can just push the boundaries and tables go and we can't let them do that'. The views imply that isolation is the last resort, when other approaches have failed **'you would hope that curriculum support is a pro-active measure; the isolation rooms are a reactive measure... time out cards; trusted adults. All of those strategies are prevention, not the cure. But if that doesn't work, then it is the isolation'**.

Two headteachers felt use of isolation booths was justified as they had been used in other schools they were employed in **'we've got the consequences room, which is more of an isolation room; both schools that I've been head at in the last couple of years have been a very similar provision'**. The remaining participants said they did not have isolation booths but had alternative approaches, where **'maybe walk up and down the corridor to try and regulate them'** and **'space just beyond the classroom where members of staff will go and sit with them'**. There was an acknowledgement from all professionals interviewed that isolation was ineffective at modifying behaviour. They felt it was meaningless, pointless and did not address the need **'it's a sticking plaster over a haemorrhage'**.

4.5.5. Specialist headteachers: Views on isolation

With 12 references, all four specialist headteachers who took part in the research spoke about isolation as a behaviour tool in school.

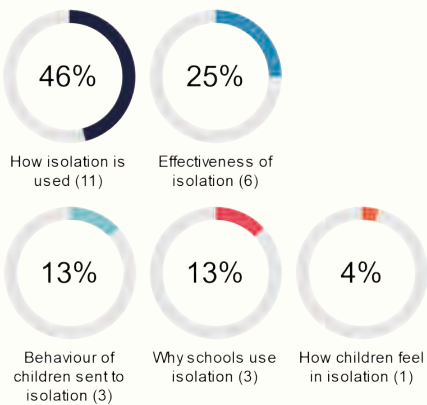


The four headteachers views corroborated those of the primary and nursery headteachers; that isolation booths were not used as a behaviour management tool for reasons such as **'they don't have the emotional resilience to deal with it'**. Some described that their schools do

have processes for removing children from classrooms, but this is to allow them to access sensory rooms, or to have conversations with staff in accessible, calming spaces about what they are finding difficult. The focus was on giving children opportunities to talk and to be listened to.

4.5.6. Special Educational Needs Coordinators (SENCOs): Views on isolation

Of the fourteen SENCOs who took part, 11 shared their opinion on the use of isolation in schools, generating 24 references.

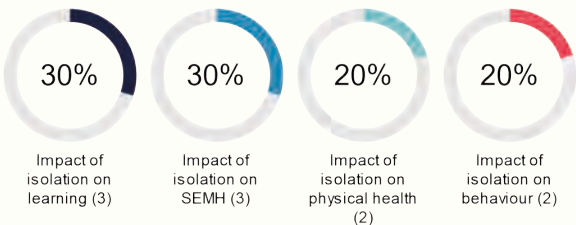


The SENCOs' views echoed those of the headteachers, in that isolation was used to manage behaviours that the class teacher was unable to cope with. This suggests that if isolation booths were removed, there will be a training need for those schools to enable them to confidently teach and support children (Carter, 2015b; NCTL, 2018). Their views were mixed on the effectiveness of isolation: **'as an immediate response when a child is having an episode to get them out of that lesson and get them back into the next one, yes I think that has quite a good effect'** and **'no, it is all SEN children generally... when it's repeating it's the same children going in the room time after time, there is no learning, no improvement behaviour and no, I don't think it works. They have identified needs not being addressed. It just helps the rest of the cohort move on with their learning. It doesn't sort the problem out for that particular child'**.



### 4.5.7. Health and support professionals: Views on isolation

Three health and support professionals out of a sample of nine made reference to the impact of isolation on children, generating ten comments.

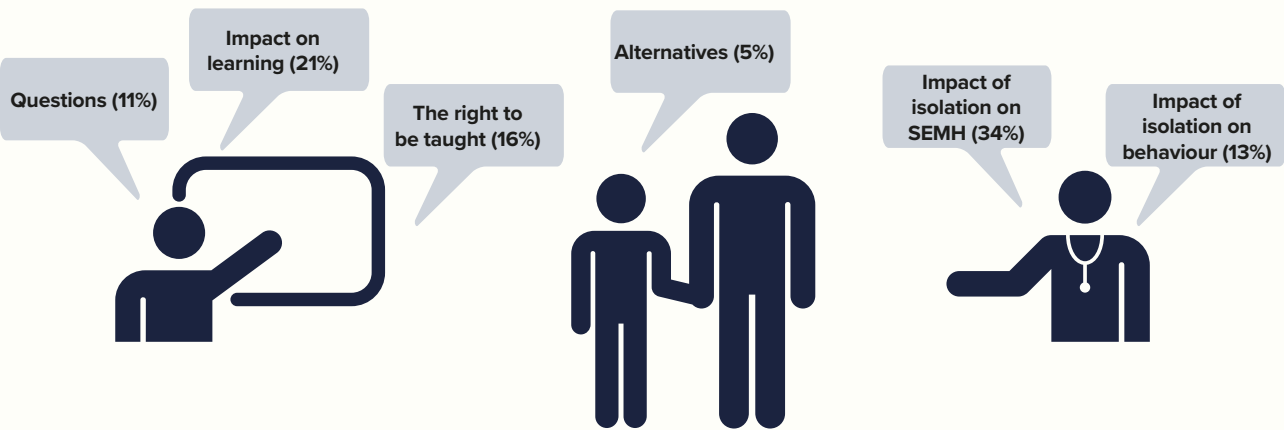


It was clear from the interviews with health professionals and support services that they were unable to understand how and why isolation booths were used in some schools. They commented on the impact on the child’s learning **‘they can bring work if they want; they don’t have to because they have lost the right to be taught’**. This view was echoed by those of the children who also stated they were not taught when in isolation booths. One participant raised the point that **‘you only need to look at the policies; it is all written down, I don’t know how they dare. I sit in schools and I look and they have prominent signs about how much education you miss if you have one day off school. But I think ‘you have just made that child sit in an isolation booth for an hour or for a whole day’. How does that work?’** Some described concern over the impact on the child’s mental health of not being

able to socialise at break and lunchtimes, and of not being spoken to when in isolation. Both of these issues were raised by the children and caregivers in their interviews and conversations with the research team. The overarching view of health and support professionals was that they felt that being consistently sent to isolation was out of the child’s control **‘you could say that the isolation booths are false imprisonment. Even detention. I know the children could walk out but there would be consequences for that’**. This suggests that health professionals feel that the children do not have liberty and freedom as legislated in the Human Rights Act (1998). They also believed that isolation does not positively improve behaviour but instead causes resentment, particularly for children who are retained for long periods of their statutory education, supporting the views of the children and the caregivers.

### 4.5.8. Advisory group of professionals: Challenges, questions and concerns around the use of isolation booths

This section shares the views of the ten professionals who were shown the overarching themes relating to the use of isolation booths in education.



The main concern identified by health and support services was that the repetitive use of isolation booths could be detrimental to the mental health and wellbeing of children **‘the impact of sitting in silence for a day, week, month or year, you just cannot imagine’** and **‘by stripping children of their dignity you are perpetrating a corrosive culture, it is dehumanising’**. They discussed the importance of social integration rather than social isolation as a means to learn positive behaviours and to prevent future mental health diagnoses. They made the point that missed education will make children further behind.

They also identified the importance of additional training in some schools that would challenge staff attitudes towards the use of isolation booths. They felt there needed to be a focus on supporting schools in identifying where a child is dysregulated, has unmet learning or mental health needs or requires

reasonable adjustments **‘what is the impact of isolation on children with regulation needs? Isolation is not a reasonable adjustment’**.

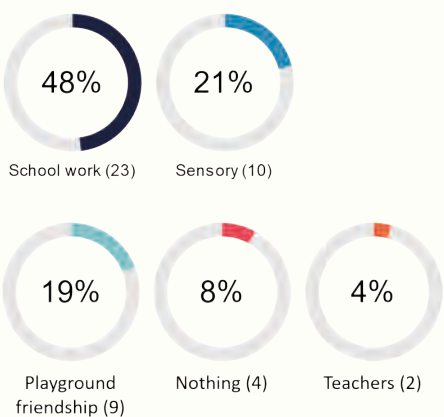
The health advisory group were concerned about the impact of isolation booths on learning; this supported the thoughts of children and caregivers and is at odds with the agenda around school attendance and attainment. The comments ranged from **‘I cannot understand why isolation is used, what purpose it serves. The quieter environment may help some, but it seems no educational instruction takes place’** and **‘why are the children contained on school premises if they have not been taught?’** They described how there was no therapeutic benefit to isolation booths and that consideration needed to be given to the curriculum if it demands are too much for some children in mainstream school with increased demand on restricted movement and less practical work (Power and Taylor, 2018).

4.6. Children’s views on additional challenges in mainstream schooling

The children were asked about what they found challenging about mainstream education.

- 20/20 children in KS1 (48 references)
- 14/15 children in KS2-3 (67 references)
- 20/20 children in KS4 (67 references)

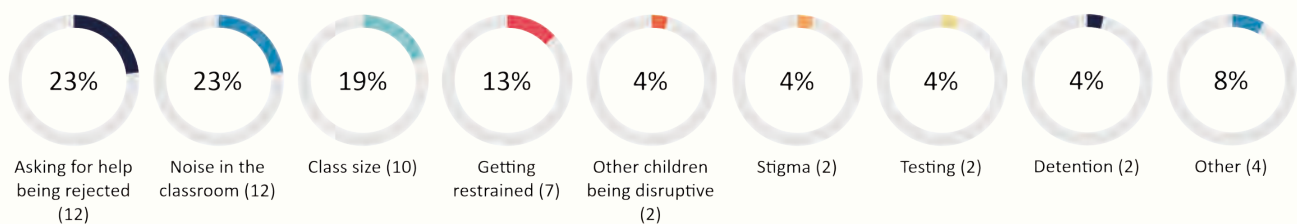
4.6.1. Children’s views on additional challenges in mainstream schooling: Key stage 1



School work was the most common response to what the KS1 children found difficult about mainstream school **‘I find it difficult to do maths ‘cos I don’t really like maths’ and ‘I find it difficult because the work is too hard’**. It was found that the majority said school work too hard, or there was too much of it to do. The remaining themes all had one response, with the children describing challenges (staying seated, too many children in the class, not liking school work, sharing, and a dislike for handwriting). This implies that these children are not coping with the day to day curriculum demands. They were able to articulate that they had **‘failed in mainstream’**, which supports the findings of both the NUT (2015) and Hutchings (2015), who found that young children are now more anxious and stressed about school, as they are required to achieve in areas of the curriculum before they are ready.

Ten responses related to sensory challenges that the children were able to describe **‘I find it hard when I am doing PE, sometimes punch people because everyone is shouting and chanting [and] it makes me angry (PE)’** and **‘noise made me feel pressure, I was upset and angry’**. Noise interfering with children’s levels of tension, leading to aggression, is supported in research (Suter, 1989). Half of the difficulties related to noise in the school and a need to regulate through screaming **‘sometimes I do scream; that’s how I stop hurting people’** and avoiding kinesthetic experiences **‘I hate the mud’**. These behaviours could be indicative of underlying neurodiverse needs (Cheung and Sui, 2009; O’Brien et al., 2009; Wiggins et al., 2009) that can impact on a child’s health and physiological and psychological outcomes (Atmaca et al., 2005). It was evident that the children found the playground a difficult place to cope in school **‘I need help in the playground because me and a child had a problem’** and **‘playground the most’**. The children’s responses indicate that noise in their environment is a barrier to accessing school; this was also experienced by the children in KS2 and 3 and is discussed in the next section.

### 4.6.2. Children’s views on additional challenges in mainstream schooling: Key stage 2 and 3



The figure above shows that one of the predominant challenges described by children in KS2-3 was asking for help with school work but feeling it was not forthcoming **‘there were too many people and I needed so much help; I wasn’t getting any at all, I didn’t cope well’** and **‘I say ‘can you help with this’ the person says ‘no I’ll come back to you’. But they came back at the end of the lesson or at the end of the task’**. This supports findings by Blatchford and Webster (2018) that the availability of adults can affect a child’s ability to learn. There seemed to be acceptance from the children that the teachers were overstretched, with too many children in the class to teach **‘it is hard for the teachers to get round’** and **‘they didn’t have time to listen’**. The evidence suggests that there are barriers for teachers to be able to provide the level of support that some children seek as suggested by (Johnson et al. 2017). The children discussed the impact of large class sizes of between 30 and 35 and how they felt this resulted in less support being made available **‘there were too many people in a class, up to thirty people’** and **‘there were too many people and I needed so much help. I wasn’t getting any, at all. I didn’t cope well. So I would kick off a lot’**. The idea of not coping has been found to be linked to larger class sizes, particularly for children who have SEMH needs and lower levels of attainment (Smith and Glass, 1980; Blatchford et al., 2011).

Over half of the children reflected on the impact of lack of support on their self-esteem and well-being. As with KS1, it was evident with the children in KS2 that remaining calm was difficult due to high noise levels, which correspond with other research (Atamaca et al., 2005;

Kanakri et al., 2017). Children’s comments show the adverse impact of noise on their ability to engage in school **‘it stresses me out. I feel I start to go crazy. When I’m angry that I feel like I’m going crazy’** and **‘the fire alarms there are so high pitched. That’s why I’m glad I’ve left. The fire alarms’ went off a lot and it’s a lot, a lot of noises’**. This supports that early assessment and identification of the multi-faceted needs of children is a crucial aspect of maintaining access to mainstream education.

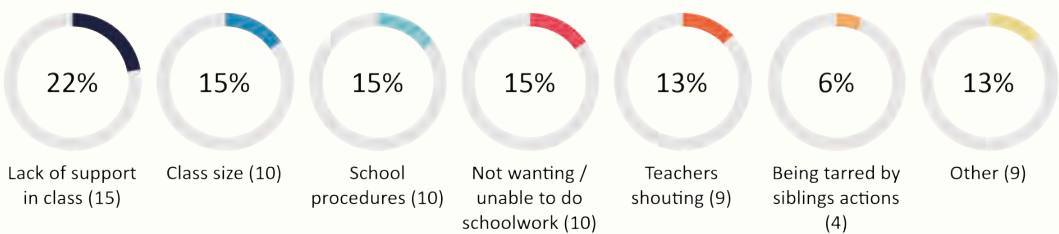
During the conversations with children, they described how they were restrained in school, **‘they would have my arms like ‘that’ and someone was on the other side, pulling my arms. Or they would have one person pushing my arms down, one would push my knees and one would push my feet’** and **‘for my arms, knees, feet, there were three. Just the arms was only one’**. It is clear from the evidence that the children disliked restraint and that it is being used in both KS2 and 3 but interestingly, was not reported in KS4. In all of the interviews when restraint was discussed, the children’s demeanour changed as they reflected on this as a disciplinary approach. All four children talked about it making them feel worse, distressed and angry **‘it made me more mad’**. The descriptions from the children on why restraint was used varied; one child described it following a fight with another child; after having her hair pulled, restraints were made on both children. Two children reflected on the reason being that teachers anticipated they were about to do something wrong due to changes in their behaviours **‘cause if you do something wrong, you get restrained straight away. Like if someone went to hit you and you**

walked away. When they start coming at you, they would just if you reacted a different way they would restrain you' and 'just have to be naughty, just do it sometimes if you react in a different way'.

The DfE (2013b) clarified that restraint is only to be used in extreme cases such as fighting. The children reported feeling that restraint was not justified and that they needed to simply be able to self-regulate **'so when I was angry, I used to go out the door and run around the track to keep us calm, one day three teachers chased me'**. These comments from the children indicate a possible training need so that signs of a child becoming dysregulated are better understood, so restraint can be avoided. The model used in health should be applied to education, where schools have restrictive intervention reduction programmes, as new approaches are explored and embedded (DoH, 2014). Alternative methods are available, such as those taught by Studio 3, which is endorsed by the British Institute of Learning Disabilities (BILD), as it promotes schools negating the need for physical restraint. This should include understanding the underlying message conveyed by the child's behaviour (American Psychiatric Association, 2013).

Other additional challenges reported by these children were due to perceived pressure **'every time the times tables get quick... I used to get one out of ten and others get ten out of ten, but they were too big and there was a timer, you had to read how many you got in front of the class'**. Detention, stigma and other children being disruptive were referred to twice each. Changes to routine, getting sent out **'that was my whole life really, getting sent out'** teachers and competitive use of rewards were each referred to once.

### 4.6.3. Children’s views on additional challenges in mainstream schooling: Key stage 4



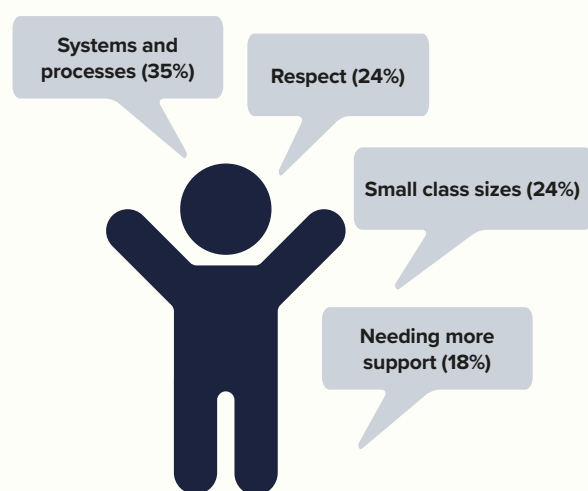
In KS4, all twenty children made comments on additional challenges with 67 references. The most common difficulty in mainstream education, accounting for over 22% of responses was the lack of support **‘they didn’t support me, so I was going home crying... because they weren’t helping me through anything, they just told me to get on with it’** and **‘the fact is when I asked for help they wouldn’t give it to me, they would just say ‘I will come back to you’**. The comments suggest that children need a personalised curriculum and teaching approaches to support them in accessing and participating in the learning, as proposed by Michale and Frederickson (2013), and Tellis-James and Fox (2016). It suggests that the lessons are not accessible given the needs of the children and that they need a strengths-based approach.

Another challenge reported in KS4 was that class sizes were too large for children to be able to learn and access support **‘thirty children and only one member of staff to support them’** and **‘they can’t get round a class of thirty, just helping one child all the time’**. This view was also an issue for KS2/3, and supports the findings of Blatchford et al. (2011), that classroom engagement decreases in larger classes, as does teacher support for learning generally (Graue et al., 2008). The children’s comments suggest they disengage because they are unable to understand the lessons or activities presented to them; this results in them not completing the work and the cycle of sanctions begins and ultimately results in them not remaining in the classroom. Unlike some findings, which suggest that teachers make more of an impact on learning than class size (Sanders et al., 1997; Blatchford et al., 2011), a common theme here is that children need smaller classes to access the support they need.

School procedures represented 15% of references to barriers to mainstream schooling experienced by KS4 children. These predominantly referred to perceived breaches of uniform **‘he came into the school and tried to change too much; he would make us line up on the morning break and dinner to make sure we were all checked’** and **‘we would be outside for twenty minutes to make sure we had our coats and correct uniform... I was always pulled out of the line and had to wait for the headteacher because I was talking apparently’**. There is a clear perception of unfairness from the children in relation to school procedures, feeling they are watched and checked constantly, with only one child accepting that it was deserved **‘I was proper lively like. I used to get wrong for doing things I shouldn’t do all the time. All the way through school. But I’ve learnt how to control it more in secondary’**. These comments support the views that discipline systems and policies in schools do not consider normative adolescent behaviours and child development (Gregory and Cornell, 2009; Kupchik and Catlaw, 2015). The children’s comments imply that some teachers and/or senior leaders are seeking out children who are not appropriately dressed. For some children, there may be a deliberate attempt to not adhere to uniform regulation but for others, there may be no choice due to factors such as low family income, working caregivers, if the child has grown or if they do not have the motor coordination to tuck in a school shirt. In acknowledgement of these reasons, the House of Commons (2018) called on schools to use zero-tolerance approaches for drugs or weapons but not for minor infractions such as uniform violations.

#### 4.6.4. Advisory group of children: Challenges encountered in mainstream school

The advisory group was held following the transcription, coding and analysis of the interviews, which identified emerging themes. These were then presented to the twelve children for discussion. The main concern they had with mainstream school was the systems and processes relating to behaviour management.



#### Needing more support (three responses)

- ‘Be fair and give more support in lessons.’
- ‘To have teachers that actually understand learning difficulties.’
- ‘Have more ways for children to cope (self-regulation).’

#### Respect (four responses)

- ‘Teachers need to respect us if they expect it back.’
- ‘Teachers need to give respect to receive it (stop using their power to belittle students.’
- ‘Teachers to have a better attitude towards children.’
- ‘Schools need respect for children.’

These views indicate that some children feel unable to cope in large class sizes and they desire more support in lessons to support them to participate and learn. They also request that they are given ways to self-regulate and that having teachers who respect them would improve their attitude towards school.

#### Systems and processes (six responses)

- ‘Teachers need to pick their priorities (I got isolated for not having my shirt tucked in.’
- ‘No more isolation.’
- ‘Take away isolation booths.’
- ‘Take isolation out of schools.’
- ‘Try to understand the problem rather than dish out punishment.’
- ‘You should be able to express yourself and not be punished for things that have nothing to do with learning.’

#### Class size (four responses)

- ‘You can’t cope in big classes; there are too many people and you cannot get any help.’
- ‘Smaller classes are not as loud.’
- ‘People distract you.’
- ‘People might get on your nerves.’

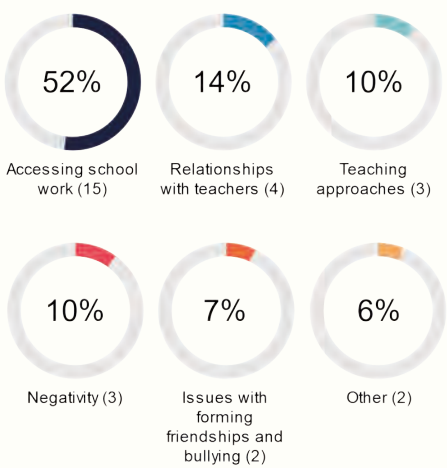


## 4.7. Caregivers’ views of the challenges their child had in mainstream school

Thirty-one caregivers shared what they felt their child(ren) found difficult in mainstream education:

- 13/20 caregivers of children in KS1-3 (83 references)
- 18/21 caregivers of children in KS4 (89 references)

### 4.7.1. Caregivers’ views of the challenges their child had in mainstream school: Key Stage 1, 2 and 3



Of the 20 caregivers, 13 commented on what their child found difficult in mainstream school. The majority described how they felt their children were struggling with accessing school work, recognising that their children do not have the academic ability and/ or support needed to succeed **‘it gets a bit more academic sort of thing; he was finding it really hard and that’s when the issues arose’** and **‘he started struggling with his work, he didn’t have the confidence’**. The views support those of the House of Commons (2018b), who acknowledge the increasing pressures children are under. It could be that for some children who are unable to manage the academic demands, there needs to be consideration of adopting an alternative approach for secondary education, such as the Swiss vocational

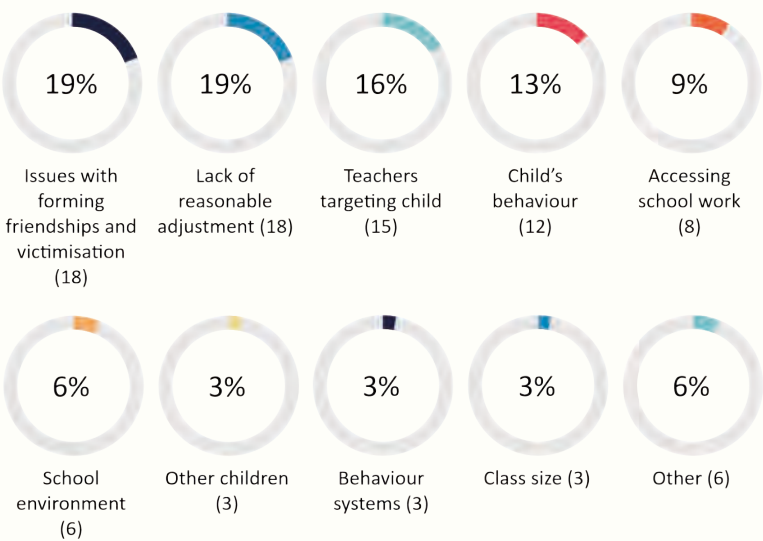
education and training model advocated by Basler and Kriesi (2019). This could give children as young as 12 options to follow alternative tracks into training programmes alongside a school education.

In the caregiver responses, 14% referred to their perception that there was a breakdown of relationships between the teachers and their child **‘he didn’t trust any of the teachers; there was no relationships, they’d all broken; they wrote him off, he knew that’** and **‘he didn’t like how they made him feel and how they treat him’**, with some comments specifying the negativity from the school **‘every report he was getting from school was negative, never any positives’** and **‘every report from school was negative, negative, negative’**. The caregivers’ views were that the relationships in mainstream school had broken down, supporting other findings whereby children felt negatively perceived by the teachers (Nind et al., 2012; Michael and Fredrickson, 2013; Sheffield and Morgan, 2017), and that teachers focus on negatives and ignore the positives (O’Connor et al., 2011).



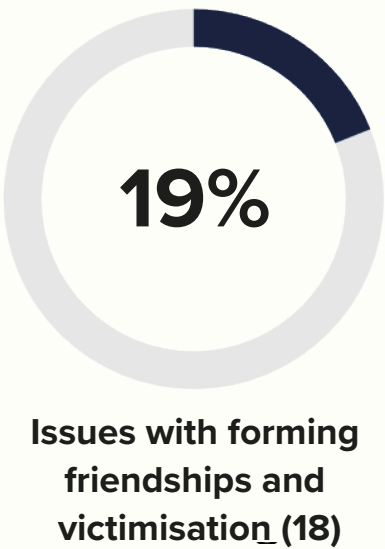
### 4.7.2. Caregiver’s views of the challenges their child had in mainstream school: Key Stage 4

This data set represents the views of 18 caregivers of children in KS4 with 92 references to this theme. Due to the large data set on this theme, it is presented by each subtheme.



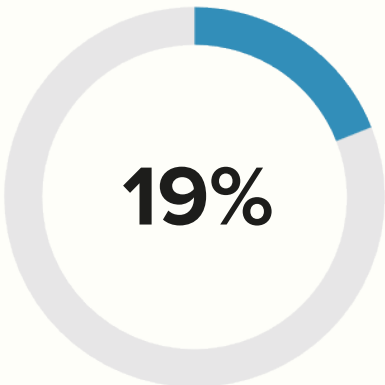
#### Victimisation

Within the caregivers’ responses, some perceived that their child was not accepted by other children or that other children were able to identify differences that led to their child being targeted **‘because the children then knew he was different, then they had a target of someone to bully, someone to wind up. They thought it was funny when he went bang’** and **‘he told me that the three boys had been mouthy earlier on in the day. They called him ‘a scummy care kid’ he said ‘I’m not going to be called those names. You know what it is like for me’ They said to him ‘your mum didn’t want you’.** These comments suggest there could be issues with victimisation in some of the secondary schools and that particular children are being targeted as they are perceived to be different. There needs to be consideration of the impact of such comments on these children and their emotional wellbeing.



Lack of reasonable adjustment, support and understanding of the child’s needs

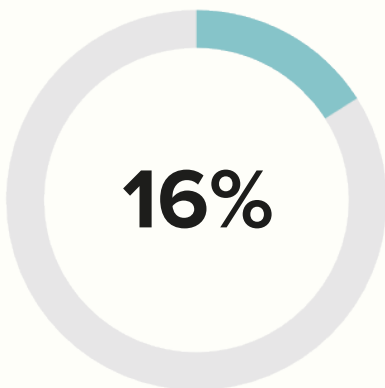
Most caregivers intimated that the challenges their children encountered in their mainstream school were due to underlying and undiagnosed disabilities, traumatic life events, neurodiversity or learning disabilities **‘CAMHS gave him a fiddle toy. But then teachers took them off him and said they were ridiculous and put them in the bin. He would get frustrated because they would take away the coping mechanisms’** and **‘for persistent disruptive behaviour, for tapping, tics and for making stupid noises. He tics when he is nervous’**. Two caregivers with children with a diagnosis of autism felt their literal interpretation of meaning from adults was not understood by teachers **‘if they got a specific [detail] wrong, he would say that he hadn’t done that’** like **‘you threw that out the window’** then he would say **‘no, I threw it at him and it went out the window. It bounced off him and then out the window.’** So they would put him in **detention for arguing’** and **‘my child asked if he could give his honest opinion about something and was told yes. When he gave his opinion, he got in trouble’**. One caregiver described how she felt several changes in significant adults in school led to difficulties in mainstream education **‘his social worker, who had been his original social worker from coming into care left. His pastoral worker at school left, they were massive losses for him’**. All of the responses to this theme suggest that maybe schools need support in assessing, identifying and responding to children’s holistic needs and this needs to include understanding adaptations and the application of reasonable adjustments as directed by Equality Act (2010) duties.



Lack of reasonable adjustment (18)

Teachers targeting the child

Some caregivers felt that their child was targeted by teachers and headteachers and that once their child misbehaved, they were stigmatised as a badly behaved child **‘a new head started and he seemed to target those with additional needs. Her dad was aggressive, so she had upheaval because of domestic violence. The head would get in her face and provoke her’** and **‘his coping mechanisms is to just leave rather than there be a massive argument. This is what we do at home. It was working but the teachers then tried to make him stay. They would step in his way, put their arm out and block his way. Then say that my child has barged them. But my child wouldn’t even touch them. He would deliberately walk under their arms’**. The responses also included caregiver concerns that the actions of schools can trigger historical traumatic adverse childhood experiences which lead to perceived negative behaviour as a response. This could demonstrate a potential lack of understanding of ACEs and trauma-informed approaches as advocated by Thorley and Coates (2018) and Martin-Denham and Watts (2019).



Teachers targeting child (15)

### Managing their own behaviour(s)

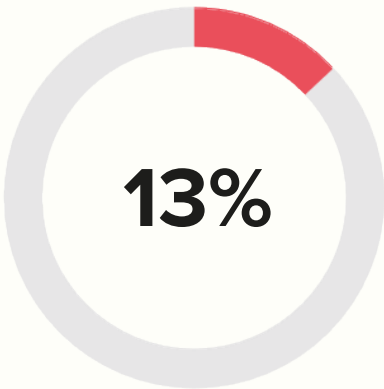
Many of the caregivers cited that their children’s difficulties in mainstream school were due to how the child’s behaviours presented at school. Their comments suggest that they agree their child’s behaviours were challenging **‘he was aggressive towards the deputy head’ and ‘shouting out, carrying on. Fighting. Everything, he was taking drugs’.**

### Accessing school work

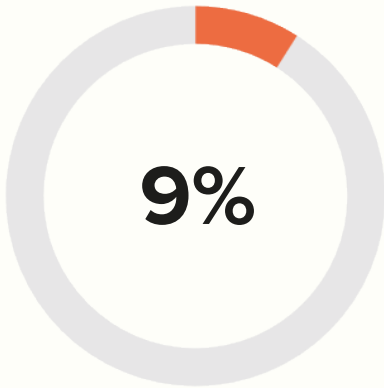
All of the responses to this theme related to the caregivers describing how their child was unable to access the school work as it was too challenging **‘When it came to work, if he couldn’t do it then he couldn’t do it. He would fling his book to the side. ‘I can’t do it.’ I think quite a lot of frustration was because he couldn’t do the work’ and ‘he started to fall behind in juniors. He isn’t academic; he fell behind a lot. He wasn’t understanding. His behaviour started, it was a cycle’.** This supports both the children’s views and the literature, in that when children are unable to manage the school work presented to them in a learning style they cannot access, they disengage (Dunlap et al., 2006; Ewen and Topping, 2012).

### School environment

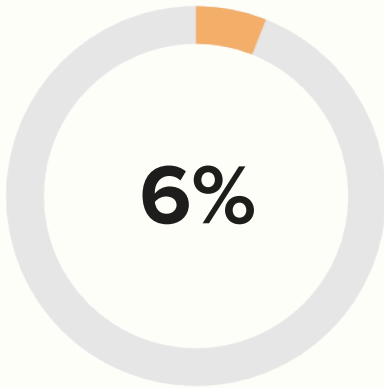
These responses related to the caregivers’ view that the demanding environment of mainstream school requires children to be fully compliant at all times and to attend to learning **‘the expectations of, not behaviour, but of conforming readily, all of the time. Sit. Speak. Work’ and ‘in a mainstream school, where you can’t even speak in class and they put you in inclusion. I think a lot of mainstream schools just focus on getting the grades. Rather than having a little bit of fun within school time. Not just having to sit there, sad, in total silence’.** The comments from caregivers suggest that their children have ongoing pressures which impact on their ability to conform (Martin-Denham, 2019).



Child’s behaviour (12)



Accessing schoolwork (8)



School environment (6)

The remaining themes related to the caregivers' views on challenges their KS4 children had in mainstream schools:

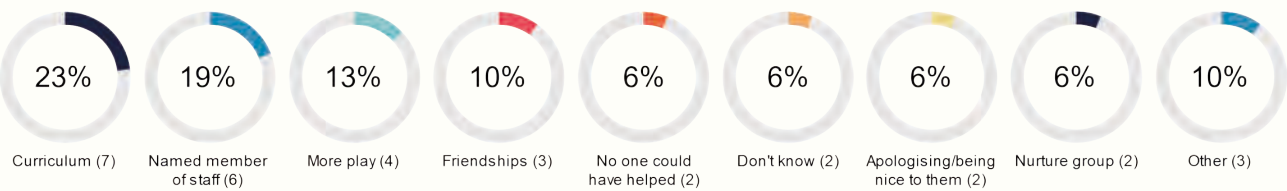
- Other children (3% - 3 references); feeling their child was easily led into negative behaviours by other children
- Behaviour systems (3% - 3 references); being punished by missing PE (their favourite subject), for too many points, wrong bag, not handing in homework...
- Class size (2 references); too many children in the classroom for teachers to meet individual needs
- Previous traumatic experiences (2 references)
- Transition to a Multi-Academy Trust regime (1 reference)
- Smoking and drug misuse (1 reference)

**4.8. Children's views of what could have enabled them to stay in mainstream school**

The children were asked to reflect on what would have enabled them to stay in mainstream school. There were 83 responses to this question from 42 children from KS1-4; these are analysed by age phase below.

- 17/20 children in KS1 (31 references)
- 13/15 children in KS2-3 (30 references)
- 12/20 children in KS4 (25 references)

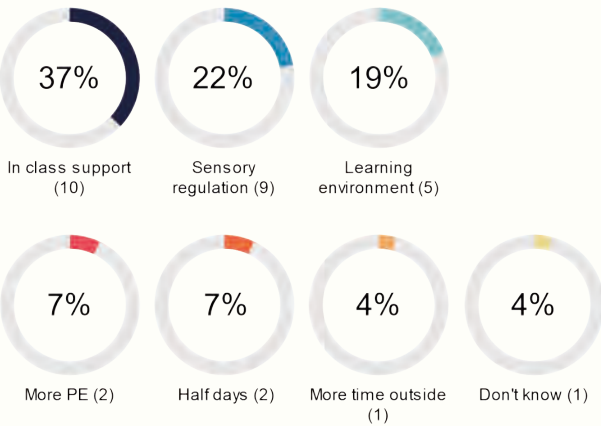
**4.8.1. Children's views of what could have enabled them to stay in mainstream school: Key stage 1**



The key change identified by children in KS1 that would have helped them stay in mainstream school was perceived to be a change to the structure and content of the school day **‘shorter school days’** and **‘I could have been helped by going to nurture group’**. The children articulated their emotional needs that needed to be met **‘cuddling makes me happy’** and **‘having time to talk room’**, which may not be available in all schools currently due to staffing and funding limitations. Some comments related to them asking for support with behaviour **‘help me make good choices’**. Some children were able to describe what they needed to be able to self-regulate in school **‘to bring in teddies and fidget cubes’** and to give them focus **‘if I had some targets; I have targets now’**. The children were able to articulate what their needs were in school. This shows the importance of listening and responding to children’s views (DfE, 2015a).

The second most common response related to additional support from staff (19%). This was followed by more play (13%) and secure friendships (10%) **‘to not be excluded I could be helped by my friends. Because they said if you keep being naughty, you will not see us’** and **‘having more and more friends’**. The remaining four references were children who were not able to say what could have helped them, or believing that no one could have helped them stay **‘I don’t think anything could help me not get excluded’**.

4.8.2. Children’s views of what could have enabled them to stay in mainstream school: Key stage 2 and 3



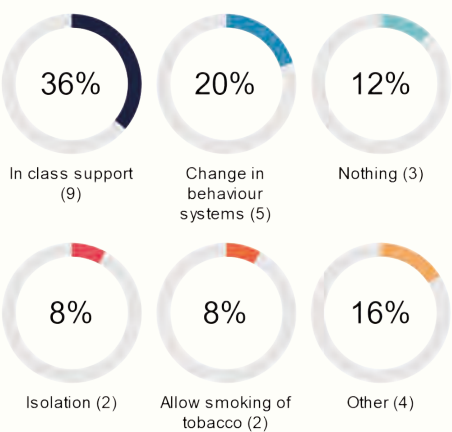
The main theme that emerged (37%) was the children describing that they needed better in-class support, both with learning and managing their own behaviour **‘if someone had sat and explained the work, I would have done it. I would have understood it’** and **‘If they had given you a list, like a PowerPoint. It tells you; you need to do this, then this and this’**. **‘I need more staff helping, explaining things, maths was the only lesson I could get because I have dyslexia, they weren’t helping with that’**. As found by Cosma and Soni (2017), this suggests that educational provision is not appropriate for the child’s needs; that pressures are too high and the support is too low. One child explained that if they were restrained less, that could have helped them stay in mainstream **‘maybe not restrain me as much’**. Alternative approaches should be explored, such as building trusting relationships, understanding triggers and identifying solutions and defusing and distracting the child (Ofsted, 2018, p. 3).

Other comments suggested adjustments to the learning environment and being allowed to self regulate **‘if you are annoyed, you can take it out by playing the music. You can explain yourself through the music, instead of taking it out on other people and hitting walls’** and **‘definitely a quiet room. Not noisy and stressful. I would say put me in lessons where I know people. Where I get on with them, even just a few weeks to get settled in’** and the need to accommodate sensory regulation **‘It’s something to do, even in my lessons, I take apart my pens. I fiddle all the time’**. These comments suggest that local training is needed to ensure those working with children are equipped to support the mental health and wellbeing needs of children (DfE, 2015b).

An additional sub-theme within sensory regulation was that the children felt they were unable to cope with teachers who shout **‘the more they shout, the more I shout’** and **‘teachers not shouting when they think they are big, stop screaming at us’**, they felt this caused an escalation in behaviour. The final comments related to their need for exercise. Two children suggested **‘I wasn’t going to run out of school I just wanted to go on the track. I prefer to be outside. I like fresh air and doing outdoor stuff’**

and ‘football calms me down when I am with my friends’. Finally, two children said they needed a reduced school day either through a reduced timetable or half days. The remaining child was not able to articulate what could have helped them.

4.8.3. Children’s views of what could have enabled them to stay in mainstream school: Key stage 4



As with KS2-3, the children felt that the main change to help them remain in mainstream education was more in-class support (36%) ‘talk to me and help with my work, they wouldn’t help me, then I would end up kicking off, distracting people because I had nothing to do’ and ‘give more support with work instead of removing from lessons’. These views also support those of the caregivers. 20% suggested changing behaviour management systems ‘not to be so harsh on every single thing you do. What difference does it make if your shirt is out or in? It’s not going to affect how you learn’ and ‘I go from C1 to C5 in ten minutes’. This indicates that there needs to be some flexibility in behaviour policies and provision for additional support. The remaining responses related to preferring isolation to lessons ‘I liked isolation more than my lessons’ and quicker diagnosis ‘if I had gotten it earlier I might have stuck mainstream better’.

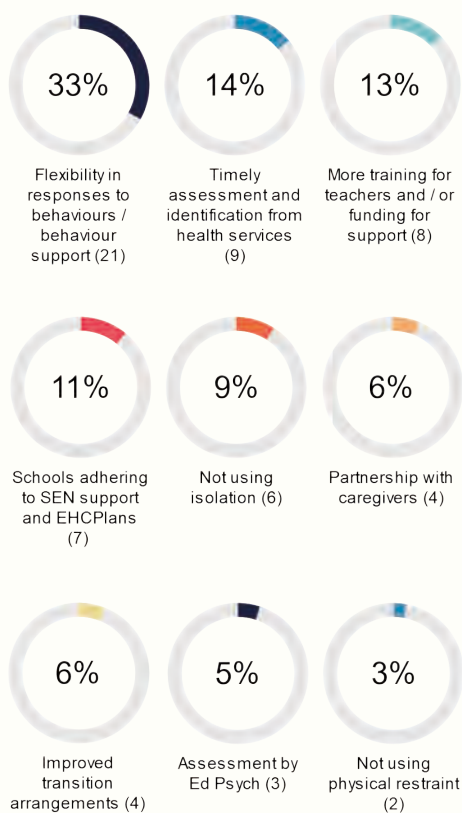
4.9. Caregivers’ views on what could have prevented the permanent school exclusion(s)

Twenty-seven caregivers shared what could have prevented their child(ren) from being excluded:

- 13/20 caregivers with children in KS1-3 (64 references)
- 14/21 caregivers with children in KS4 (46 references)

4.9.1. Caregivers’ views on what could have prevented the school exclusion(s): Key stage 1, 2 and 3

Thirteen out of the 16 caregivers who felt the exclusion could have been prevented, with 64 references.





Caregivers felt that the main change that could be made to prevent the permanent exclusion was for schools to have flexibility in the application of their behaviour policies. Their views alluded to the fact that schools did not understand their child's needs and that their behaviours in school escalated because of this. They also felt schools did not listen to their concerns and suggestions of how to respond to the child when they were dis-regulated **'they needed to listen. They were very quick to just say he was naughty' and 'listen to the kids when they get a bit silly in their chairs, they can't sit still. Now's the time to take them out, to make them run around the field a couple of times'**. Some caregivers described how the school did not understand the impact of diagnosed conditions on their child's ability to 'conform' and adhere to behaviour expectations **'he was just classed as the naughty boy. I don't think they understood his syndrome' and 'fidgeting as well... They try to get him to stand in a line, we know he's not going to stand still, so he gets told off and he gets detention. But they know he can't do it. So why make them?'** The general consensus was that if the teachers had a better understanding of the child's needs, they would be equipped to support them effectively and to identify when flexibility to school processes should be applied.

The importance of having detailed plans to support the transition between key stages and classes within a school was suggested as an improvement to current mainstream practices. One caregiver discussed the impact of transition plans not being in place and their view that this was a key factor in the mainstream placement failing **'they didn't find out from the infant school how they managed him. They didn't put any support in place. They didn't put any timeout breaks in place, no sensory support in place. I mean nothing I literally mean nothing. So, he was dumped into a classroom with 30 odd children and left to get on with it. It went downhill drastically and very quickly'**. The comments by the caregivers justify a need for a review of training to prepare teachers across key stages to provide evidence-based approaches to **support children with multifaceted needs 'they need training. They need to understand not just the strategies but how to apply them' and 'go and**

**do a course to understand sometimes their reaction is anxiety'**. In light of the evidence presented, this should also include training on preparing for and implementing transition arrangements.

The second most cited view from caregivers of how to prevent school exclusion related to the need for timely assessment and identification from health services. The caregivers knew their child had difficulties but felt there were barriers to gaining access to appointments with medical professionals, such as being turned away by General Practitioners (GPs). **'Doctors pushed me back to nursery staff who pushed back at me, I had nowhere to turn'** or waiting too long to be seen by Children and Young People's Services (CYPS) **'my first response from CYPS took a year'**. A frequently reported issue from caregivers was that they felt, when raising concerns about their child to a GP during the preschool years, they were advised to wait a few years before returning to request a referral **'I was told to wait until he was five; he was only three. As soon as he was five he was permanently excluded'**. This indicates that the caregivers perceived that their concerns were not always listened to and because of this, they were in limbo.

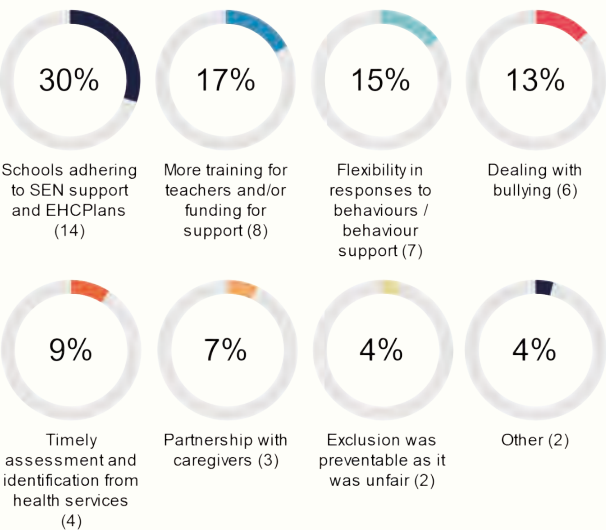
There is a sense that the caregivers felt that the only route to getting support from schools is through gaining a diagnosis from a health professional. Without these plans, adjustments and flexibility in terms of behaviour sanctions would not happen in their child's school. However, for those caregivers whose children had diagnoses, they also reported inadequacies with schools in adhering to both SEN support, EHCPs and medical plans:

- **'The medical report said he needs good support mechanisms or he will experience significant behavioural difficulties and he did'** (no formalised plans)
- **'We were never given a copy of his plan until they excluded him'** (SEN support plan)
- **'Stick by the plans; they haven't got the staff or resources to do it; a lot of it is about resources I think'** (EHCP)

This supports the need for localised training to ensure staff working with children understand their statutory and regulatory duties – that the legal test for an EHCP is that the child ‘may’ have an SEN (Martin-Denham and Watts, 2019). The graduated approach needs to be implemented whenever a child meets the definition of special educational needs, to assess if an SEN support plan or EHCP is required (DfE, 2015a).

The caregivers also highlighted the use of isolation booths as being a contributing factor leading to school exclusion. Their views echo those of health and support professionals, as well as the children who reported they were not listened to or given breaks from the physical space **‘he was in isolation mainly, shoved in a room and not spoken to’** and **‘he’s made to sit and don’t move’**. Comments were also made about restraint and the impact of this being a key factor that led to exclusion **‘you’ve got an eight-year-old child and he is up a height and he is panicked, what is pinning him to the floor going to achieve?’** and **‘he would get upset and end up being restrained and it would escalate constantly, day in and day out’**.

4.9.2. Caregivers’ views on what could have prevented the school exclusion(s): Key stage 4



The views of the KS4 caregivers were similar in some respects to those reported by KS1-3 with the only new themes being schools need to deal with bullying and the view that the exclusion was unfair. The main preventative factor cited by the caregivers to prevent school exclusion was for schools to adhere to SEN and EHC Plans. Some described that when plans were put in place for their child, they were not implemented or adhered to a view shared by some caregivers with children in KS1-3. Similarly, they believed this was the case even when there were reports from other professionals clarifying the child’s specific needs **‘they just said he’s badly behaved, he doesn’t listen, he’s not engaged. He doesn’t follow instructions. I was saying ‘he struggles with the work’, this is his Ed psych report’**.

In the analysis, a proportion of the caregivers raised that once a plan was agreed, not all teachers seemed to be aware that it was in place. Or, if they did know, the perception was that they did not follow it and this led to an escalation in the child’s behaviours. An example one caregiver gave was an agreement with the school that if their child was asked to leave the classroom, no other teachers were to engage with him until he self-regulated. However, she felt this was not followed through. Similarly, another caregiver said it was agreed with her that her child would be given a cold drink to cool down as an approach to support them to regulate, but in her view, this was never offered. Others reported incidents where teachers responded to behaviours in a way that would further distress the child **‘there was a plan for them not to get in his face. I was at work. So my son came in and he was bright red in the face and his arms were bright red. I said ‘what’s wrong?’ and he said ‘ a teacher pinned me down and ripped my blazer off me.’ ‘Why?’ ‘because I had a fag in my pocket’**.

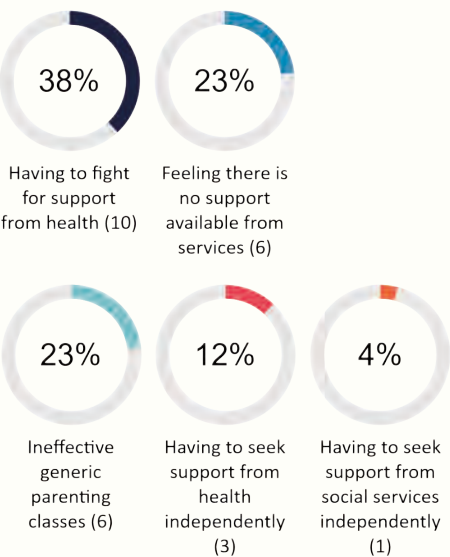
It is evident that by KS4, the caregivers are more aware of what should be in place in terms of reasonable adjustments for their Child; they understand the system. This is less evident in the data from the caregivers in KS1-3. As with KS1-3, the caregivers identify training as an issue, to enable teachers to understand the underlying reasons for the behaviours.



‘the answer is to exclude him. Not to get to the bottom of what was the root cause of the anger and the outbursts’.

4.10. Caregivers’ views on the level of support available from health services: Key stage 1, 2 and 3

All 16 caregivers commented on the support available from local services, generating 26 references.



Caregivers used the recurring term ‘fight’ when they described their attempts at accessing timely support from health services. Their perception was that they had to be persistent to get a referral and subsequent appointments from some health services (not paediatrics). Many caregivers described how they felt this was unfair, noting that not everyone would have the skills to navigate the range of services they needed to access for their child.

**‘Most parents won’t have the ability to fight; they won’t be able to adequately express themselves to do it or may feel that they can’t, and for a parent to put themselves through that is a really difficult thing. But no one else will do it. There is no one standing at the sidelines within a body somewhere, saying this is wrong’. These children are being marginalised and treated in a way that is shoddy and unlawful, and there is no one stopping it from happening and at some point,**

**somebody has to stop it from happening, and it can’t be the parents; can’t always be the parents because they can’t do it’.**

Some caregivers acknowledged that health services were underfunded and that this impacted on the level of service **‘they are underfunded and under-resourced in my view. You know there are thousands of kids, thousands of kids, in Sunderland’**. There was a sense that they were at a loss of where to go for support due to the demands on health services and long waiting times for appointments. They described the impact of this on children and families:

**‘CAMHS is saying its twelve weeks, CYPS is saying go away, Autism Outreach team were massively stretched and the school have got rid of him and where did I go from there? I think the vast majority of the parents would say ‘I don’t know, I’ve no idea’ and they wouldn’t have the resources to figure it out in a lot of cases and that’s the shame of it. There’s no support for the children and there’s insufficient support for the parents in figuring out where you go from there and if the school aren’t engaged and aren’t interested, then they’re on a hiding to nothing, really’.**

Equally, some caregivers felt there was no available support from some health and support services and many also stated that the parenting classes they attended through CAMHS were not specialist enough. They felt that these classes were too generic and needed to relate more to children’s individual needs.

Many caregivers also described how they perceived that they were blamed for their child’s behaviour(s) by some health services (not paediatrics or CYPS). They felt they were going through a stressful time and this compounded their feelings of failure.

‘The health visitor said that my child hit me probably because of me, so I thought it was my fault. I know it wasn’t me now she has [a diagnosis of] autism.’

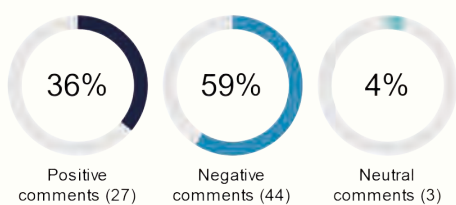
‘They said that her behaviours she displayed were our fault because we weren’t managing her properly, rather than it being an underlying problem that she had.’

‘I think they believed it was me and my husband. That’s how it makes you feel, that the fingers are being pointed at you... Not being funny but when you have a child with severe difficulties, I probably knew more than the person presenting it. That’s just the nature of the child with ADHD and ODD. Also, I had one compliant child that excelled and one with these difficulties.’

‘We tried to get a diagnosis but couldn’t. We were told it was our parenting and we weren’t firm enough. We were sent on classes but they didn’t really help.’

‘We just felt it was just doing something wrong. If you fed back in a parenting class something you have tried, they would say you shouldn’t do that we don’t understand why you would do that; you should do it like this. There weren’t more than ten in the class. It was a very general class, general stuff; they try to cover everything. We would talk about things we have tried. We just used to go back and it didn’t work and they say we haven’t tried hard enough and we are doing it wrong.’

4.11. Caregivers’ views on the enablers and barriers to health and support services



This section examines the enablers and barriers to health and support services, as identified as an emerging theme in the interviews across

participant groups. All 20 caregivers spoke about the support they received. They made 74 comments in total; 27 were positive, 44 were negative and three were general or neutral.

4.11.1. Caregivers’ views on the enablers and barriers to health and support services: Key stage 1, 2 and 3

The paediatric service was viewed to be a strength by the vast majority of the caregivers who were interviewed:

‘It was about two weeks for the paediatrician. We got a diagnosis straight away... they also took blood tests and arranged the speech and language therapist, but they knew my child was on the spectrum. The paediatrician wrote a letter so we could get support and a place for her with school; this really helped’ and ‘they even come to the school, the paediatrician pushed for our daughter to stay at the mainstream school. They agreed that support should be provided there so that she could continue.’

However, one caregiver described having difficulty getting a paediatrician to acknowledge the need for their child to be assessed:

‘I saw a paediatrician, [my child] was anxious, so he was throwing stuff about the room because he knew we were talking about him. The paediatrician said ‘normal, ignore it’. I said ‘you know, it’s got to the point where I can’t ignore it anymore; he’s going to throw a chair off my head.’ So my mum took him out of the room so I could speak to them one-on-one about him. It was agreed he did need further assessment in three months’.

One caregiver described a positive experience with a consultant from out of the area ‘**we have to visit five different doctors, if they do advise anything about her care, they also let the mainstream school know**’. Within the area, a caregiver valued the work of a psychologist from social services in Sunderland ‘**they were quite good. We’re keeping going with that**’.

The caregivers described that if they can get an appointment with CYPS, they generally have a positive experience **‘when you actually get into the system. They are great. I have to say. CYPS are brill. They are the most helpful professionals who work alongside children with ADHD and other issues’**. The issues seem to be when they access one health professional to then be told they need to be seen by a different service:

**‘After one assessment, CYPS referred him back to the paediatrician from everything I’ve said, so they said they didn’t think it was ADHD but that it was ASD which has got to be diagnosed by the paediatricians. It took us six weeks to get seen. The worker that we had seen at CYPS was lovely. They emailed through to the paediatrician they had obviously said he was a matter of urgency, so CYPS did massively help him’.**

The caregivers also reported what they perceived to be excessive wait times **‘I’m thinking of the CYPS and that’s taken like a year’** and caregivers feel they have to fight for the appointment **‘we pushed for CYPS and for his psychological review to be brought forward. It was good but you’ve got to push them. That’s the hardest bit, you’ve got to push them to get seen, re-tracked’**.

The caregivers’ views illustrate the need for a triage service in Sunderland to provide early identification and/or to support children across the age phase 0-25 years. This would ensure that a health professional can decide which pathway is most suitable for the child (paediatric disability service, community CAMHS or CYPS).

Some caregivers discussed how their child would be discharged from key health services if they were unable to engage during their first appointment (not in the case of paediatrics). The reasons the caregivers gave for their child not speaking were: due to being nervous around new people and anxiety around discussing the difficulties they were having at home and school. One caregiver felt there was no acknowledgement that the child may need more time to become familiar with the staff. A few also described how, following the discharge

for their child not talking, their difficulties continued and they had to be ‘re-referred’ by a GP and rejoin the waiting list, even when the need to be seen was reinforced by a paediatrician **‘the paediatrician was saying that we need to look into this (through CYPS). So I said ‘he is not waiting again. He is just not. He has already been in the system for permanent exclusions and managed move.’ So he went back in then... it has been intermittent because he won’t engage’**.

The findings consistently suggest that caregivers encountered barriers to referrals from their General Practitioner (GP). Three comments alluded to negative experiences with GPs, all relating to a reluctance to refer to another health professional **‘the GP weren’t going to refer us, they thought there were nothing the matter with him’** and **‘we had to really fight for it. It took a long time, we kept getting turned away from the GP. We took an educational psychologist report from the nursery. We took the report to the GP about three times but they wouldn’t look at it’**. This correlates with the views shared of their experiences of the health visiting team, where the caregiver’s view is not always believed to be right **‘I told them she hit me with force and she was aggressive. They said that was probably because of me, so I thought it was my fault. I know it wasn’t me now she had [a diagnosis of] autism’** and **‘I told them, but nothing came of it’**. This indicates that some caregivers are encountering barriers to accessing support and having their concerns taken seriously.

Two caregivers reported positive experiences of CAMHS, saying **‘they were great but it was more like playful, but they were there for you’** and **‘it was quite quick with CAMHS. I rang the doctors with the way he was going on and said I needed some help. I think it was in about eight weeks that I had my first appointment and I spent nearly a year with them’**. The main issues identified by the caregivers were: children being discharged, having to go to CAMHS before you can go to CYPS, not being seen due to their age, or status of the child, as illustrated in the following comment:

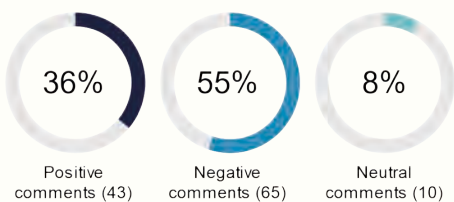
**‘CAMHS had him first. You can’t get into CYPS without being referred from CAMHS and you don’t just get that, it’s not automatic. They kept saying ‘oh no, he’s too young’, he was 5. But I said that he’s been suspended from school. I could see all of this behaviour. I wondered, is this ADHD or Autism? But they kept knocking him back, saying he’s too young, to go away. By the time he was eight, things were really bad. Finally, they decided to refer because I kept on going back and I kept going to my GP and said he’s been suspended again, so they referred him to CAMHS. Then we had to wait ages for an appointment with them and then eventually we got referred to CYPS. You’re talking four years, four and a half years. It’s terrible, really. When I was crying on my knees for help’.**

This is one of the main issues arising from the interviews, that the families and children in Sunderland don’t always have a route to support. CYPS do not appear to be assessing children under the age of six if there are any indicators of ADHD, and age nine for ASD. However, the CYPS website suggests the service is for children from 0-18 years, who are experiencing psychological distress or mental health difficulty. Children with emotional and behavioural needs can get general advice from the paediatric disability team, who can also exclude physical health conditions. The children need specialist assessment for ADHD and ASD, and other neurodevelopmental needs. It needs to be considered if CYPS could reduce age limits, more in line with early intervention and the graduated response (DfE, 2015a).

The caregivers felt that CAMHS could be improved if they observed the child in their school environment, if that is where the concerns were. Some caregivers did say a CAMHS worker had gone to school but this seemed to be inconsistent. Again, children are discharged if they are not willing to engage; the caregivers felt that it would take their child some time to open up to professionals, given their difficulties but this is not possible within the service. An alternative approach could be to change the practitioner to see if they are able to form a relationship with the child. It is also the case that for these children, they will then be

relying on schools for support, which is unlikely to be within their expertise.

**4.11.2. Caregivers’ views on the enablers and barriers to health and support services: Key stage 4**



All 21 caregivers spoke about the support they received. They made 108 comments in total; 43 positive, 65 negative and ten general or neutral comments.

Similar to the caregivers’ views with children in KS1-3, the paediatric disability service was identified as a strength, as were educational psychologists. Again, there are caregivers who perceived they did not get any support from health services **‘we’ve had doors shut for years. We’ve had loads. I’ve lost count. None have helped. We’ve had no full assessments; this is despite school exclusions and requests for support’** and **‘what do you want me to do?’ We said ‘well, he is shutting down, why? Is there a reason behind it?’ The GP said ‘You are just clutching at straws’**. All the comments for this age phase were negative regarding support from health visitors, as either nothing was ‘picked up’ or nothing happened to follow up concerns expressed by the caregivers.

Similarly, the descriptions from caregivers for this age phase relating to their experience of CYPS were more negative than positive. The positive experiences related to being seen in a timely manner when children presented with extreme behaviours such as attempting to take their own life. Positive experiences also related to support plans for use in schools and the identification of neurodiverse needs such as ADHD, dyslexia and post-traumatic stress disorder (PTSD). The negative aspects of CYPS included caregivers feeling that there was a lack of support when a child is in crisis, with limited access to an out of hours service; lengthy waiting times of up to a year, and the time it takes to receive a diagnosis (years in many cases); and staff in the service being off work, meaning changes in workers or cancelled appointments. It seems that the caregivers see the securing of a label for their child as necessary if they are to access support in school. It is understandable that caregivers are driven to secure a diagnosis.

In relation to CAMHS, it became evident that there were more negative than positive experiences. The positives identified were: assessments taking place in the school environment and the knowledge of the team **‘they said ‘I believe that he has ADHD’.**

**And I said ‘he hasn’t; he’s not hyper. But they explained it to me. He’s at CAMHS still because he is on ADHD medication’.**

The main issue described by the caregivers was long waiting times and a feeling that they are discharged too soon **‘he only had one initial meeting and the school decided it hadn’t worked for him. But we had only just gotten for the first interview, where you just say what the issues are and then you decide to set up appointments. So to say that comes hadn’t worked, it hadn’t even been given the chance to work’.** Some caregivers reported that they are on the ‘overtime list’, their perception of this is that they are only seen if there is overtime available and their child can be ‘fitted in’. This was echoed by other caregivers, saying a worker said ‘I am just working overflow’. The caregivers reported that they feel their child doesn’t matter as much as children on the main lists. A key challenge cited by caregivers

is the CAMHS ‘exemption list’ or ‘special circumstances’, which means some children are unable to be seen and have to wait for a CYPS appointment. The list includes children:

1. Who have learning disabilities
2. Who are, or have been looked after or accommodated, including those who have been adopted
3. Who have been neglected or abused or are part of a child protection plan
4. Who has a learning or physical disability
5. Who have a chronic, enduring or life-limiting illness
6. Who have substance misuse issues
7. Who are at risk of, or have been involved in offending
8. Who are homeless or who are from families who are homeless
9. Whose parents have problems including domestic violence, illness, dependency or addiction
10. Who are placed out of the area
11. Who are placed in a secure placement
12. Whose parents are in prison
13. Who are from a minority ethnic or minority cultural background including travellers
14. Who are not involved in education, employment or training

The result of these special circumstances is that caregivers felt there were too many barriers to accessing CAMHS **‘as it was out of CAMHS threshold then we had to be referred to CYPS, that was another twelve-month wait’** and **‘they wouldn’t deal with us because of my son’s father’s status’.** This research highlights that it is imperative that the special circumstances list is withdrawn to allow the securing of support earlier for children who are unable to wait for other service appointments. Education Policy Institute research continues to identify eligibility criteria as the main reason specialist mental health provisions reject referrals into service, often citing the necessity of high thresholds due to capacity (Frith, 2017). The caregivers’ views show that the impact of prolonged waiting times is that their child’s difficulties escalate. During this time, without accessing the specialist support, children and young people’s mental health may deteriorate (CQC, 2017), impacting their education.

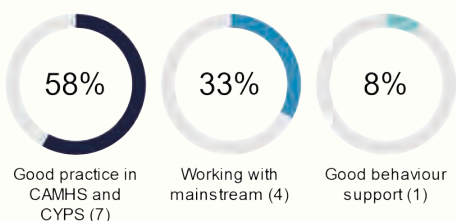


4.12. Health and support professionals’ views on the health and support services

This section represents the data collated from professional cohorts on the existing Health and Mental Health provision within Sunderland.

4.12.1. Views of health and support professionals: The positives of health and support services

Of the nine health and support professionals interviewed, five reported positive aspects of services, generating 12 comments.



Good practice was reported in both CAMHS and CYPS relating to signposting between the services to ensure the child is referred to the most appropriate organisation

**‘There is a path between us two. If a parent refers to them on the phone, a phone consultation, they will signpost it back to us. So if it goes to the wrong place it doesn’t matter. We have a formal manager meeting once a week and stuff gets passed. So things get filtered in. If a referral comes in with the mum being bipolar, then that immediately goes to CYPS, even if it comes in on our referral’.**

and

**‘The referral system is effective in one sense; there is a dialogue between CYPS and the Tier 2 service. Referrals can come through all of these means. They do get triaged by our managers on a daily basis. We have an on-call system here for the clinical leads. So we do triage and if any other service can provide a quicker response and a meaningful response, then we do signpost those, for example, if counselling is**

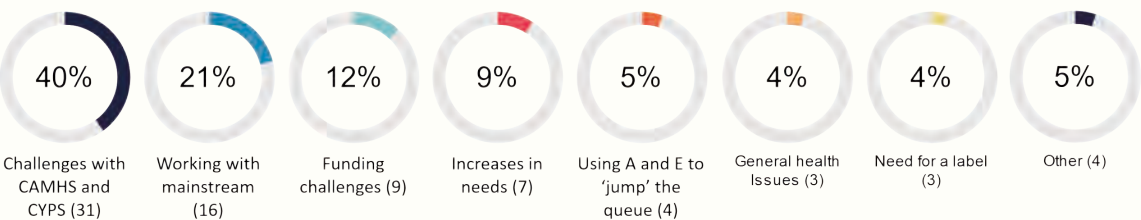
**needed they could get that from MIND. If they are 16-17 there is the ‘I am’ service’.**

It was evident that the health organisations do not want children waiting on lists for support. The exemptions list in CAMHS means that some children are automatically filtered out of their service **‘every week we have a meeting and we take some referrals there and thrash it out, with the special circumstances ‘Which can you work with? Which can you not?’ It’s like, we do try’.** This echoes the concerns of the caregivers around the threshold to be seen by the CAMHS service. An approach to reducing wait times in one service was by employing **‘lower banded people to do low-level interventions, almost off-the-shelf’.** It was reported that these practitioners support children with low-level anxiety **‘it lasts 6 weeks and for some families that is enough. It has massively impacted on the waiting list. Because those 7 people, even if they see one a week, that is seven off our list’.**

Health and support services had four positive comments regarding working with mainstream schools. One comment was that **‘my experience of schools generally is that they will try everything within their remit and their resources to try and accommodate young people’.** Two comments specifically commended some mainstream schools for their support of children with looked after status **‘more schools do take into account the looked after status. The headteachers have been in receipt of training’** and **‘there are some attachment-friendly schools and I think there are those schools who really embrace the social-emotional aspect of learning’.** A final comment commended one school’s reasonable adjustments for a child with multi-faceted needs **‘a little girl, where the school has been amazing at making reasonable adjustments. This little girl with primarily a physically disabling condition and a movement disorder but she’s also on the autism spectrum, she’s typical intellectual ability and the school have really bent over backwards to accommodate and make adjustments for her’.**

### 4.12.2. Views of health and support professionals: The challenges with health and support services

All nine health and support professionals shared their opinion of the issues with services, creating 77 comments



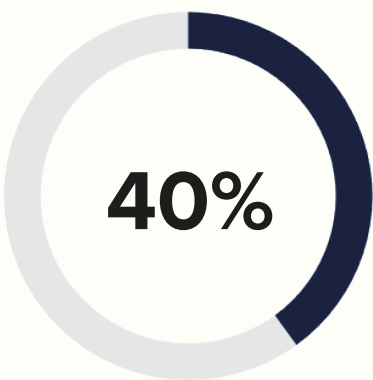
#### Challenges within CAMHS and CYPS

The perceived challenges within CAMHS and CYPS was the dominant sub-theme shared by health and support professionals. Due to the size, it has been broken down below.

#### Challenges with CAMHS and CYPS: Pathways to support

##### Unclear pathways to different services

Five of the comments were explicit that there was confusion about the different pathways for children of different ages who had different types of needs. These views echoed those of some of the caregivers (4.11.1), that there is not always a clear route to support. A health professional agreed feeling that this led to most people sending referrals to paediatrics **‘but there is a limit to what paediatricians can do. As I said at the outset, I think there are major capacity issues with CYPS’**. Another reported that CAMHS are unable to work with children as soon as they have a diagnosis **‘as soon as they do, it’s CYPS’**. One participant was unclear of which pathway to follow, as referrals had been rejected. These views support the findings of the Department of Health and the NHS England Task Force (2015), that there is a fragmentation and lack of cohesion nationally, resulting in children falling between the gaps in service provision which can lead to multiple referrals to get to the right service (Iskra et al., 2015). The impact of confusion around which service is best able to meet a child’s needs was raised by National Association of Headteachers (2018), that schools need to know the support available to ensure effective mental health support is gained.



Challenges within CAMHS and CYPS (31)

Another question was raised around the appropriateness of all caregivers following a parenting programme **‘regardless of if they get a diagnosis or not, that the first intervention should be parenting’**. This correlates with the views of some key stage 1-3 caregivers, who reported that the parenting classes they attended through CAMHS were, at times, too generic.

### Exemption list CAMHS

The five comments intimated that the current exemption list in CAMHS means that many children who would benefit from the service are unable to access it **‘the special circumstances involve a lot of different factors...The exclusion list is a barrier’** and **‘I guess CAMHS are little more, I’m being careful what I say, but are a little more flexible about the special circumstances. Because it is possible that a young person with a diagnosis of Asthma is still able to benefit from a counselling intervention’**. The other views expressed proposed that the exemption list needs reviewing, as some of the historic needs of the children were low level but the checklist limits access to support **‘so it is a tick box. Is there Domestic Violence? Is there a diagnosis? Is there a mental health need diagnosed in a parent? Are they LAC? All of those are special circumstances, even if they are quite low level’**. One participant suggested that some teachers had been driven to lying about a child’s history, so that they would be seen by CAMHS. This is an issue as the CAMHS staff then check with caregivers and they don’t meet the threshold to access the service **‘we identify at initial assessment that they need to go to CYPS. So they go to the bottom of CYPS list. It’s wait, wait, then wait’**. The exemption list could result in caregivers being unclear as to where to go to seek support, as found by Iskra et al. (2015).

### No pathway available

Four participants in health and support services claimed that there are challenges with the current pathways to support within the different health services. These were as follows:

- ‘There is no pathway for 3-6-year-olds with challenging behaviours. Some have behaviours that stem from learning difficulties, Autism, ADHD and from genetics but the early years needs a better service’.
- ‘Sometimes we get referrals for younger children. The paediatric person we work with, the neurodisability consultant, they don’t do ADHD assessments but they do ASD assessments ‘til the age of 9. If they get some referrals like that, underage, we will pass those over to them. After that, we triage them and get them on the waiting list’.
- ‘Sunderland is joined with South Tyneside but we have different processes, which isn’t working. South Tyne will only assess their children for Autism at the age of 5, whereas we do this for 0-9 years’.
- ‘CAMHS won’t see children for ADHD until they are 6 years old. This is unhelpful as I see in clinic children who are clearly showing indicators of ADHD but there is no pathway for them; it doesn’t work. The fact is, they have needs and should be seen’.

These comments support the claims of the caregivers (4.9.1), that they felt they encountered barriers to gaining access to appointments with health professionals and being turned away from GPs; being told to return when their child was older.



## Transition to adult services

There was a sense from the comments from three health and support staff participants that there could be improvements in relation to the transition between child and adult mental health services **‘we don’t get many but I can think of young people who it was appropriate to go to adult services. But I can think of one young person, who was nearly 18, who wasn’t ready for adult services’** Another felt there was an issue for those who turn 18 halfway through support **‘I had to refer. Because on your 18th birthday is your cut off for CAMHS, which is too rigid. If they were with us and turned 18 and I was halfway through then we would finish it. But we couldn’t then refer to CYPS. Because CYPS would just refer to adult services’**. The other participant would refer 17 year olds to adult services due to wait times **‘I’ve had a number of young people who I have done CBT with who are about 17. They may need an additional service. We know they will wait around 9 months. It’s longer for ADHD or ASD pathways. We know they would be nearly 18 so we decide with the young person to just refer to the adult service’**.

## Challenges with CAMHS and CYPS: Waiting times for appointments

Three participants shared concerns regarding wait times for both CAMHS and CYPS appointments. One reported **‘it is a big concern, it is a big wait, which is a concern and is no good for families. Early and timely identification of each and every need is what we ought to be delivering. CYPS and CAMHS ought to be held to account’**. Another commented on how the wait times affect the progress of an EHCP assessment **‘CAMHS and CYPS are not meeting waiting times and the impact of this is, for an EHC assessment, there is not a full picture of each and every need, as they cannot be seen in the 20 weeks, so the EHC is based on when I have seen them.’** The final comment agreed with this, adding that there is a high percentage of children who are excluded from school awaiting an appointment with CAMHS or CYPS **‘mainly it is continuous disruptive behaviour. And with**

**those, they either clearly have a diagnosis of ADHD or ASD or something like that. Or they are going through the assessment or waiting to get assessment’**. Three participants felt that the main service with long wait times for appointments was CYPS. In two cases, the wait was nine months and in another case it was a year. A further two comments suggested that the wait time for CAMHS was also too long **‘I wouldn’t agree with a 2 to 3-week wait for CAMHS. I know of children who are at least 3 months for either service’**. These views echo those shared by some of the key stage 1-4 caregivers, that they felt they had to fight to access a CYPS or CAMHS referral, raising that not all caregivers would feel equipped to persist (sections 4.10; 4.11.2). However it is important to acknowledge that the greater demand on mental health services continues to increase, compounding demand on other local services (Roa et al., 2010; Bone et al., 2015; Crenna-Jennings and Hutchinson, 2018).

## Working with mainstream

Health and support professionals noted that some mainstream schools were extremely good at meeting the needs of children, whereas others were less so, in relation to applying reasonable adjustments before and after a diagnosis.

**‘Reasonable adjustments should be based on needs and I put this in my letters all the time. That doesn’t always happen, but some schools are absolutely fantastic. You can name which schools embrace disability better than others and in some schools, your heart sinks and they come to the clinic and you realise what school they are in because you just know the adjustments aren’t going to be good enough.’**

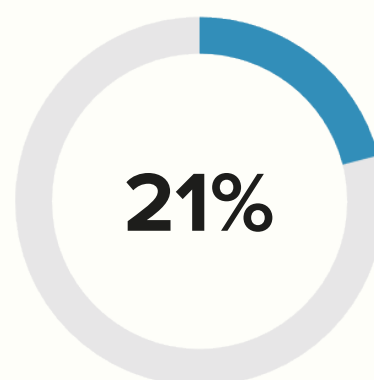
**‘When I write back to SENCOs I say ‘Please make adjustments now based on this’. This family has come along to me to say that SENCO said we can’t do anything until we have a diagnosis’ and I turn that back and say ‘no the school should be doing what they need to do based on the needs instead of waiting for labels.’**

These comments correlate with those made by the key stage 4 caregivers (sections 4.7.2; 4.9.1; 4.9.2), who shared that it is imperative that all teachers understand the impact of diagnosed needs on children’s behaviour and that reasonable adjustments are consistently applied by all schools where a child has a recognised disability.

Some participants also felt that some education colleagues did not recognise a child’s behaviour in school **‘sometimes I’ll have to try and convince them... they just see it perhaps as a behavioural issue’** and **‘the greatest sadness for me is that it’s not always recognised it’s just somebody being really badly behaved. You’ve got to really peel back the layers.’** One participant went on to suggest the system as a whole was not good enough at identifying need and this was evidenced in school exclusions **‘it breaks my heart when children and young people are excluded from settings because of symptoms which are usually behaviours. It is because of system failure because we haven’t identified each and every need. We haven’t put the right adjustments in place and we haven’t supported the family.’**

Further comments from health and support professionals note how the accuracy of data collected in some schools did not reflect the actual levels of need in children, and this had knock-on effects particularly around transition points in education.

**‘Unfortunately, a lot of our schools, I was only doing data last night, actually only identify that they may have a need and they will identify what that primary need may be. However, they don’t actually tick the box that says they have a SEN need, so**



**Working with mainstream (16)**

the data that goes off to official people will say they don't have a SEN need. [...] I think there are some hidden needs of children that are not being identified in some of the statistical data. I know that because if I asked them for plans for an Alternative Provision, they might write ASD on there, but they haven't ticked that box on SIMS, our data system.'

'I have gone to the permanently excluded meeting; normally parents do ask me to go with them. I have sat and questioned myself: 'Can I ask what was that child's SEN status when they were in primary?' They've said it was down as SEMH; I've said 'So what was the transition plan when that child came in?' They will say a little bit but then they will say his academic data didn't show me that'. They will look at the academic data and say 'this child is achieving level 4 and 5'. They get the levels they're supposed to get but in the background, it says this child may have a need. So when they get put in a completely different environment, they may have that data but they fail because they are not given that nurturing support.'

Participants acknowledged the challenges schools face and the impact of limited resources.

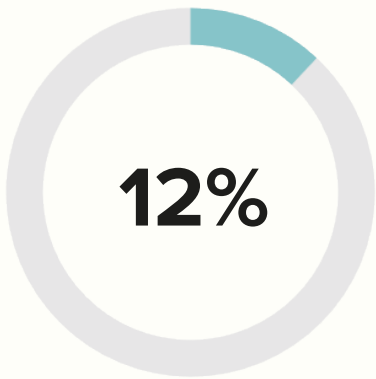
'Previously, children with special needs would have had additional support, a lot more flexibility from staff; a bit more time, a bit more explanation, then they can cope. That is also limited. And it is the same staff, they all mean well and they do try. But the resources that they have are limited. So then what happens is they are struggling more, they are getting excluded more, they are just not coping.'

Funding challenges within health services

The health and support professionals noted challenges with funding for mental health services. A concern was raised regarding how funding reached front-line services 'I'm not confident that the money that was supposed to filter down to front line services actually has done. So there are long waiting times, still. And the waiting times to some extent are disguised. Because they will offer an initial appointment but then the child is then on a waiting list for a year, or even more than a year, for whatever the further assessment work or intervention is'. This could be indicative of health spending being poorly measured, in particular children's health services, which are more vulnerable to cuts (Children's Commissioner Office, 2018a).

One participant raised concerns regarding the impact of staffing of key mental health services.

'So there may be some issues about vacancies and having enough trained people coming through, but the bottom line is that resources haven't translated into capacity in teams



Funding challenges (9)

to identify each and every need in a timely way. This notion was announced by the government of: every child and young person with a mental health problem being seen within four weeks. Oh my goodness, we are light years away from that being achieved. But if that was achieved, it would be transformed and it would make my job a lot easier because I am the sticking plaster for families at the minute, because at least I will listen to their issues. I can't diagnose the mental health conditions but I can be an advocate for them. But I get fed up of continually writing letters that are rejected to mental health services and I find that really frustrating. The families find it really frustrating'.

This view was endorsed by other participants who further acknowledged that lack of funding for transforming children and young people's mental health was a national issue. It has not filtered down to improve the capacity of services, so services **'just don't have the capacity'** and **'there is only me, how can I possibly treat everyone'**. It was also raised that due to a lack of funding in mental health services **'they can only offer 10 sessions because of funding? The way it is commissioned is ridiculous from our point of view. The workers on the grounds here say that. I'm sure that CYPS would say that as well'**. A view was also shared that funding was needed for therapy **'some children need more therapy. And that is where the gap is. In the therapeutic support that children need.'** A final point raised by two participants was a perceived demise in services impacting on families. Some of the caregivers themselves acknowledged that health services were underfunded and that this impacted on the level of service, meaning they did not know where to go for support (4.10).

**P1: 'So in the past, we had things like Sure Start Activity Centres and all of those things. And now mostly they have gone.'**

**P2: Yes, definitely. I think that parents really have nowhere to turn. They come to me and I can only...this service is billed as the saviour which it completely isn't. I don't think there is much, outside Autism Outreach, who are great, but they are massively worked off their feet. [...] Then there is a massive waiting list for CAMHS and CYPS. Two years ago I was approached by somebody who does private work, Mental Health work [...] I didn't believe that people should be in this position, for it to cost thousands of pounds when it should be free at the point of delivery. I think there is not much help out there and what is there is rationed. And if you want to go privately, or if you want something extra, people can't afford it. Certainly not in Sunderland'.**

Increase in needs

The views expressed by the health and support professionals suggest that there has been a notable increase in social, emotional and mental health needs of children over recent years **‘I think self-harm is very common’ and ‘emotional and behavioural difficulties, and request for assessment for that has gone up quite significantly over the years I have been working here... What has gone up is the other things; emotional regulation issues, attachment difficulties, parenting difficulties. Probably they ask the questions, query ADHD or Autism or learning needs, not coping at school, bullying-related emotions, that sort of thing has gone up really high’.** The remaining comment spoke of rising numbers of looked after children.

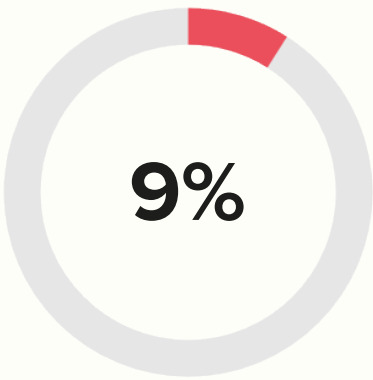
**‘Then in Sunderland, we have some LAC facilities. Placements for LAC who can come from out of the area, where they are special closed placements. Those children come with their own challenges. Drugs, offending, sexual exploitation. Those children who are out of parents’ control, there are a few of those facilities in Sunderland. That does increase the demand as well. Not just for those children but for that area; the other children in that area are also affected’.**

Using A and E to ‘jump’ the queue

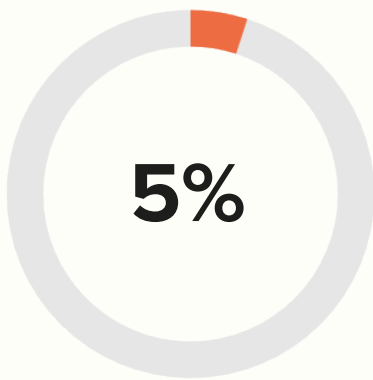
Four of the health and support participants perceived that schools were advising caregivers to take children to accident and emergency departments, as they felt they would be seen sooner than through other referral processes **‘schools are saying just take them to A and E. Someone will see them’ and ‘but those SENCOs, that is the only way they have found to get through the door in a desperate situation’.**

General health issues

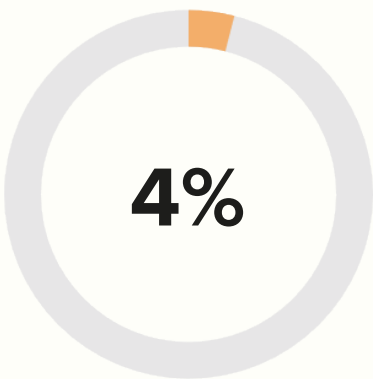
An area of concern raised by health and support professionals regarding health and support services was that they felt it was difficult, at times, to get children to be seen by particular mental health services. One participant perceived that **‘I write to the other services but I get a letter back saying there isn’t enough information to see them. The point is they are meant to assess them, I assess for autism, physical and learning disabilities. CYPS should be seeing children for mental health and neurodevelopment. They are in a silo’.** Another participant said they **‘get fed up of continually writing letters that are rejected to mental health services and I find that really frustrating. The families find it really frustrating’.**



Increase in needs (7)



Using A and E to ‘jump’ the queue (4)



General health issues (3)

One participant suggested that children who are excluded from school should be automatically referred for a paediatric assessment, as should any children entering the behaviour intervention provisions. They added:

**‘You know, I remember one girl in the clinic who was on her last day in her nurture group provision and was going back into mainstream the next day. She came to me from community CAMHS and they had been involved, but her autism hadn’t been diagnosed. So I diagnosed her with Autism, but then she was going back into mainstream the next day, so there wasn’t time to get those proactive adjustments in place. So I think we should be assessing children earlier in their journeys, not when the wheels have all dropped off and it’s all too late. It definitely shouldn’t be when the clock started ticking on Education Health and Care Planning. It should be much more proactive’.**

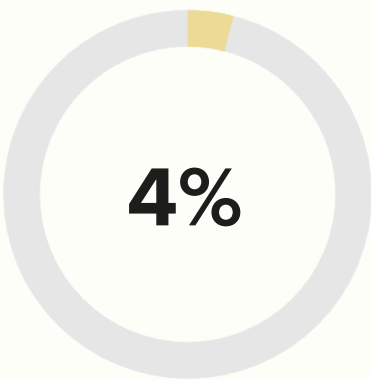
**Need for a label**

Three health and support professionals shared their concerns about schools needing to have a label of need for a child’s needs. The first participant commented on the importance of diagnosis for some children **‘it is having an impact on their ability to function, they are unable to function without that diagnosis being recognised. Without support.’** There was also concern that labels were needed to access necessary support in schools.

**‘If a label is needed, there is pressure from parents and from school, ‘What diagnosis have they got?’ Previously, we could say they have traits of this and traits of that; this is what they will cope with. But that is not enough unless you have a label. Talking about ADHD and ASD traits, we know traits are quite common in the general population of school children. But if you have the capacity to be flexible, you can manage this. You don’t necessarily need a label and the external support; you can manage with the resources that you have. But the resources people have are so stretched, they need to have a label’.**

Another participant perceived that the pressure on health services increased due to the pressure of attaining an EHCP.

**‘The pressure on our services has gone up significantly with the pressure for EHCPs. Parents will say ‘All through primary’ – ADHD and ASD doesn’t suddenly come on in secondary school, so what was happening? How come they managed in primary? Parents will say it was just brushed under the carpet and we knew all along. Other parents say ‘We knew there was a difference, but they were coping and that is all we want.’ They will have been supported by Primary school; more teacher support, someone else supporting would have been shared out between two or three children. And they were fine. It’s only when they went to secondary school and nothing was offered that they were pushed into the deep end and are not coping’.**



**Need for a label (3)**



### 4.13. Advisory group of health and education professionals: Challenges, questions and concerns

The ten professionals from education, health and support services were asked to give their views on the emerging themes from the interviews. The main areas identified were to reform key services.

Health recommendations from interviews and advisory group

- A duty SEMH crisis (CYPS) worker to take calls from 8 am until 5 pm to allow for issues arising before, during and after school.
- A review of the age ranges of children CYPS is able to assess to ensure equity with South Tyneside. CYPS won't see children under six for ADHD and nine for ASD. There should be a pathway for assessment alongside appropriate physical health investigations including genetics. This, links with caregivers saying the Health Visitor (HV) and GP send them away until the child is six age.
- When a child won't engage with CAMHS or CYPS practitioner, rather than discharge them, alternative approaches should be sought. For example, a change in staffing or
- appointments within the school and/or familiar home environment.
- To explore the possibility of a mental health nurse practitioner or other approaches, to work across a range of schools where there is a high level of need.
- Remove the inequitable special circumstances list in the CAMHS referral system, as this results in some children not being seen. There are long wait times for CYPS, affecting the availability of timely support. This is at odds with the system in South Tyneside, which sees all children.
- Review the impact and suitability of generic parenting courses. The findings suggest that these are not suitable for supporting families with children who are neurodiverse.

### Other health services

- To reduce wait times for ASD and SaLT teams to send reports to consultant paediatricians. Increase capacity for ADHD assessments to be carried out by training learning support or health care assistants (does not need to be a doctor).
- Good practice guidance to be circulated to GPs and HV team on when to refer to other health professionals; quality principles for paediatric disability services.

### Community support

- Volunteering programmes so that experienced caregivers mentor those less experienced with parenting, e.g. in cooking and participating in locally provided events such as sports,
- To inform schools of the benefits of youth workers and community organisations to work alongside schools supporting children and young people. This will include sharing the work and opportunities through Sunderland All Together.

## 5. Concluding Remarks



## 5. Concluding Remarks

The first objective of this research, 'to elicit the perceptions and experiences of excluded children, their caregivers and professionals of the barriers and enablers to mainstream schooling', has been achieved. The second objective was to 'to determine if it is possible for children at risk of school exclusion to feel and be included while attending mainstream school'. The evidence suggests that, for many reasons, these children struggled to cope in a mainstream school environment. There will need to be a shift in the values and ethos of some stakeholders involved in their education and care. These are described in greater detail in the main body of the conclusion. The final objective was 'to evaluate the effectiveness of national policy in supporting children to remain in mainstream school'. The main red flag highlighted by this piece of research relates to the vague national guidance on the use of isolation booths within schools. Until this issue is addressed in policy, schools will continue to isolate children without sufficient constraints, placing them in situations similar to those reported in this research. It could be argued that placing a child in isolation for any length of time would fall under the NSPCC (2019) definitions of emotional neglect: 'the child doesn't get the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them', and emotional abuse: 'continual emotional mistreatment of a child, which can involve deliberately trying to scare, humiliate, isolate or ignore a child'. There also needs to be an investment to ensure children at risk of exclusion have the most appropriate academic and/or vocational model/ curriculum, teaching approaches and class sizes to develop and learn to their full potential. It has been a privilege to have had the opportunity to hear the voices of the children, their caregivers and the professionals who provide their education and care. They have all provided useful intelligence for TfC to shape services, provision and training across the City. Through the interviews and subsequent analysis, it is evident that there were multiple factors over time that led to the children no longer being

able to continue their mainstream education alongside their peers. This section shares the circumstances and policies that would have likely contributed to school exclusion and highlights what could be done to improve mainstream schooling.

### The importance of creating and sustaining relationships

One of the main findings in this research is that children thrive where there are positive relationships with teachers and peers, where they are listened to and supported with learning. The research validates how these positive connections create a sense of belonging and act as a protective factor, supporting children to remain in mainstream provision. It is also evident that some children do not feel they belong and this is reinforced by their caregivers, who felt their children were victimised by other children, and at times teachers, because of their differences or challenges with meeting behaviour expectations. There will be many schools who have supportive and nurturing environments, who promote acceptance within and outside their school communities. The current secondary education model of multiple teachers across a school day seems to be detrimental to those children at risk of school exclusion. An alternative model, perhaps based on the structure of primary education, should be explored, so that the likelihood of building positive and sustainable relationships is increased.

### Curriculum issues

As schooling becomes more formalised in KS1, the obstacles to participation and engagement are increasingly evident for some children, as the curriculum moves from play-based approaches in the early years to the national curriculum. Schools should be promoting academic and vocational excellence through high aspirations and quality teaching, but this needs to be balanced with safe and nurturing environments so children can become purposeful and healthy children and adults.

This research shows that as children move through school, their enjoyment of learning diminishes as the child-centred approaches and opportunities for play and creative approaches to learning decrease. From as early as KS1, many children knew they were unable to access the academic level and volume of school work. This reinforces prior research that has identified that young children are more anxious and stressed about school work than in previous years. It is likely this is due to accountability measures on teachers and an ever-demanding curriculum that does not take into account the multi-faceted needs and abilities of children. The caregivers echoed the views of the children that they are unable to meet the academic demands expected of them, reinforcing the idea of exploring alternative routes. The concern is that the expectation on children to attain is the same, regardless of any underlying difficulties they may have with mental health, learning needs or experiences of childhood adversity.

This research supports the need for alternative curriculum models for children for whom an academic route is not desired nor appropriate to their strengths, interests and diverse needs. The current academic pathway, particularly in secondary education, is not relevant to the wishes and aspirations of many of the children who participated in this research. There needs to be a move away from studying multiple GCSE subjects when a vocational route is more suited to, realistic, and importantly, requested by the child.

### **Classroom issues/reasonable adjustments**

The youngest children in this study felt that teachers were the main source of support within the school but this view changes drastically by the time the children reach KS4. Schools have a legal obligation under section 21 of the Children and Families Act, 2014 to ensure that planning for learning is differentiated and personalised to meet the individual needs of children. Schools are in an impossible position of having to meet the varying needs of children, with large class sizes, limited resources, limited staffing and evidence-informed training. Additional funding

for schools is needed if teachers are to be enabled to provide the level of support needed to secure learning and maintain self-belief in those children who have barriers to learning. The children and caregivers across the key stages have shared that lessons are not accessible due to learning and mental health needs, this results in a downward spiral of low self-worth affecting children's ability to participate and learn and to conform to high expectations of behaviour.

### **Responses to behaviour**

The caregivers alluded to the feeling that schools did not understand their child's needs and that their behaviours in school were due to their needs not being met. They suggested increased flexibility in behavioural policies, and behaviour support in mainstream schools is necessary to prevent school exclusion, a view supported by the children. There also needs to be an in-depth understanding of the reasons for children's behaviour(s). The children themselves say they wanted to talk to teachers and for teachers to listen to them. Therefore schools need to invest in giving children the earliest opportunity to talk about their views on school and their barriers to education. In addition, a review of training should be carried out to better prepare teachers across key stages in providing evidence-based approaches to support children instead of, in the opinions of children and caregivers upholding inflexible and unrealistic behavioural policies.

### **The use of isolation booths**

This research has highlighted the widespread use of isolation booths, particularly in secondary education but also in the primary phase of schooling. Isolation is not monitored locally or nationally and this allows schools to retain children day after day, for months and in some cases years, without education or positive interaction with teachers and peers. For eight of the children interviewed, isolation booths were used as continuous provision, with lengths ranging from one to three years. Based on the accounts from this research, we cannot fully understand the implications of this sanction on children's mental and physical health, and educational outcomes, but the reality is that

this suggests emotional abuse and neglect (NSPCC, 2019). The conversations with children highlight the long-lasting impact of isolation booths on those who had to sit for long periods of their mainstream secondary schooling. Ofsted (2018) confirmed that schools can use isolation for limited periods of time but that it should be lawful, reasonable and proportionate. The evidence in this research suggests some schools are contravening this guidance, as it became apparent in our conversations that some children were placed in isolation for reasons that were seemingly neither reasonable nor proportionate to their actions.

Several children mentioned that they had been sent to isolation for reasons they found hard to understand, such as 'I had just arrived from a managed move' to wearing makeup, the wrong skirt, false tan, not wearing the correct shoes or being late for a lesson. Until the Government provides a directive on the use of isolation booths, schools will be able to continue with this sanction.

It was evident in the interviews with the children that when they were in isolation, it was a solitary experience. For some children in this study, isolation booths became their 'statutory education', as they were not, in the vast majority of cases, spoken to by teachers or taught. The expectation that children will complete work set by teachers without guidance is beyond comprehension and has no regard for their strengths and multi-faceted barriers to learning.

It appears that for some children in this research, the impact of isolation may have long-lasting and detrimental impacts on their mental health, wellbeing, academic attainment and ultimately engagement with school. The children in key stage 2-4 referred to the impact of isolation on their mental health using language such as 'depression', 'coping' and 'loneliness'. This research strengthens the argument that isolation booths do not transform or modify behaviour, as all of the interviewed children who experienced isolation, went on to be permanently excluded from school. Only two secondary headteachers believed isolation would improve behaviour and there was no consensus among SENCOs

on its effectiveness, with one reporting the disproportionate number of children with SEN who end up in isolation.

This is a recipe for resentment, frustration, anger and sullen defiance, and is not a way to persuade a child to engage with others in learning. Overall, the data suggest that for some children there may be an over-reliance on the use of isolation booths in secondary schools and as a result, there is limited or no education for children who are regularly isolated. Both the health and education advisory groups agree there needs to be a shift in school policy around placing children in isolation booths due to the negative impact upon the child's holistic development. Local Authorities have no power to address this with academy schools, only those in the maintained sector. However, this raises serious questions at a local and national level as to why isolation booths are continuing to be advocated as an approach for use in schools.

## Health services

This research highlights caregivers' perception of the need to secure a formal diagnosis to gain support from a school in terms of interventions and flexibility in behaviour sanctions. It is understandable therefore, that the caregivers are driven to secure a diagnosis. The impact of this could, in part, explain the high numbers of children within the health services and the compounding impact on resources resulting in lengthy waiting times and frustration for all parties involved. It is clear that the caregivers view health services positively when the appointments are timely and when they are listened to. It seems the challenges with being referred for support begins in the early years, with many caregivers believing they raised concerns at the two-year progress check with health visitors only to be dismissed predominantly as 'bad parents'. It needs to be ensured that caregivers' concerns are taken seriously regardless of the child's age, with signposting to the most appropriate pathway. This research has also indicated a training need for health visitors to ensure there is consistency in how the teams recognise and respond to the caregivers' concern when they share concerns about their child's development. The research

has also highlighted the need for a review of the pathways in health to ensure there is equity in access to services regardless of the child's age or particular needs. This view was shared by caregivers and health and support professionals alike and both suggested that in some instances, there were no obvious pathways available. Professionals also cited the special exemptions list for CAMHS as a challenge in their service area, suggesting it acts as a barrier for children accessing support.

## Training

Education providers across all age phases need support and guidance to ensure they access high-quality training across education, health and care, to enable them to meet the diverse needs of children through evidence-based approaches. The advisory groups in this research all emphasise the need for targeted training, beginning with the secondary schools in Sunderland. This must focus on classroom-level practices to support teachers in the use of the graduated approach (DfE, 2015a) and application of their legal duties for children with SEND (Equality Act, 2010; Children and Families Act, 2014).

The main factor cited by the caregivers to prevent school exclusion was for schools to adhere to SEN and EHC plans. Their overwhelming view was that when plans were put in place for their child, they were not followed or implemented properly. This seemed to be the case even when there were reports from other professionals clarifying the child's specific needs. This needs to be accompanied with the dissemination of the pathways to the paediatric disability service, community CAMHS and CYPS, as it appears these are not fully understood by either caregivers or professionals.

Without the commission from TfC, and the views of children, their caregivers and professionals across education and health/support services, it would not have been possible to carry out this research. This research is a starting point in capturing the current views of the barriers and enablers to mainstream schooling and will enable stakeholders in the local area to strategically

review provision and practice for all children across the City. It would have deepened the analysis to have a sample of children in mainstream school and their caregivers who were not at risk of school exclusion so that views could be compared. However, this was not the remit of this commission. It is hoped that the evidence provided in this and the other four commissioned publications, will support TfC in working with all schools in the City to provide a high standard of education for all children.

## 6. Recommendations

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The recommendations in the report are intended to enable the local area to develop expertise and capacity in schools, to allow children to thrive emotionally and socially. Some schools need to challenge their current policies and practices, working alongside caregivers, children and multi-agency professionals to better understand the holistic needs of children who find school a barrier to learning. Implementing these recommendations will require a shared commitment.

The first two recommendations were created collaboratively by the advisory group of 12 children in KS2-4 who had experienced exclusion from school.

**Recommendation 1:** We think isolation booths should be removed from all schools as they do not work and don't improve behaviour but make it worse.

**Recommendation 2:** We need smaller class sizes in mainstream schools. Thirty in a class is too noisy; there is too much distraction and teachers can't give us the help we need. This will help us learn.

**The following recommendations are from the interviews, conversations and advisory group comments.**

**Recommendation 3:** Governing bodies must work with senior leaders and SENCOs to embed alternatives to isolation booths that are based on child-centred approaches. This needs to include training, so there is a clear understanding of the need to apply the graduated approach of: 'assess, plan, do and review' (DfE, 2015a) to identify, understand and respond to children's needs through evidence-based practices.

**Recommendation 4:** Schools should access training to reinforce their reasonable adjustment duties as legally required by the Equality Act, 2010 and obligations within the Children and Families Act, 2014. These need to be made explicit in school policies such

as SEND, safeguarding, equality, behaviour/discipline, positive handling, mental health and looked after and previously looked after children.

**Recommendation 5:** Schools should access training on alternative and child-centred approaches to restraining children. For example, Studio 3's Managing Challenging Behaviour course (MCB) accredited by the British Institute of Learning Disabilities. This needs to include the impact of traumatic adverse childhood experiences (ACEs) on children's mental health and wellbeing.

**Recommendation 6:** For stakeholders in key stage 2, secondary education and TfC to explore the adoption of a vocational education and training model for children who have aspirations outside of academic routes and/or who find the current curriculum stressful and unmanageable. With agreement from the caregiver and child, there should be consideration of continuing the primary education model into years 7 and 8 for children who have been identified as needing an alternative route within secondary mainstream education.

**Recommendation 7:** Review of health services pathways, including the introduction of a health and support services triage service in Sunderland for children across the child and adolescent years. This would ensure that a decision is made by a health professional about which pathway is most suitable for the child or young person (e.g., paediatric disability service, community CAMHS or CYPS, or other support services). This will need to include a review of the procedures for responding to caregiver concerns at the two-year progress check.

**Recommendation 8:** To immediately revoke the CAMHS special circumstances list so that all children can access timely support.

**Recommendation 9:** Children on the edge of, or allocated, a fixed-period or permanent exclusion should be referred to health services to determine any underlying genetic, learning disability or neurodiversity causes.

**Recommendation 10:** To provide training to health visitors to ensure there is consistency in how teams recognise and respond to the caregivers' voice when they share concerns about their child's development and/or behaviours.

**Recommendation 11:** To create a crisis response team as part of the CYPS to be available to schools from 8am until 5pm to allow for issues arising before, during and after school.

**Recommendation 12:** Further consideration needs to be given across the health services of the consequences applied when a child either fails to attend an appointment, or when a child is unable to communicate during the meeting. This should be led by the paediatric disability consultants, as they were commended for their procedures and practices.

**National recommendation:** The Department for Education (DfE) must take steps to address the use of isolation booths in schools. They should review guidance on the use of this method of sanction and commission case studies of alternative child-centred approaches.

I am grateful to all the participants who have taken part in this research and openly shared their experiences. Thank you for your time and your stories; you have been honest and sincere and this will allow the local area to move forward with research-informed evidence. I would particularly like to thank the children and caregivers; being able to hear from you directly has been fundamental to this research. You are all brave and inspirational, and I wholeheartedly wish you the best life.

## 7. References



## 7. References

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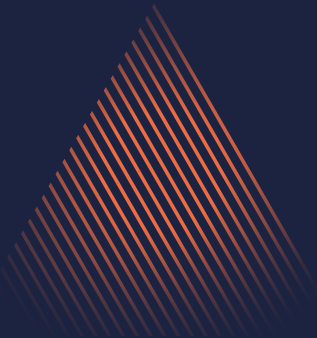


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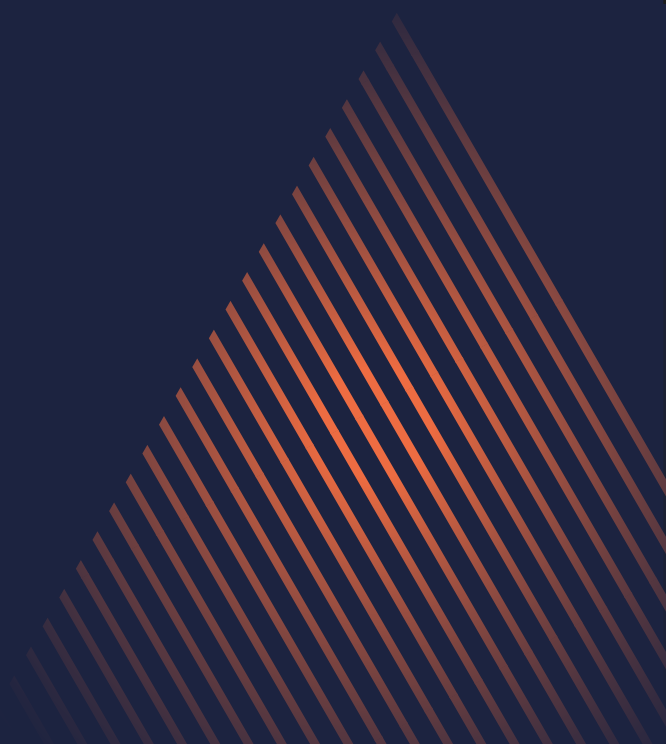
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# **The enablers and barriers to successful managed moves: The voice of children, caregivers and professionals**

**Principal Investigator and Author: Sarah Martin-Denham**  
**University of Sunderland, School of Education**  
**Commissioned by Together for Children, Sunderland**

**March 2020**



**University of  
Sunderland**





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## Executive summary

In Autumn 2018, the University of Sunderland was commissioned by Together for Children (TfC) to 'investigate the factors that impact upon the social and emotional wellbeing of children and young people from 3-16 years in Sunderland City, which may lead to exclusion from school'. During the research, a core theme related to negative experiences of the managed move process emerged. The literature review provided is a synthesis of current and well-established academic research concerning the history and process of managed moves. It also includes a discussion of relationships, effective communication, personalised support, belonging and connectedness, and the importance of these for the social and emotional development of children and young people. The literature review and primary research also provide the theoretical foundation for a suggested managed moves model for adoption in the city of Sunderland (appendix 1).

### Research aim

To investigate the factors that impact upon the social and emotional wellbeing of children and young people from 3-16 years in Sunderland, which may lead to exclusion from school.

### Research objectives

- To elicit the perceptions and experiences of multiple stakeholders, including those who the protocol of managed moves aimed to support, that is, those who were deemed to be on the verge of school exclusion.
- To produce a report with supporting evidence to inform strategic provision planning and training for education professionals within the local area of Sunderland.
- To create a model that exemplifies good practice in managed moves.

174 individuals participated in the research through face to face semi-structured interviews, which discussed the barriers and enablers to mainstream schooling. Of the total sample, 49 referred to the managed move process. This included 20 children and young people (7 of whom also formed an advisory group), 12 caregivers of excluded children, 11 special educational needs co-ordinators (SENCOs), two health professionals, and two secondary and

primary school headteachers. Their responses form the basis of this report.

This research found that the managed move process did not work for these children; some had multiple moves, each one failing, leaving a long-term impact on their self worth. The findings signify that a formalised transition structure, underpinned by person-centred approaches and thorough knowledge of, and empathy for, the child's learning and social, emotional, and mental health needs, is crucial. The development of enduring relationships with teachers and peers is fundamental to creating a sense of belonging within the receiving school. There also needs to be consideration that managed moves are not appropriate for all children; some will inevitably fail due to the unsuitability and ethos of the new placement school.

This research suggests that in flexible behaviour systems are a further barrier to the children succeeding in their new school. The caregivers and children felt that there was a lack of leniency for challenging and misunderstood behaviours during the transition period. Many of the children are moving to mainstream education following placement in alternative provision or a pupil referral unit, which requires a period of adjustment. Many of the caregivers believed their children had unidentified learning and emotional needs. Unidentified needs may be a contributing factor that leads to non-viable mainstream school placements and could explain why managed moves are requested in the first instance. The failure of managed moves affirms the need for a timely assessment and identification of a child's holistic needs across education and health services, to ensure any underlying needs are identified. This would enable schools to have a better understanding of the child's multifaceted needs and strengths, to allow for an evidence-based response in provision and practice. The research indicates that there is a training need in the local area to ensure that evidence-based approaches in meeting the varied abilities and needs of children with special educational needs and disabilities (SEND) are embedded across all schools and age phases of learning.

The recommendations provided are both local and national, with a focus on protecting the wellbeing of children and young people during a managed move. For ease of reading, the term 'children' will be used to refer to all children and young people.

## Recommendations

**Recommendation 1:** The local authority to adopt the managed move model in appendix 1, with careful consideration of the appropriateness of this approach for individual children. The model should be incorporated into protocol documentation and cascaded during training with schools. The managed move model should be monitored for impact to see if it increases the number of successful managed moves with a pilot group of children and schools.

**Recommendation 2:** Local training for senior leaders in education to make explicit the legal position for the use of managed moves. One of the recommendations of this training would be to clarify that managed moves cannot be used where a child has additional needs or a disability that the school is unable to cater for.

**Recommendation 3:** Further training for schools on the particular needs of children with SEMH and/or learning needs to ensure effective and timely evidence-based learning and teaching approaches. The training needs to be evaluated for impact by the SENCO and senior leadership teams.

**Recommendation 4:** Early assessment and identification of any underlying special educational needs and/or disabilities before negotiating the managed move. All children need a transition plan, SEN support plan, and, where required, an application for an EHC needs assessment. These must be agreed in partnership with the child and caregivers, including reasonable adjustments to support wellbeing, learning and behaviour.

**Recommendation 5:** To implement a monitoring system alongside school exclusions data records to analyse the following:

- The number of managed moves each child has attempted; the number of successes and a narrative outlining the reasons for any failed placement. The records should include the length of time the child was in the school before the termination of the placement.
- The long-term outcomes of children who have experienced managed moves.

### National Recommendations

- To create a national system of recording managed moves, to capture: the number attempted by individual children, how many succeed, how many fail, the length of time they sustained the placement and a narrative account of why they failed. This evidence will support if there is a need for a thorough review of the managed move process.
- Due to the stigma of 'pupil referral units' and 'alternative provision' the terminology should be reviewed with a consideration of the name 'school' or similar regardless of the designation.
- To invest in further research of the long-term academic and wellbeing outcomes of managed moves, to evidence that this system is an appropriate alternative to school exclusion.

**Sarah Martin-Denham**  
March 2020

## Sarah Martin-Denham: Principal Investigator, Project Director and Author



Sarah is a Senior Fellow of the Higher Education Academy, a Vice-Chancellor Teaching Fellow, Chair of an independent SENCO network and a Convenor of an Interdisciplinary Research Network for developing knowledge, understanding and approaches for supporting children who are experiencing adverse childhood experiences. She has extensive knowledge of learning and teaching in the North East of England in a variety of settings ranging from Early Years to Higher Education. Sarah has successfully developed and led four programmes and research projects in the School of Education at the University of Sunderland and is the Programme Leader for the National Award for Special Educational Needs Coordination. Through her work with children and families over the last twenty years and her neurodiverse abilities, she has developed a particular interest in special educational needs and disabilities.

### Publications:

Martin-Denham, S. and Donaghue, J. (2020) 'The impact and measure of adverse childhood experiences: Reflections of undergraduates and graduates in England'. *Journal of Public Health*. DOI:10.1007/s10389-020-01359-z.

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I would like to express my appreciation to Jacob Donaghue and Noah Chisholm. You have been a great source of moral support during the project, and without you, it would not have been possible.

# Glossary of acronyms

|                                                         |                                                        |
|---------------------------------------------------------|--------------------------------------------------------|
| <b>ADHD</b> Attention Deficit Hyperactivity Disorder    | <b>PEX</b> Permanent Exclusion from School             |
| <b>ARP</b> Additionally Resourced Provision             | <b>SEN</b> Special Educational Needs                   |
| <b>CAMHS</b> Child and Adolescent Mental Health Service | <b>SENCO</b> Special Educational Needs Coordinator     |
| <b>CSIE</b> Centre for Studies on Inclusive Education   | <b>SEND</b> Special Educational Needs and Disabilities |
| <b>DCSF</b> Department of School and Families           | <b>TfC</b> Together for Children                       |
| <b>DfE</b> Department for Education                     |                                                        |
| <b>DfES</b> Department for Education and Skills         |                                                        |
| <b>ECHR</b> European Convention on Human Rights         |                                                        |
| <b>EHCP</b> Education Health and Care Plan              |                                                        |
| <b>FEX</b> Fixed-period Exclusion from School           |                                                        |
| <b>LA</b> Local Authority                               |                                                        |
| <b>LEA</b> Local Education Authority                    |                                                        |
| <b>NHS</b> National Health Service                      |                                                        |

## Glossary of terms

**ADHD:** Attention deficit hyperactivity disorder is a lifelong difficulty with indicators that include persistent inattention, lack of concentration, hyperactivity and impulsivity.

**ARP:** Alternative Resourced Provisions are situated within schools and receive additional funding to meet the additional needs of pupils with SEND.

**CAMHS:** Child and Adolescent Mental Health Services assess and treat children and young people with emotional, behavioural or mental health difficulties. The support offered ranges from basic pastoral care, such as identifying mental health problems, to specialist 'Tier 4' CAMHS for children with severe mental health difficulties.

**EHCP:** An EHC plan details the education, health and social care support that should be provided to a child or young person who has SEND.

**Fixed-Period Exclusion:** Fixed-period exclusions refer to when pupils who are excluded from school for a set period of time. It can involve a part of the school day and does not have to be for a continuous period. A pupil may be excluded for one or more fixed periods up to a maximum of 45 school days per academic year.

**Permanent Exclusion:** Permanent exclusions refer to pupils who are excluded from school and are not allowed to return. Excluding a pupil permanently should only be done in response to a serious breach, or persistent breaches, of a school's behaviour policy, and where allowing the pupil to remain in school would seriously harm the education or welfare of the pupil or others in the school.

**Pupil Referral Unit (PRU):** Any school established and maintained by a Local Authority under section 19 (2) of the Education Act 1996. PRUs are specially organised to provide education for pupils who would otherwise not receive suitable education because of illness, exclusion or any other reason.

**SEN:** A child has Special Educational Needs if they have a learning difficulty or disability that requires special educational provision to be made.

**SENCO:** A qualified teacher in a school or maintained nursery school who has responsibility for coordinating SEN provision.



# 1. Literature review

# 1. Literature review

## 1.1 The historical context of managed moves

Managed moves are believed to be the most common alternative to school exclusion in the UK (Gazeley et al., 2015; Mills and Thomson, 2018; Craggs and Kelly, 2018). They have been defined in previous government guidance as enabling a child to have a fresh start in a new school, when senior leaders believe their current school place is no longer viable due to their negative behaviours (DCSF, 2008). More recently, Flitcroft and Kelly (2016) suggested that managed moves were introduced as an opportunity for a new beginning, to give children on the edge of school exclusion the chance to form new and positive relationships, escape previous reputations and to experiment with new behaviour. The process was intended to be a voluntary arrangement between all parties, including the child, caregivers and the admission authority for the new school (DfES, 2008; DfE, 2017a). However, research by the Office of the Children's Commissioner (2019) found that some families felt they were pressured into agreeing to a managed move because the school told them that the alternative, 'a permanent exclusion', would go on the child's school record.

## 1.2. Fixed and permanent exclusions

The Education Act (1986) introduced 'fixed period' and 'permanent exclusions' as disciplinary sanctions that prevent a child from attending school. The exclusion guidance in the Act states that exclusions should only be used as a last resort. This received further support from DfES (2004a), who called for schools to be creative and resourceful in finding alternatives. In subsequent guidance by the DfES (2008), alternative approaches were suggested in the following order: a) restorative justice, b) mediation, c) internal exclusion and d) managed moves. Interestingly, in more recent documents, most of these approaches have not been included (DCSF, 2010; DfE, 2011a; DfE, 2015).

The school exclusion guidance from DfE (2017a) clarifies that any decision of a school to exclude must be legal, and in reference to the Equality Act (2010) and the European Convention on Human Rights (ECHR) (2010), which was made domestic law as part of the Human Rights Act 1998. Furthermore, the decision to exclude a pupil must be reasonable and fair, with schools ensuring they do not discriminate against a child based on protected characteristics such as disability (Equality Act, 2010). The Act sets out legal duties for organisations, including schools, to make reasonable adjustments, including the provision of auxiliary aids and services, to prevent the child from being at a substantial disadvantage. Importantly, this should be anticipatory; schools need to prepare in advance the adjustments for children meeting the definition of disability (DfE, 2015).

## 1.3. Managed moves and behaviour

A breakdown in the relationship between the child and their teachers is often reported as the main reason for requesting a managed move (Muir, 2013; Craig, 2015; Bagley and Hallam, 2016). They are commonly used where a child displays behavioural difficulties linked to special educational needs (SEN) and/or social, emotional, mental health (SEMH) needs that the school finds too difficult to manage (Chadwick, 2013; Craig, 2015; Hoyle, 2016; Atkinson, 2017).

The Education and Inspections Act 2006, section 89 (1) states that maintained schools must set out measures in their behaviour policy which aim to:

- Promote good behaviour, self-discipline and respect
  - Prevent bullying
  - Ensure that pupils complete assigned work
- and which
- Regulate the conduct of pupils.

The DfE (2017b) guidance adds that teachers can discipline pupils if they misbehave, break a school rule or fail to follow a reasonable instruction. It adds that a punishment must be proportionate, as dictated by section 91 of the Education and Inspections Act 2006. The penalty must be reasonable and in all circumstances, account must be taken of the pupils' age and any special educational needs or disability they may have. The punishment must be given by a member of the school staff, on the school premises, and it must not breach any other legislation (such as disability, special educational needs, race, other equalities, and human rights). It is the role of schools to identify if a child has a disability and they must take steps to find out if the child meets the definition (Martin-Denham and Watts, 2019) if they present with 'a physical or mental impairment that has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities' (Equality Act, 2010, section 6).

Mills and Thomson (2018) cite the following reasons why managed moves may not be suitable for all children:

- Not all children can have their needs met in mainstream education
- Some children cannot cope with the mainstream environment
- Not all children can cope with the pressures of academic attainment in mainstream education

## 1.4. The managed moves process

In 2004, the then Department for Children, Schools and Families held a series of workshops across 118 local education areas (LEAs), with the purpose of evaluating the managed move process and school exclusions. In summary, they raised concerns over the practice of managed moves, proposing they did not address underlying issues the children had but instead passed the problem onto other schools. Later, DfES (2008, p. 10) stated that it 'may' be helpful to have a 'full support package' and a 'protocol' in place to support children,

though they did not specify what this should include and it was not made a statutory duty.

Since 2008, there has been concern over the number of fixed and permanent exclusions and the increased use of managed moves despite their frequent failure (Gazeley, 2010). Messeter and Soni (2017) raised the concern that managed moves were practised across England without close monitoring by government and without analysis of the experiences of those who know the process. Ofsted (2010) have also reported that the lack of accountability or regulation has meant that children become lost in the system during the managed move process. Later, Ofsted (2019) called for the Department for Education to gather data about managed moves in the same way it does for school exclusions. They added that no single accountable body has a clear picture of the number of children who have been 'managed moved' to different schools; how long for, for what reason and with what effectiveness. Despite this, there continues to be no national regulation or monitoring, though local authorities (LAs) do provide locally agreed protocols for the managed move process.

Chadwick (2013) found variability in managed move protocols across LAs, noting the following themes relevant to this study:

- No reference to obtaining the views of the child or caregivers when considering a managed move
- No reference to a key adult or advocate during the process
- No consideration of the pupils' strengths

## The stress of the managed move process on the family

Family members of children experience stress from the start of the move until a successful transition (Chadwick, 2013; Muir, 2013; Bagley and Hallam, 2016; Messeter and Soni, 2017). Their stress is primarily due to feeling disempowered and overwhelmed by the process (Muir, 2013; Chadwick, 2013). Bagley and Hallam (2015) agree, arguing that some caregivers perceive managed moves as giving licence to schools to move children they feel are a ‘problem’ rather than working with them. They also found that the managed move process takes too long to negotiate and that the move causes stress for the child and family. Some caregivers have had to leave employment to care for their child, which has dire consequences on household finances (Munn et al., 2000). The positive aspects of managed moves have been associated with tailored support, care and commitment from the receiving school (Vincent et al., 2007), person centered approaches, and listening to the views of children and families during the process (Chadwick, 2013; Bagley and Hallam, 2015).

## Enablers to successful managed moves

Research has suggested that open lines of communication with a personalised support plan facilitate a successful managed move process (Chadwick, 2013; Bagley and Hallam, 2015; Flitcroft and Kelly, 2016). In their research, Mills and Thompson (2018) found that schools employed a range of support systems to aid reintegration (see Figure 1).

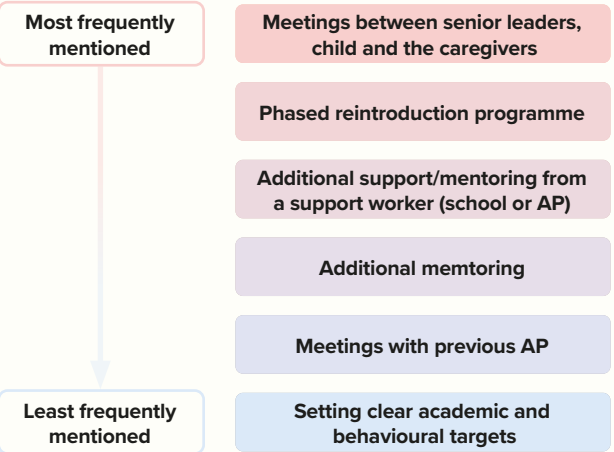


**Figure: 1.** Support systems used by schools to aid reintegration following an Alternative Provision (AP) placement

## 1.5. Relationships

In 1969, Bowlby emphasised the importance of responsive relationships between children and key adults to enable the creation of positive relationships in later life. To thrive, children need emotional containment and interpersonal support in the form of reliable, stable, attentive, friendly and empathetic significant others (Holmes, 2001; Cairns, 2002; Gerhardt, 2004). Through these protective factors, children can engage with learning, as they feel safe and secure due to relationships founded on genuine care and empathy (Rogers, 1983). With managed moves, Muir (2013) emphasised the importance of positive relationships at the receiving school for successful reintegration, to ensure the child felt supported, included, welcome and secure. These protective factors are particularly important in supporting children to adapt during a managed move from alternative provision to mainstream education (Michael and Frederickson, 2013; Thomas, 2015). Overall, the creation of new positive relationships, with improved progress and learning, greater emotional wellbeing and central to positive outcomes for children following a managed move (Messeter and Soni, 2017). Research by Goodman and Burton (2010), Carter (2015) and Driver Youth Trust (2015) has also highlighted that one of the critical issues with managed moves is how able teachers and support staff are to effectively support children, particularly those with SEMH needs.

Other barriers to successful reintegration include the negative connotations around the fact the child is on a ‘managed move’, which often stigmatises them and blights a fair chance of the new placement being successful (Messeter and Soni, 2017). Recent research by Flitcroft and Kelly (2016) revealed that forming new and productive relationships in school is particularly challenging for children presenting with social, emotional and behavioural difficulties. For example Craig (2015) suggests that a child’s emotional wellbeing fluctuates with their feelings of social connectedness, as leaving friends can cause sadness until they create a new network in the following school.

## 1.6. Belonging and connectedness

For decades psychologists have tried to define the complex and multi-faceted term ‘belonging’ (Cartmell and Bond, 2015). There is agreement that a sense of belonging is of particular importance during the changing priorities and expectations of adolescents (Migden et al., 2019). Baumeister and Leary (1995, p. 497) examined current literature relating to belonging and defined the term as ‘a need to form and maintain strong, stable interpersonal relationships’. They concluded that ‘belongingness is a need rather than a want’. This definition is close to that of Maslow (1943), who identified that having a sense of belonging is fundamental to wellbeing and healthy development. In his hierarchy of needs theory, Maslow identified a sense of belonging as the third most fundamental need, arguing that the need to belong must be satisfied before other needs can be fulfilled. Maslow (1954; 1970) and Baumeister and Leary (1990) shared the view that children and adults have a basic psychological need to feel a sense of belonging to a social group. Collectively, they suggest that an internal need to foster and maintain relationships is characterised by approval and intimacy, to enable the forming of close social bonds. Multiple studies have indicated that a positive sense of belonging is associated with good mental health and hopefulness about the future (Ryzin et al., 2009; Kidger et al., 2012; Marraccini and Brier, 2017), resulting in a powerful effect on children’s emotional, motivational and academic functioning (Craggs and Kelly, 2018). Maslow (1943, p.381) claimed that when individuals did not belong and had unmet learning needs, they would ‘hunger for affectionate relationships’. He suggested that these children would ‘strive with great intensity to achieve this goal. He will want to attain such a place more than anything else in the world’. The most recent Government guidance (DfE, 2016, p. 8) on supporting mental health and behaviour in schools identifies a sense of belonging as a protective factor in building resilience within children. It adds that ‘schools should be a safe and affirming place for children, where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems’. To create

a sense of belonging, children need to feel cared about and accepted into the community (Cutrona, 1982; Smedley, 2011). It is only through this strong sense of social connectedness, stemming from the need to belong, that children will experience a sense of relatedness (Barber and Schluterman, 2008). Osterman (2000), Furrer and Skinner (2003), and the Centers for Disease Control and Prevention (2009) share that there is an association between classroom belonging and support. They highlight that positive interactions with the teacher and peers are associated with school belonging. It is through trusting relationships that children learn to ‘trust in oneself and others’ and to ‘provide oneself as being trustworthy’ (Erikson, 1968, pp. 128-129). Antrop-Gonzalez (2006) agreed, emphasising the importance of promoting a sense of belonging for pupils, and advocating schools as caring communities and sanctuaries for children. Rovai (2002) provided a broad and holistic definition of connectedness, suggesting it was a feeling of belonging and the creation of bonding relationships. Two types of connectedness are identified in research:

1. Through satisfaction with interpersonal relationships and various social groups, known as social connectedness (Cutrona, 1982; Rovai, 2002) and
2. Through connectedness with the institution, through feelings of belonging and acceptance with organisations and programs (Sidelinger and Booth-Butterfield, 2010)

In the context of this report, children with SEND are less likely to have a sense of belonging than their non-SEN peers. This varies further depending upon their type of need. For example, Dimitrellou and Hurry (2018) found those with hyperactivity are more likely to have a lesser sense of belonging than those with learning difficulties. The active involvement of children with special educational needs in decisions that affect them has been found to have a positive effect on their sense of belonging (Martin-Denham and Watts, 2019). Person-centred approaches are at the heart of legislation and policy for provision and practice

for children with SEN (Children and Families Act, 2014; DfE, 2015, p.19). This includes that local authorities (LAs) must have regard to 'the views, wishes and feelings of the child or young person, and the child's parents'. To be engaged in school, children need to feel respected and valued, to feel an affiliation with the organisation (Finn, 1989). If this positive sense of belonging is not achieved, then they are more likely to exhibit low academic attainment, low attendance, risky behaviours and school refusal (Voelkl, 1997).

Social connectedness is associated with positive life outcomes, which include increased emotional well-being (Cutrona, 1982), less substance misuse and better health (Blum et al., 2002), and decreased risk of violent or defiant behaviour (McNeely and Falci, 2004). Historic research also shows that if a person perceives a lack of social connectedness, it can result in depression, social anxiety, and jealousy (Leary, 1990), and a perception that surroundings are threatening and unfriendly (Swann, 1990). Connectedness at school is inextricably linked to improved academic engagement, motivation and outcomes (Freeman et al., 2007; Abdelnoor, 2007). It can be defined as 'feeling close to, part of and happy at school; feel that teachers care about students and treat them fairly; get along with teachers and other students and feel safe at school (Libbey, 2007, p. 52). Demanent and Van Houtte (2012) supported this view, adding that children who experienced connectedness were less likely to engage in truancy and display inappropriate behaviours.

Social identity theory explains how people develop personal identities and their perceptions of others (Tajfel and Turner, 1979; Abrams et al., 2002). Hogg and Abrams (1998) believe that when identifying within a group, individuals will naturally compare themselves to others. They add that it is these social comparisons that develop group identities. If a child does not 'fit' into these identities, then they are considered to be an out-group (Tajfel and Turner, 1979), which leads to children experiencing a lack of connectedness. Furthermore, when a child identifies with a particular group, they will

actively seek participation and approval (Brewer, 1999). Social identity theory may explain why Craig (2015), in a study of four students, found that managed moves left young people feeling isolated, vulnerable and insecure.

## 1.7. Inclusion

**'Inclusion is not a matter of where you are geographically, but of where you feel you belong. There are many children, and especially adolescents, identified as having SEN who never feel that they belong in a large mainstream school'** (Warnock, 2005).

The Centre for Studies on Inclusive Education (CSIE, 2011) agrees with Warnock (2005) that inclusion is not about where the child is taught, but around a need to change the cultures and practices of educational establishments. Cole (2005) shares that what matters most to caregivers is that their children are cared for, treated with dignity and that teachers are willing to try different approaches. Research by Harris et al. (2006) found that children on managed moves had difficulties accessing the curriculum, which the authors felt contributed to their lack of sense of worth and acceptance in a learning community (Harris et al., 2006). This can cause challenging behaviours, which further prevent the child from being able to access the learning (DfEE, 1999; Pomeroy, 2000; Yuen et al., 2004). Warnock (2005) herself referred to her disastrous legacy of integration, adding that for inclusion, there needs to be, for some children with SEND, distinct provision, which best meets their individual needs. Likewise, Crowther (2011) suggested that inclusion is no longer seen to be about the location but quality and outcomes.

## 1.8. Behaviour policies

In England, there are definitive links between schools, disciplinary processes and social inequalities (Munn and Lloyd, 2005; Daniels and Cole, 2010; Gazeley, 2010). The reality is that children who reach the point of permanent exclusion are likely to have experienced multiple disciplinary sanctions and preventative strategies that have had



no impact on their behaviour (Gazeley et al., 2015). Panskeep (1998) suggests that without clear and consistent boundaries and internal support, children with fear and anxiety may be in a constant state of hyper-arousal (vigilance and paranoia) and inhibited hypo-arousal (numbness, avoidance and depression). Indeed, literature has suggested that the most effective policies provide consistent, predictable, clear boundaries that support children in developing a 'secure base' and allow them to build self support strategies to manage anxiety and fear (Cashdan, 1988; Macleod, 2004).

## 1.9. Biological/medical perspectives

Historically, special ,educational needs and disabilities have been entwined with medical terminologies such as 'condition', 'impairment', 'disorder' ,and 'syndrome', suggesting that the focus is identifying a difficulty or flaw within the child (Martin-Denham and Watts, 2019). This biological perspective does not consider the broader environment, quality first teaching, or reasonable adjustment, but identifies the child's natural make-up as the source of the problem (Thomas and Loxley, 2007; Glazzard et al., 2015). The medical model views the challenges the child has as needing to be cured or fixed by medical and other professionals, following assessment and diagnosis (Avramidis and Norwich, 2012; Glazzard et al. 2015). Examples include prescribing Ritalin for a child with a diagnosis of ADHD, often alongside a behaviour support plan, which will include targets to show improvement in the child's behaviour (Martin Denham and Watts, 2019). This places the onus on the child to correct what others view as problematic responses to the environment or experiences. A perceived benefit of having a label that meets the definition of disability is that this establishes a legal right, through the Equality Act 2010, to access reasonable adjustments to prevent substantial disadvantage. Norwich (2009) has identified that the labelling of children does have negative aspects associated with stigma and lower expectations from teachers in terms of their abilities.

## 1.10. Sociological perspectives

Sociological perspectives challenge biological views and suggest that 'disability' is due to oppression and an exclusionary society, rather than arising from the biology of the child (Avramidis and Norwich, 2012). Thus, those viewing disability from sociological perspectives believe that disability is socially created through physical, social, cultural, political and economic barriers, that have disabling effects. This view is in direct contrast to the biological model (diagnosis, needs, intervention, cure) and focuses instead on equality, participation, person-centred approaches, social justice and collective belonging.

This literature review has discussed key themes to support the readability of the remaining sections. The next section shares the methodological approaches used to answer the following research aims and objectives:

### Research aim

To investigate the factors that impact upon the social and emotional well-being of children and young people from 3-16 years in Sunderland, which may lead to exclusion from school.

### Objectives

- To elicit the perceptions and experiences of multiple stakeholders, including those who the protocol of managed moves aimed to support.
- To produce a report, with supporting evidence, to inform strategic provision planning and training for education professionals within the local area of Sunderland.

## 2. Methods



## 2. Methods

This section presents the methodological approach for this research. It will share how the study was carried out, the researcher's philosophical perspective, the methodology adopted, sample characteristics and recruitment, and the methods used to collect and analyse data. It will also include the ethical procedures upheld to preserve and protect the rights of all participants.

### 2.1. Paradigm

Paradigm is a term used to describe a researcher's philosophical perspective or worldview when carrying out a particular piece of research (Mackenzie and Knipe, 2006). Epistemology, ontology, methodology and axiology are the four components of a paradigm that, when combined, link the research philosophy and the practice of research (Newby, 2014). It is essential to disclose the underlying philosophical perspective of the researcher, as it is a prerequisite to data collection methods, analysis and interpretation (Kivunja and Kuini, 2017). The philosophical perspective for this research aligns to an interpretivist paradigm, in that reality is subjective and differs from person to person (Guba and Lincoln, 1994). The researcher aimed to discover the effectiveness of managed moves through participants' views based on their experiences. Interpretivists predominantly use qualitative methods (Silverman, 2000; Willis, 2007; Nind and Todd, 2011), which are described below.

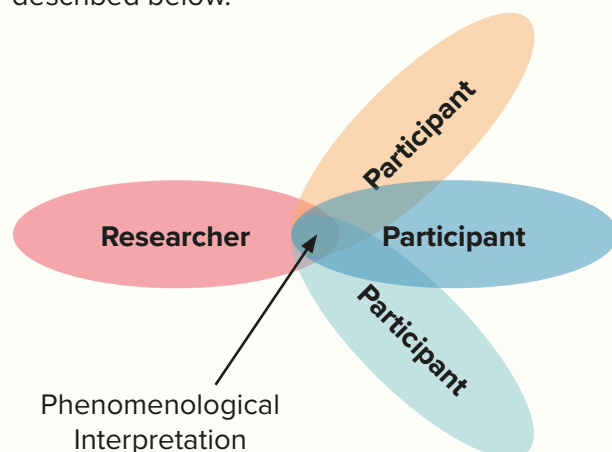


**Figure 2:** Phenomenological interpretation

### 2.2. Methodology

The qualitative approach chosen was interpretative phenomenological analysis (IPA). The aim was to provide a detailed examination of personal lived experiences of the participants (Smith and Osborn, 2008). This methodology was most relevant, as it examines in detail each participant experience in turn before making generalisations. The role of the author was to understand the experiences of participants and develop a phenomenological interpretation, as in Figures 2 and 3. This approach is characterised by:

- Emphasis on the phenomenon as a single idea or concept
- Focus on broad philosophical assumptions
- Data collection, typically through interviews
- Data analysis that moves from narrow units to broad themes and
- Culminates in a description of the essence of the phenomenon (Cresswell, 2013)

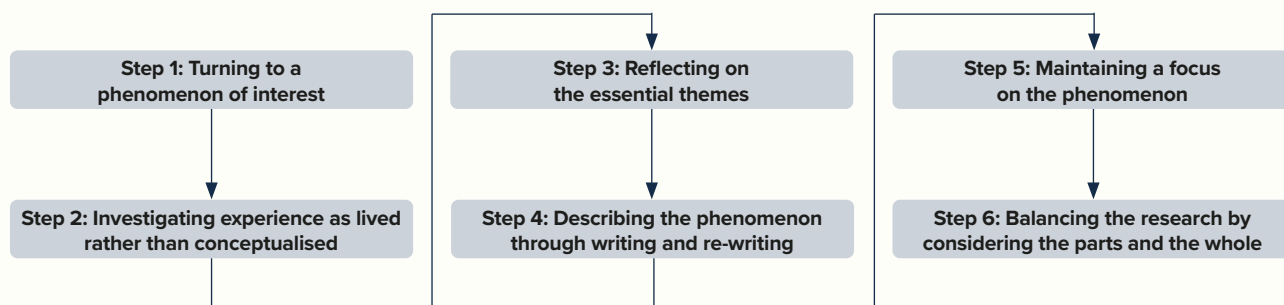


**Figure 3:** Six steps in phenomenological Inquiry (adapted from van Manen, 1997)

## 2.3. Methods

Data collection for this research involved a multi-method approach with a combination of 1:1, 1:2 semi-structured interviews and a children’s advisory group, held 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). For children and young people, interviews were referred to as ‘conversations’ to create a relaxed approach and to put the children at ease. All interviews were recorded using a Dictaphone and transcribed verbatim with the omission of personal identifiable information.

The interim findings were shared with an advisory group of seven children to clarify that nothing had been missed or misinterpreted (Maykut and Morehouse, 1994). The children were not chosen by the research team but responded to an open invitation from two schools to be part of the group. The children who elected to take part were also part of the core interview sample. There were also opportunities for them to examine and contribute to the coded themes and sections of the analysis, an approach advocated by Xerri (2018). The children were able to validate their views, to correct any misconceptions and to provide additional information, a process promoted by Creswell and Miller (2000), Lewis (2009), and Pilnick and Swift (2011). The approach not only ensures participant voices are heard but also improves the credibility of the research, as the participants act as ‘reviewers’ (Harden

et al., 2004; Lewis, 2009; Tracy, 2010). This triangulation of data also allows for making a study more comprehensive, as it encourages reflexive analysis of the data overall (Pope and Mays, 2008).

## 2.4. Participants

Individuals who had experienced managed moves on either a professional or personal level were invited to participate. The children were all accessing alternative provision at the time of the study. Only one child was reported to be on the SEN register at the time of the managed move. Participants included children, their caregivers, education professionals (e.g. headteachers and SENCOs), health professionals and broader support services (those employed by the National Health Service and local authority officers). Table 1 presents the final sample size and individual participant groups.

**Table. 1** Participant group size

| Participant Group             | Number of participants |
|-------------------------------|------------------------|
| Children in Key Stage (KS)2/3 | 3                      |
| Children in KS4               | 10                     |
| Caregivers KS2/3              | 2                      |
| Caregivers KS4                | 10                     |
| SENCOs                        | 11                     |
| Health professionals          | 2                      |
| Primary headteachers          | 2                      |
| Secondary headteachers        | 2                      |
| Advisory group                | 7                      |
| <b>Total</b>                  | <b>49</b>              |

## 2.5. Participant recruitment

Two types of purposeful sampling were used to recruit participants. Purposeful sampling is defined as: the identification and selection of individuals that are experienced in or are knowledgeable of the subject of interest (Palinkas et al., 2015). The alternative provision schools were approached as they were responsible for the education and care of children with school exclusion or, in the case of key stage 1, at risk of school exclusion. It is these schools where most of the children who experienced managed moves were taught. Due to the low number of children with a successful managed move, it was deemed unethical to interview them in their mainstream contexts, as this would increase the chances of identifying them in the research. Snowball sampling was used when recruiting children and their caregivers. The principal investigator liaised with the gatekeepers of the schools, as they had access to the caregivers and the children who had experienced managed moves. This approach complied with ethical procedures but also ensured that the sample reflected the local population with a range of experiences and characteristics (see appendix 2).

## 2.6. Ethics and procedures

Ethical approval for the research was obtained from the University of Sunderland Ethics Committee in March 2018 (ref. 001546). The research team adhered to NSPCC (2012) and Save the Children (2017) guidelines on the safe interviewing of children. The subsequent sections refer to the research ethics procedures followed for each participant group.

### 2.6.1. Process for interviewing professionals

Professionals within schools were made aware of the rationale for the research via a letter from Together for Children (TfC). This included: a follow-up email and, where requested, a telephone conversation to clarify the aim, objectives and process for the research. Professionals who worked outside of school settings or TfC's jurisdiction were

contacted directly by the principal investigator. Information sheets and consent forms were sent before any interviews took place, and consent was checked and clarified prior to the commencement of the interview.

### 2.6.2. Process for interviewing caregivers

To explain the purpose of the research, letters were sent home by the alternative provision schools in Sunderland. These were followed up with a phone conversation from a familiar member of the school team to talk through the research aims, objectives and process, and to discuss participation and voluntary consent. Contact details for the principal investigator were provided, and five caregivers requested additional information. All caregivers were given the choice of where they would like the interview to take place and were invited to bring a friend, family member or to have a member of the school staff present. Most caregivers were interviewed at their child's school except for two participants, who requested it took place at the University of Sunderland. At the start of each interview, consent was reaffirmed and participant rights were made explicit, including the right to withdraw. No incentives were given to take part, though participants were able to claim travel costs. The interviews with caregivers ranged from 20 to 90 minutes. At the end of their interview, further consent was requested for a conversation to take place with their child.

### 2.6.3. Process for conversations with children

After securing gatekeepers' permission, the school staff approached the children on behalf of the research team. The schools used their knowledge of individual children to determine if they should be approached to take part, as they knew their life stories and whether participation would have a negative impact on them. If the gatekeeper and caregivers consented for a child to take part but the child declined, they were not then encouraged to participate (Martin-Denham and Watts, 2019). One child was not

included in the discussion (they consented, but their caregiver declined consent). Social worker consent was sought and gained for all children who wished to take part but who had ‘looked after’ designations.

In addition to the consent gained by the teachers, the principal investigator reaffirmed consent using a comic strip and a child-appropriate consent form with the children, to ensure they understood the purpose of the research and how their responses would be reported. It was made clear to the children that the principal investigator would be the person reporting the findings in a report and future publications. A time-lapse between initial and reaffirmed consent was built in to allow the children to reflect on their decision. Emojis were used alongside ‘not sure’, ‘yes’ or ‘no’, for those who were unable to identify without visual representation (Martin-Denham and Watts, 2019). During the research, consent was treated as an ongoing process; the researcher ensured children knew they could stop at any time by pointing to the ‘stop sign’ or verbalising their wish for the next question or the interview to end.

The conversations with the children were face to face in their education setting with a member of the school staff and/or caregiver present as a ‘safe adult’. NSPCC (2012) and Save the Children (2017) guidelines were adhered to throughout the conversations. Children in key stage one were asked the questions by their teachers, due to their young age, and the responses were given to the research team. Adaptations to the questions were made to allow for varying cognitive abilities of individual children, with guidance from the school staff. Conversations with the children ranged from 20-45 minutes.

### 2.7. Analysis strategy

Qualitative content analysis with an inductive process was used to analyse interview transcripts using nVivo 12 (a qualitative data analysis programme). Qualitative content analysis is a process in which interview transcripts are condensed into smaller units of text to allow for the identification of emerging themes that describe the phenomenon of interest (Smith and Osborn, 2008). This is achieved by categorising units for analysis (transcripts) into salient smaller

units of meaning (sentences/phrases) and further condensing these into codes (Graneheim and Lundman, 2004). Codes that share an underlying meaning or some commonalities are combined into subthemes. The particular type of analysis used in the research was latent analysis, whereby the underlying meaning of what was disclosed by participants was analysed as opposed to description only, in keeping with interpretative phenomenological analysis. This also allowed the author to generate sub-themes and themes to determine what was being said (Graneheim and Lundman, 2004).

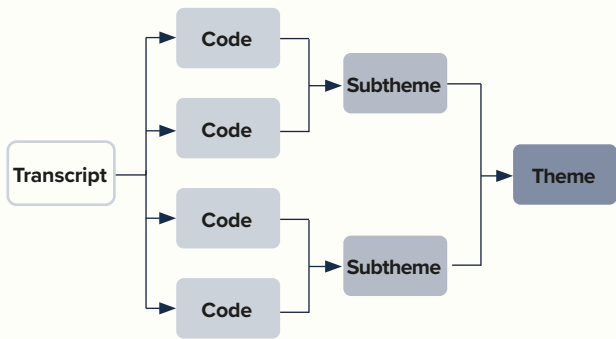


**Figure 4.** Iterative example of the coding process used in the content analysis where themes emerged from the data.

Participant groups were coded sequentially, using a coding list generated in nVivo from the first group analysed as a point of reference (the headteachers). This was to limit cognitive load and maintain reliability when analysing across groups due to the size of the study (Morse and Richards, 2002). It should be noted that the approach undertaken was still inductive, as codes could emerge from the data and were added to the coding list. The language and subject content of the children, caregivers and professionals varied. In response to this, each participant set was stored in its own nVivo folder. For example, KS2 and KS3 children, or KS2-3 caregivers.

## 2.8. Research limitations

The principal investigator carried out all the conversations with the children; an interview schedule was adhered to. 20% of the transcriptions were reviewed for accuracy and 50% of the coding in nVivo was also quality assured. As stated, the research focus is on the interpretation of the participant's lived experiences. It is acknowledged that the author is reflecting on their own meaning-making in relation to the research data as well as that of the participants. However, by adopting an inductive approach, themes could emerge from the data using careful and structured means of analysis to keep descriptions as true to participants' as possible. In acknowledging that the author could have different interpretations to others, the advisory group of seven children was convened to ensure the interpreted meaning of their views could be checked against the interviews.

Finally, the research does not include any children or caregiver who had experience of a successful managed move.

## 2.9. Trustworthiness

In qualitative research, the principles of validity, reliability and generalisability, must be adhered to in order to maintain a level of trustworthiness in the research. These concepts are more commonly referred to in quantitative research. However, they are acceptable for studies using content analysis (Long and Johnson, 2000). To strive for trustworthiness, the research had to be carried out fairly and the outcome had to be a true reflection of the participants' perceived experiences (Ely, 1991). Eisenhart (2006, p. 573) clarifies that 'the trustworthiness of the research depends on the evidence that the researcher was, in fact, there and did directly participate in the scenes of action'. The author of the research conducted 41 (84%) of the 49 interviews directly, and reviewed the transcripts of the remaining participants.

# 3. Analysis

### 3. Analysis

The data gathered from the interviews, conversations and the children’s advisory group were analysed for themes that related to the managed move process. This allowed consideration of the aims and objectives of this research, namely:

- To elicit the perceptions and experiences of multiple stakeholders, including those who the protocol of managed moves aimed to support, that is, those who were deemed to be on the verge of school exclusion.
- To produce a report, with supporting evidence, to inform strategic provision planning and training for education professionals within the local area of Sunderland.
- To create a model that exemplifies good practice in managed moves

The themes are presented per participant group where appropriate, and are followed by a discussion of the findings and excerpts from the data. Where a reference relates to key stage 2 or 3, this is indicated, as all other quotes relate to children in key stage 4. The quotes from adult participants are grouped by caregiver or professional.

#### 3.1. Children’s views on the managed moves process: Key stages 2-4

Children were asked ‘can you tell me about any managed moves you had?’ The three children in KS2/3 who discussed experiencing a managed move made nine responses about their experiences, and of these, 7 referred explicitly to why they felt the managed move failed. Similarly, the ten children in KS4 who discussed managed moves made 49 references in total, the majority of which (31) related to the same theme. The responses related to behavioural, belonging or learning factors that the children perceived caused their managed move to fail.

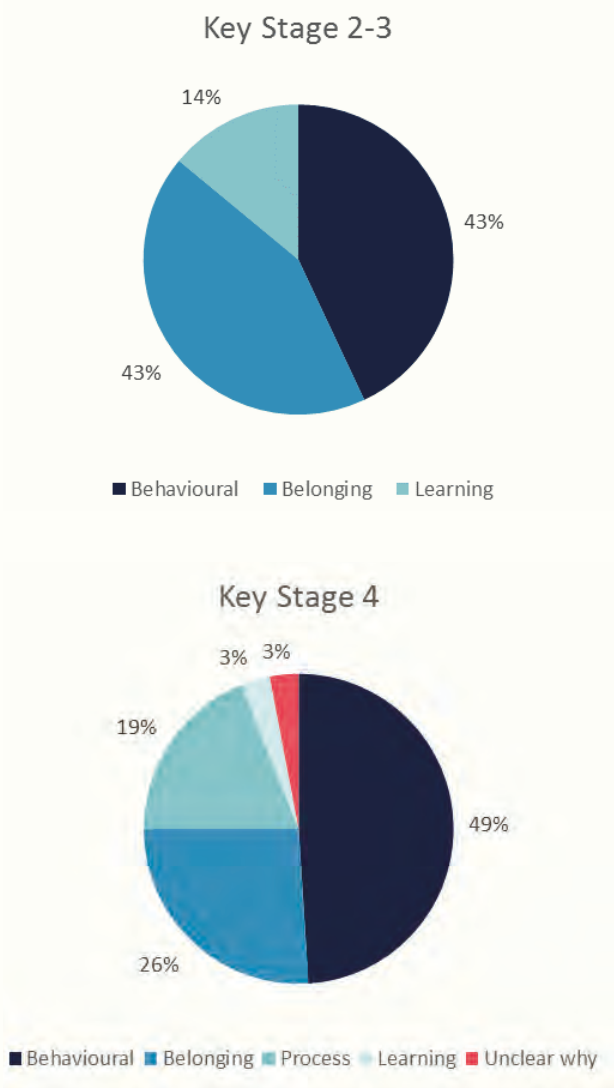


**Figure: 5.** Children’s perception of why the managed move failed: key stages (KS): 2-4



**Table 2.** Children’s perception of why the managed move failed: KS2-4

| Theme       | KS2/3 children | KS4 children | All children |
|-------------|----------------|--------------|--------------|
| Behavioural | 3 (43%)        | 15 (48%)     | 18 (47%)     |
| Belonging   | 3 (43%)        | 8 (26%)      | 11 (29%)     |
| Process     | -              | 6 (19%)      | 6 (16%)      |
| Learning    | 1 (14%)        | 1 (3%)       | 2 (5%)       |
| Unclear why | -              | 1 (3%)       | 1 (3%)       |
| Total       | 7 (100%)       | 31 (100%)    | 38 (100%)    |

**3.1.1. Children’s views on why the managed move failed (behavioural factors): Key stage 2-4**

Figure 5 and Table 2 present the children’s perceptions of why their managed move failed. They believed it was mostly due to reasons aligned to behavioural and belonging factors. During the analysis of the behavioural factors, it appeared that managed moves were terminated for minor misdemeanours **‘you don’t get very many chances. I was actually quite good in that school... I got a point for laughing, so that is why I was kicked out’**. Table 3 shows the 18 responses, of which seven related to perceived inflexible behaviour policies as the reason why the managed move placements were terminated by the school **‘I was meant to have 6 behaviour points, I had 10’**. One child expressed the view that there was no accounting for the fact that they have just come from alternative provision **‘going from being naughty, to a behaviour school, back to a normal school in 12 weeks, how do they expect me to only get six behaviour points’**.

Children described four examples that could be seen to be unfair termination of managed moves. The following example could indicate there is a stigma resulting in potentially harsher sanctions for them compared to the general school population: **‘they said they saw me check my time on my phone... she said I had to give her my phone, I said I didn’t have it, so I got sent home. I didn’t have my phone, but I still failed it’**.

Seven responses related to the children acknowledging responsibility for the failure of the new placement, accepting their behaviour was unreasonable **‘I shouted ‘fuck’ across the room, they told me to “get out” I said “no” and**

**walked out of the school’** and **‘another child told me to fuck off, saying he was going to do me, the teacher sent him out, then she started screaming at me so I flipped the table, I said sorry and picked it up straight away. The next day they asked me what I was doing in school, they told me it had failed’**. In this example, the child reported that their mother had told the new school that he was unable to cope with shouting due to sensory sensitivities. This could indicate that the teachers were not effectively trained or briefed to meet his individual needs or that there was a lapse in communication.

It needs to be considered as part of the managed move process if the child could or does have difficulties that meet the definition of a disability: ‘a physical or mental impairment, which has a long-term and substantial adverse effect on their ability to carry out normal day to day activities’ (Equality Act, 2010). As an anticipatory duty, schools are required to prepare in advance of a child arriving on the managed move, by agreeing on reasonable adjustments that need to be applied in these instances (DfE, 2015). The final comment is further evidence of the need to understand the reasons for a child’s behaviour as the child felt the impact of a bereavement in his life meant he struggled to cope in a mainstream school environment **‘I had a death, as you can understand I didn’t bother with school. I felt like I coped but I went into school, just cried my eyes out, I just blew up at a member of staff. He was shouting ‘go to your classroom’ they didn’t understand what was going on in my head’**.



**Table 3.** Children’s Views: Why the managed move failed (behavioural factors – all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Inflexibility in behaviour policy (all KS4)</b></p> <ul style="list-style-type: none"><li>• ‘The teacher would give points for loads of different reasons; talking, not doing enough work, not doing your homework’</li><li>• ‘Going from being naughty, to a behaviour school, back to a normal school in 12 weeks, how do they expect me to only get 6 behaviour points’</li><li>• ‘I got too many behaviour points (2nd attempt at managed move)’</li><li>• ‘I had apparently done something wrong but I didn’t know what, they wouldn’t tell me, so they put me in isolation...So I kicked off, which was stupid really. That isn’t why it failed though, I just got too many points’</li><li>• ‘I was meant to have 6 behaviour points. I had 10’</li><li>• ‘They wanted a minimum number of behaviour points; we want this much attendance’</li><li>• ‘I was always disappointed when I got behaviour points. I tried not to but I did... I still did my work’</li></ul> |
| <p><b>Acceptance of their inappropriate behaviours</b></p> <ul style="list-style-type: none"><li>• ‘I didn’t listen’ (KS2/3)</li><li>• ‘I shouted ‘fuck’ across the room, she told me to “get out” I said “no” and walked out of the school’ (KS2/3)</li><li>• ‘It was going alright. I dunno what happened, I started being really naughty (KS2/3)’</li><li>• ‘I just got back into my old routine’ (KS4)</li><li>• I got another managed move back to my first school. I thought I had sorted myself out, but nothing had changed’ (KS4)</li><li>• ‘I got too comfortable, I thought I would be allowed to stay, I was in isolation twice in one day and they said they were terminating my placement’ (KS4)</li></ul>                                                                                                                                                                                                                                                             |
| <p><b>Unfair termination of managed move</b></p> <ul style="list-style-type: none"><li>• ‘She thought I had written my name on the wall, but I hadn’t. I wouldn’t write my name on a wall. So, she said, ‘You can go downstairs and get the cleaning stuff and scrub the whole wall’ So I said “No”. She told my mum to come and pick me up’ (KS4)</li><li>• ‘I had a death, as you can understand, I didn’t bother with school. I felt like I coped but I went into school, just cried my eyes out, I just blew up at a member of staff. He was shouting ‘go to your classroom’ they didn’t understand what was going on in my head’ (KS4)</li></ul>                                                                                                                                                                                                                                                                                                                                |

### 3.1.2. Children's views on why the managed move failed (belonging factors): Key stages 2-4

The findings support the idea that children have a basic psychological need for a sense of belonging in a social group, and this increases as the child progresses with age (Maslow, 1943, 1954, 1970). Some of the reasons for failed managed moves appear to be due to the child seeking a sense of belonging, by forming and maintaining strong interpersonal relationships and seeking approval from peers, which often appear as negative behaviours, as discussed by Baumeister and Leary (1995). Examples would be **'we got caught smoking'** and **'I got in with the wrong crowd'**. The move failed for the behaviour of smoking, but the child may have been smoking with others to be accepted as part of a new social group and to feel connected with others already established in school (Craig, 2015).

The findings support other established research by Cutrona (1982), Smedley (2011) and Craig (2015), indicating that there can be a stigma associated with a child who is on a managed move from an alternative provision to a mainstream context. This means that they do not feel they belong and don't feel accepted **'I didn't want to tell them how I was feeling 'cos I was new. I was the new naughty boy, so everyone thought I was bad and stuff. I didn't really talk to anybody'**. This suggests that this child felt the staff would have already decided that he would not behave appropriately. Other children reported missing their old school and friendships. **'I missed my old school'** and **'I got caught smoking, the head said if I lie and say I didn't smoke, he would send me back, which is where I wanted to be, with my friends, so that is why I said that; saying that made me say it'**. The comments suggest that the stigma of 'the managed move child' can be a blight on the move being successful, as all children who participated in the research did not have a successful transfer, a finding echoed in the review by Messeter and Soni (2017).

**Table 4.** Children’s views: Why the managed move failed (belonging factors - all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inflexibility in behaviour policy (all KS4)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"><li>• ‘A teacher walking past heard me swear at my friends, she had a go at me. Three weeks later, I got told off for it and they cancelled my managed move’ (KS4)</li><li>• ‘I got in with the wrong crowd’ (KS4)</li><li>• ‘I was in science and there was a milky fluid, I said it looked like cum. The teacher gave me a behaviour point. The next day, I was told my MM had failed because of what happened’ (KS4)</li><li>• ‘We got caught smoking’ (KS4)</li><li>• ‘I was cheeky, it was fun and naughty, other children would tell me to do silly things... I didn’t want to do them because I was on a move, but I knew if I didn’t then I wouldn’t fit in’ (KS4)</li></ul> |
| <b>Stigma</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ul style="list-style-type: none"><li>• There were students much worse behaved than me, it is just the fact that I am not permanently in that school, that I didn’t stay’ (KS4)</li><li>• ‘You don’t get very many chances. I was actually quite good in that school’ (KS4)</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Longing for previous school</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <ul style="list-style-type: none"><li>• ‘I missed my old school’ (KS2/3)</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Bullying</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"><li>• ‘It was the people in the room. Not the teachers in that school. They called me [full version of name] I don’t like that name. Someone else being called it is fine but not me’ (KS2/3)</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

3.1.3. Children’s views on why the managed move failed (process factors): Key stage 4

The data indicated other reasons why the managed move failed, relating to processes in the receiving school. The data analysis of key stage 4 children suggested that the child required a period of adjustment during the transition process to learn about the systems and processes in their new school. **‘They expect you to know everything’** additionally, children often start mid-term. There were reports of variability on how children are welcomed (or not) into the new provision with one child reporting: **‘when I arrived, I met the isolation staff, they said “this is where you will be sitting”, that was basically it, everyday... I was put straight into isolation, I just had to sit there and do nothing, not talk and not move’**. Other children said they were allowed in the classrooms but had reduced sanction points compared to the rest of the class, increasing the risk of them failing. Two children described that managed moves were not limited in terms of how many attempts you could be given **‘I was in my first school a year and a half, then**

**managed move to a second, that failed, then a third, that failed, then another then here’**. This child felt there were negative consequences for their mental health, well-being and academic attainment, supporting research that multiple failed managed moves are more likely to have repercussions on mental health, wellbeing and educational attainment (Brown, 2007 and Michail, 2012).

Another issue identified regarded the ‘trial period’ of twelve weeks. In this time, the children perceive they must ‘prove’ themselves to earn a permanent place in the school. Some children did not seem to understand the reason the placement was terminated **‘both times I have failed it has been the day before the meeting at the end of the 12 weeks... they both went back to something that happened a while before, suddenly pulled me up and started having a go about it. I think it is money related. It’s ironic that it was both times the day before the meeting’**. These findings support Ofsted’s (2019) recommendation that there is a need for accountability in terms of how long the child remains in the school and the reason the placement fails.

Table 5. Children’s views: Why the managed move failed (process factors - all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Receiving school processes</b>                                                                                                                                                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"><li>• ‘They expect you to know everything (about how the school works)’</li><li>• ‘They don’t exclude managed move people they just don’t accept them back’</li></ul>                                                                                                                                                                                             |
| <b>Managed moves just don’t work</b>                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"><li>• ‘You are taken away from your original school for 12 weeks, then you get bounced back, the same thing happens, you go somewhere else, then bounced back. It’s just repeating, it’s boring’</li><li>• ‘I was in my first school a year and a half, then managed move to a second, that failed, then a third, that failed, then another, then here’</li></ul> |

3.1.4. Children’s views on why the managed move failed (learning factors): Key stages 2-4

Table 6 shows the two responses from the children, who remarked that the reason for not succeeding on the managed move was being unable to access the learning. **‘They were giving me work that was too hard for me; they wouldn’t make it easy so I just sat and refused to do anything’**. This supports earlier concerns raised by the DfE (2004b) that for a managed move to be successful, there needs to be a full support package in place. Consideration needed to be given to how well the transition

to a new school was led, planned for and documented, ensuring that person-centred support plans to enable the child to participate, progress and learn were in place (Vincent et al., 2007). Where the school felt the child ‘may have an SEN’ there needs to be deliberation as to whether an application for an education, health and care plan is required (DfE, 2015). All of these suggestions need to be underpinned by staff training to ensure they have the confidence, knowledge, understanding and empathy to effectively support children with a range of learning and SEMH needs before their transition to the receiving school (Carter, 2015; Driver Youth Trust, 2015).

Table 6. Children’s views: Why the managed move failed (learning factors)

| Subthemes                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Lack of differentiation and knowledge of prior learning</b>                                                                                                                                  |
| <ul style="list-style-type: none"><li>• ‘They used to ask me questions that I didn’t know the answer to; they would embarrass me in front of everyone, I would feel really bad’ (KS4)</li></ul> |

In addition to the data presented above, one child was unsure as to why their managed move failed, and another was unclear as to the reason **‘shit, it just failed’**.

3.1.5. Children’s views on what could improve the managed move process: Key stage 4

Table 7 shows that some of the children felt schools needed to be more lenient in terms of allocating behaviour sanctions, **‘I did want to stay in that school. And it’s annoying when you try. That was what annoyed me so much about that school, I tried for all the weeks I was there to be good. It was working. But it was just that one thing that happened and that was it’**. The children recommended that they could be given a look around the school when there are no other children there to put them at ease, to allow them to familiarise

themselves with the new building and to meet some members of staff. Two children suggested being given emotional support, whether from a member of staff they have a good relationship with or being paired with another child. These suggestions support the findings of Muir (2013), who evidenced the importance of positive relationships at the receiving school, so that the child felt supported, included, welcome and secure. This is particularly relevant for children moving from alternative provision to mainstream school and for those with SEMH needs (Michael and Fredrickson, 2013; Thomas, 2015; Flitcroft and Kelly 2016).

**Table 7.** Children’s views: What could improve managed moves? (all comments)

| Theme                   | Subthemes                                                                                                                                                                                                                                                                                            |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What could be improved? | <b>Leniency</b> <ul style="list-style-type: none"><li>• ‘They need to be more lenient’</li></ul>                                                                                                                                                                                                     |
|                         | <b>Transition with support</b> <ul style="list-style-type: none"><li>• ‘I got chucked straight in. In the second school, I went in for a look whilst everyone else was there. So that was hectic. Then the next week I started... I got nothing that the other children wouldn’t have had’</li></ul> |
| What works well?        | <b>Support</b> <ul style="list-style-type: none"><li>• ‘Two teachers had hearts of gold; they helped me all the time; it was just the deputy head. I couldn’t stand him’</li><li>• ‘They paired me with someone’</li></ul>                                                                           |
|                         | <b>Listening to the child</b> <ul style="list-style-type: none"><li>• ‘If you didn’t want help you could say no, not like my other school... I was in a smaller group, but it wasn’t all children with problems’</li></ul>                                                                           |

**3.1.6. Advisory groups of children and their views on how to improve the managed move process**

Following the interviews, one advisory group meeting was held with a group of seven children with previous school exclusions to discuss key themes arising from the data analysis. The children ranged from 9-16 years old. Each was currently attending local alternative provision or a pupil referral unit, and was invited to be part of the group following a request from their headteachers (open to all children). The coded themes and participant comments that related to managed moves were shared with the children at the advisory group meeting. They were then asked to share their thoughts on the managed move process and how, if at all, they felt it could be improved, as outlined in Table 8. A key theme that arose

from the discussion concerned having ‘time’ to decide if the school was right for them and having time to readjust to the new environment and form relationships.

The children did not mention any improvements to learning and teaching that they believed were needed, but instead related to refining transition processes and creating a sense of belonging through developing relationships. This supports the findings of Chadwick (2013) and Thomas (2015), who suggested that children need to create new relationships with staff and peers to develop a sense of belonging. Phased reintroduction to school and additional support was also discussed as an enabling factor for a successful move, a view shared by Mills and Thomson (2018). One of the children implied that they felt stigmatised by being on a managed move, so they felt they were not experiencing a fresh start – the

premise of the managed move system. All seven children in the advisory group held the perception that the main issue with managed moves was the low expectations of them when they arrived because of the difficulties in their first school. They said they were told it would be a fresh start, but it felt like some staff were waiting for them to fail. Following the discussion, the advisory groups agreed that to improve the managed move process, children should slowly transition into the new school with a reduced timetable and a key worker.

**Table 8.** Children’s advisory group comments on improving the managed move process (all comments)

| Theme                                   | Subthemes                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| How to improve the managed move process | <b>Transition</b>                                                                                                                                                                                                                                                                                                        |
|                                         | <ul style="list-style-type: none"><li>• ‘To have time to settle and get along with people’</li><li>• ‘To have someone from your last school to go with you that you respect’</li><li>• ‘To start slowly, maybe half days at first’</li><li>• ‘To visit to the school to see if it is the right school for you’</li></ul> |
|                                         | <b>Friendships</b>                                                                                                                                                                                                                                                                                                       |
|                                         | <ul style="list-style-type: none"><li>• ‘To have time to make new friendships and to know what help you will need’</li></ul>                                                                                                                                                                                             |
|                                         | <b>Teachers</b>                                                                                                                                                                                                                                                                                                          |
|                                         | <ul style="list-style-type: none"><li>• ‘If the teachers didn’t have an opinion of us because of what we did in a different school’</li></ul>                                                                                                                                                                            |

### 3.2. Caregivers’ views on managed moves: Key stages 2-4

The caregivers were asked ‘Can you tell me your experiences/ views of managed moves?’ Twelve caregivers with children in KS2 to KS4 shared their experiences of the managed move process. The two KS2-3 caregivers commented:

**‘He never settled there. He started in September and was already on a managed move by the January’**

**‘..Then you’ve got to the managed move to a second mainstream secondary and he was doing all right there. Then he went off the rails and same again, too late for me to do anything’**

These comments could be interpreted as the caregivers feeling that their child never settled in mainstream education.

#### 3.2.1. Caregivers’ views on why the managed move failed (behavioural factors): Key stage 4

The ten caregivers with children in key stage 4 made 62 references to their experiences surrounding managed moves, including the reasons for failure, the impact of failure and reasons for agreeing to a managed move. Ten comments that specifically discussed why the managed move failed were placed into the following groups: behavioural, belonging and learning factors.

Table 9. Caregivers’ perception of why the managed move failed

| Participant group | Behavioural | Belonging | Learning | Total     |
|-------------------|-------------|-----------|----------|-----------|
| KS4 caregivers    | 6 (60%)     | 2 (20%)   | 2 (20%)  | 10 (100%) |

The main reason the caregivers perceived the managed move failed was due to behavioural factors and a lack of leniency in the receiving school **‘other kids in the school do these things but they don’t fail’** and **‘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’**. This could indicate that there needs to be improved training to identify and respond to children on the edge of school exclusion. Only one caregiver suggested that the failed placement was the child’s fault **‘he lasted about six weeks; it was a 12 week managed move. He only had to behave for 12 weeks, and he couldn’t. It was always to do with his shouting out. Being a gobshite, answering back. Doing what gets the teacher’s backs up’**.



**Table 10.** Caregivers’ views on why the managed move failed (behavioural factors - all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Lack of appropriate leniency</b></p> <ul style="list-style-type: none"><li>• ‘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 alternative provision, 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. Just one person got me; he was fair. He had 12 before they kicked him out. But the points were for little things, like being told to be quiet. I was so ashamed at the time. No one wants to hear; they just run a mile. One teacher, I, identified that they were after him. I did bring it to their attention, but nothing was done about it’</li><li>• ‘Other kids in the managed move school do these things, but they don’t fail’</li><li>• ‘Lots of the kids have them ... They fail on something really petty, like being silly in class, then they go back to the first school. I think it is the headteacher showing it is the kid with the problem, not the head’</li></ul> |
| <p><b>Lack of understanding of the child’s needs/views</b></p> <ul style="list-style-type: none"><li>• ‘He was asked for an honest opinion, he gave one, but it didn’t go down well. It is a religious school and he doesn’t believe in God’</li><li>• ‘My child being unable to cope with shouting. It makes him feel dizzy and triggers him. He told me he would ask teachers not to shout at him, but they would say he was being cheeky.’</li><li>• ‘I informed the school and health services. He failed his move because, while the teacher was marking papers not teaching the class, a boy in his class started trying to incite him to fight with him. The boy got sent out, but at the end of the lesson, the teacher asked my child to stay back. The teacher started shouting at my child, though he asked her to stop shouting, she began to shout louder. He became so distressed when she would not stop shouting at him that he flipped a table and burst into tears’</li></ul>                                                                                                                                                                                        |
| <p><b>Acceptance of the child’s bad behaviour</b></p> <ul style="list-style-type: none"><li>• He lasted for about six weeks. It was a 12 week managed move. He only had to behave for 12 weeks, and he couldn’t. It was always to do with his shouting out. Being a gobshite, answering back. Doing what gets the teacher’s backs up’</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

3.2.2. Caregivers’ views on why the managed move failed: (learning factors): Key stage 4

Table 11 presents the KS4 caregivers’ perceptions of the learning factors that led to the failure of the managed move. **‘My eldest child went on a managed move, but the root of the problem was not recognised or supported. How is anything going to change? That is exactly what happened with his managed move. He came back because it**

**wasn’t working. But he wasn’t diagnosed, and he had nothing in place for his dyslexia’.** This could indicate that the graduated response of assess, plan, do and review was either not in place or effective, as his problems were not identified (DfE, 2015a). Again, there needs to be a consideration as to whether children have SEND due to their learning and SEMH needs (Equality Act, 2010; DfE, 2015). One possible reason for the lack of identification could be due to training issues in the schools as raised by Carter (2015), Driver Youth Trust (2015), DfE (2015), and Martin-Denham and Watts (2019).

Table 11. Caregivers’ views on why the managed move failed (learning factors - all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Lack of assessment or identification of SEN</b>                                                                                                                                                                                                                                                                                                           |
| <ul style="list-style-type: none"><li>• ‘My eldest child went on a managed move, but the root of the problem was not recognised or supported. How is anything going to change? That is exactly what happened with his managed move. He came back because it wasn’t working. But he wasn’t diagnosed, and he had nothing in place for his dyslexia’</li></ul> |
| <b>Low self esteem</b>                                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"><li>• ‘I just think it stems from the primary school setting, where his confidence was shattered. He has very low self-esteem. He’s got no confidence in himself. If you ask him what he can do, he will say nothing. If you ask him to write, he’ll say he can’t, and he says he can’t read’</li></ul>                    |

3.2.3. Caregivers’ views on why the managed move failed (belonging factors): Key stage 4

In terms of belonging factors, two caregivers recalled victimisation from other children as reasons for the managed move failing. Comments included: **‘the second week he was bullied continuously. Some of the children had friends in his old school, so they knew about him’** and **‘it went well for a few weeks, but as soon as the other children realised he was different, it started again. Then he came home**

**and had a meltdown. Basically, we decided to pull the plug. We thought: this isn’t going to work. We didn’t want him to suffer anymore’.** These perceptions suggest that there is a need for schools to closely monitor children on managed moves to ensure they are being adequately supported.

Table 12. Caregivers’ views on why the managed move failed (belonging factors)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Bullying</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"><li>• ‘It went well for a few weeks, but as soon as the other children realised he was different, it started again. Then he came home and had a meltdown. We decided to pull the plug. We thought: this isn’t going to work. We didn’t want him to suffer anymore’</li><li>• ‘The second week in he was bullied continuously. Some of the children had friends in his old school, so they knew about him’.</li></ul> |

3.2.4. Caregivers’ views on the wider impact of failed managed moves on the child and family: Key stage 4

The four comments share the view that a failed managed move can have a detrimental effect of on both the child and the family. These comments demonstrate the impact of a failed placement on a child’s well-being and lack of

connectedness. The responses show feelings of segregation, vulnerability and insecurity (Craig, 2015). The descriptions also illustrate the level of stress that a failed managed move had, not just on the child but also the family, as they are left to care for the child when they are not in formal schooling, as found by Chadwick (2013), Muir (2013), and Bagley and Hallam (2015).

Table 13. Caregivers’ views on the wider impact of failing a managed move (all comments)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Impact on Wellbeing</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"><li>• ‘He was devastated when he came back here’</li><li>• ‘I’ll never forgive that school. I had no phone call’</li><li>• ‘My son came home. His dad went to look for him two hours later. He found him in bed, fully dressed, shoes and backpack still on. He slept for two hours, crying when he woke up. When I found out what happened, I was disgusted. No one listens. You are just nothing’</li><li>• ‘I was desperate and agreeing with the staff at his managed move school. The parents at this point, we are on our knees’</li></ul> |

### 3.2.5. Caregivers’ views on why they requested managed moves: Key stage 4

Two caregivers referred to this theme; their responses were **‘we were totally failed by them. I told them he couldn’t stay and that I wanted a managed move. That they weren’t meeting his needs’** and **‘in the end I said “let’s try a managed move” because somewhere has to be better than here for him’**. These comments suggest that the caregivers recognised that the child needed support in mainstream, but felt it was not forthcoming.

### 3.2.6. Caregivers’ views on the positives of managed moves: Key stage 4

Two caregivers referred to this theme. Their responses were **‘we did get more support from the second school’** and **‘in the end, the managed move school realised what I had said all along, that he was dyslexic. They did a test’**. These descriptions are positive in that the caregivers acknowledge how the receiving secondary school made efforts to support their child by providing support and, in one case, identifying a learning difference.

### 3.3. Professionals’ views on managed moves

This section shares and discusses the opinions of 15 professionals on the managed move protocol. This included eleven Special Educational Needs Co-ordinators (SENCOs), four headteachers and two health professionals. It is important to note that managed moves became an emerging theme after the interviews with primary and secondary headteachers about the core factors leading to a rise in SEMH and school exclusion in the City of Sunderland. This explains the low discussion rate from headteachers on this theme. The headteachers, SENCOs and health professionals were asked ‘What do you feel are the enablers and barriers to managed moves?’

### 3.4. Professionals’ views on the enablers to managed moves

The analysis of the SENCOs’ responses relating to factors contributing to a successful managed move indicated a link to the themes of belonging, behaviour, process and learning. This had been teased out of the analysis of the various data from children. Analysis of the interviews with headteachers also provided data for the ‘belonging’ and ‘behavioural’ themes. Health and support professionals only made comments relating to the ‘belonging’ theme. Only the SENCOs commented on all four themes. This data is presented in Figure 6 and Table 14.

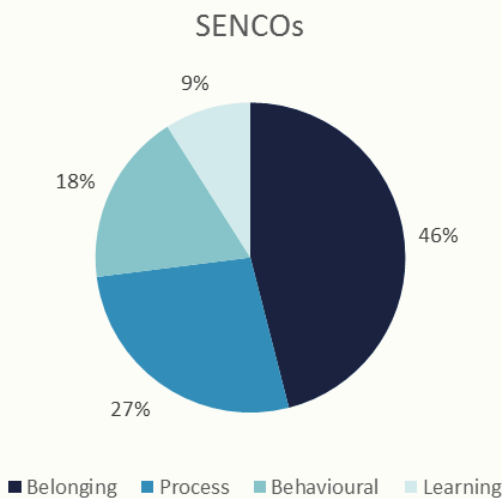


Figure 6. SENCOs’ views on the enablers to successful managed moves

**Table 14.** Professionals’ views on the enablers to successful managed moves

| Theme       | SENCOs<br>(n=11) | Health and support<br>(n=2) | Headteachers<br>(n=2) | All professionals |
|-------------|------------------|-----------------------------|-----------------------|-------------------|
| Behavioural | 5 (45%)          | 2 (100%)                    | 1 (50%)               | 7 (47%)           |
| Belonging   | 2 (18%)          | -                           | 1 (50%)               | 4 (27%)           |
| Process     | 3 (27%)          | -                           | -                     | 3 (20%)           |
| Learning    | 1 (9%)           | -                           | -                     | 1 (7%)            |
| Total       | 11 (100%)        | 2 (100%)                    | 2 (100%)              | 15 (100%)         |

**3.4.1. Professionals’ views on the enablers to managed moves (belonging factors)**

It appeared that ‘creating a sense of belonging’ was the most prominent factor reported to achieve a successful managed move from the perspective of SENCOs and health and support professionals. The data indicated the importance of positive relationships from either the child’s previous or receiving school **‘they have someone in their new school they can speak to’** (SENCO) and **‘we’ve put additional support around the child going back; they go out to see them two or three times a week in the first week, then twice weekly to keep an eye on them’** (Headteacher).

Some respondents commented on how the success is due to removing the child from problematic friendships and providing a new environment **‘he just seemed to settle. I don’t know whether it was removing him from learners he was involved with. It was smooth, but that doesn’t happen very often’** (SENCO) a **‘fresh start’**, **‘we have had children excluded and tried them at another school. It has worked well’** (Headteacher) and the child **‘changing their mindset’** (SENCO) **‘when children ‘buy-in’** (SENCO). One comment highlighted the stigma of children returning to mainstream from an alternative provision **‘we have thought that being integrated into mainstream secondary following finishing primary in alternative provision wouldn’t work. But it is a complete change, with a whole new environment with different staff completely, but for some of them changing that mindset has been amazing’** (SENCO). These comments echo the views of Warnock (2005) and CSIE (2011), that inclusion is about cultures and practices of schools rather than geographical location.

Table 15. SENCOs and Headteachers’ views on enablers of the managed move process (belonging factors - all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional support</b> <ul style="list-style-type: none"><li>• ‘They have someone in their new school they can speak to’ (SENCO)</li><li>• ‘We are a small secondary and 95% of our moves in do work’ (SENCO)</li><li>• ‘We’ve started to put in additional support around the child going back, they go out [to see the child] two or three times in the first week, then twice weekly just to keep an eye on them’ (Headteacher)</li></ul>                                                                                                    |
| <b>A fresh start</b> <ul style="list-style-type: none"><li>• ‘Some of them we have thought that being integrated into mainstream secondary following finishing primary in alternative provision wouldn’t work. But it is a complete change with a whole new environment, with different staff completely, but for some of them changing that mindset has been amazing’ (SENCO)</li><li>• ‘When children buy-in’ (SENCO)</li><li>• ‘We have had children excluded and tried them at another school, and it has worked well’ (Headteacher)</li></ul> |
| <b>Removing from a peer group</b> <ul style="list-style-type: none"><li>• ‘He seems to have managed really well, just seemed to settle. I don’t know whether it was removing him from learners he was involved with, it was smooth, but that doesn’t happen very often’ (SENCO)</li></ul>                                                                                                                                                                                                                                                          |

3.4.2. Professionals’ views on the enablers to managed moves (behavioural factors)

As can be seen in Table 16, the SENCOs advocate giving the child time to settle into the provision. This is in accordance with the views of the caregivers and children on leniency in the use of behaviour sanctions ‘**sticking with it and giving a little bit of leeway, supervising enough and pulling back when he’s not doing what we expected him to do**’ (SENCO). The headteachers discussed enablers in terms of support of teaching assistants and the need for funding alongside person-centred approaches involving the wider school team. The two headteachers commented on managing

behaviour and challenges around funding to support individual needs. The final comment from the headteacher indicates the time investment required to provide person-centred approaches.

**Table 16.** SENCOs and Headteachers’ views on enablers of the managed move process (behavioural factors - all comments)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• ‘We have a child in year 11 who came to us in year 7, it was rocky, but he has settled down quite well. Low- level reports but it has worked’ (SENCO)</li><li>• ‘Sticking with it and giving a little bit of leeway, supervising enough and pulling back when he’s not doing what we expected him to do’ (SENCO)</li><li>• ‘We have a young man at the moment on a transfer, and we have money attached to him. He needs one-to-one support, and we will appoint a TA to do that. If it is an EHCP, it is predicated on that and the funding that comes in with that’ (Headteacher)</li><li>• ‘The child who is on a managed move we’ve put in lots and lots of support work, support for parents. We try and utilise all the staff in the school. So it is just wider than the class teacher. The SENCO gets involved, the head gets involved. We do absolutely every mortal thing we can to stop a child from getting excluded. Now he comes in to read with me. You’ve just got to give more and more of your time during the school day to these children, and you pick up the paperwork when they’ve gone home’ (Headteacher)</li></ul> |

**3.4.3. Professionals’ views on the enablers to managed moves (process factors)**

The responses by three SENCOs showed that the graduated response of: assess, plan, do and review appears to be adhered to, and that steps were taken to prepare for each child’s transition to the receiving school. The comments are significant, as they suggest that the placement is planned for in advance, so that needs can be prepared for, in accordance with statutory duties (Equality Act, 2010; DfE, 2015).

**Table 17.** SENCOs’ views on enablers of the managed move process (process factors - all comments)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• ‘We start with a reintegration meeting with the parent and child; we talk about what’s gone wrong and if anything needs to be put immediately into place’ (SENCO)</li><li>• ‘We do a transition with them, so they support before the child goes to their new school’ (SENCO)</li><li>• ‘A diagnosis and onto an EHCP’ (SENCO)</li></ul> |



One SENCO reported that the key to a successful managed move was continuity in terms of teaching approaches between the two provisions **‘moving to bespoke provision, the children that go onto specialist provision say it has worked well. They teach in a similar way, and the staff are very good at listening. It has meant they have gone on to do their GCSEs and go on to college’**

3.4.4. Professionals’ views on the enablers to managed moves: (learning factors)

The one SENCO who reflected on enablers to managed moves felt it was due to utilising his passion for football to gain buy-in from the child.

**‘We sent a child to the football academy. It was a huge success, he really bought into football in the afternoon. It supported him to behave in the morning. The children that go onto specialist provision say it has worked well. They teach in a similar way, and the staff are very good at listening. It has meant they have gone on to do their GCSEs and go on to college’** (SENCO)

3.5. Professionals’ views on the challenges to successful managed moves

This section shares the perceived challenges to managed moves from the perspective of SENCOs, health and support staff, and headteachers. It begins by sharing the percentage of professionals who had views on the barriers to achieving a successful managed move. An additional theme was parents as a challenge to the managed move being successful. This has therefore been added into the analysis.

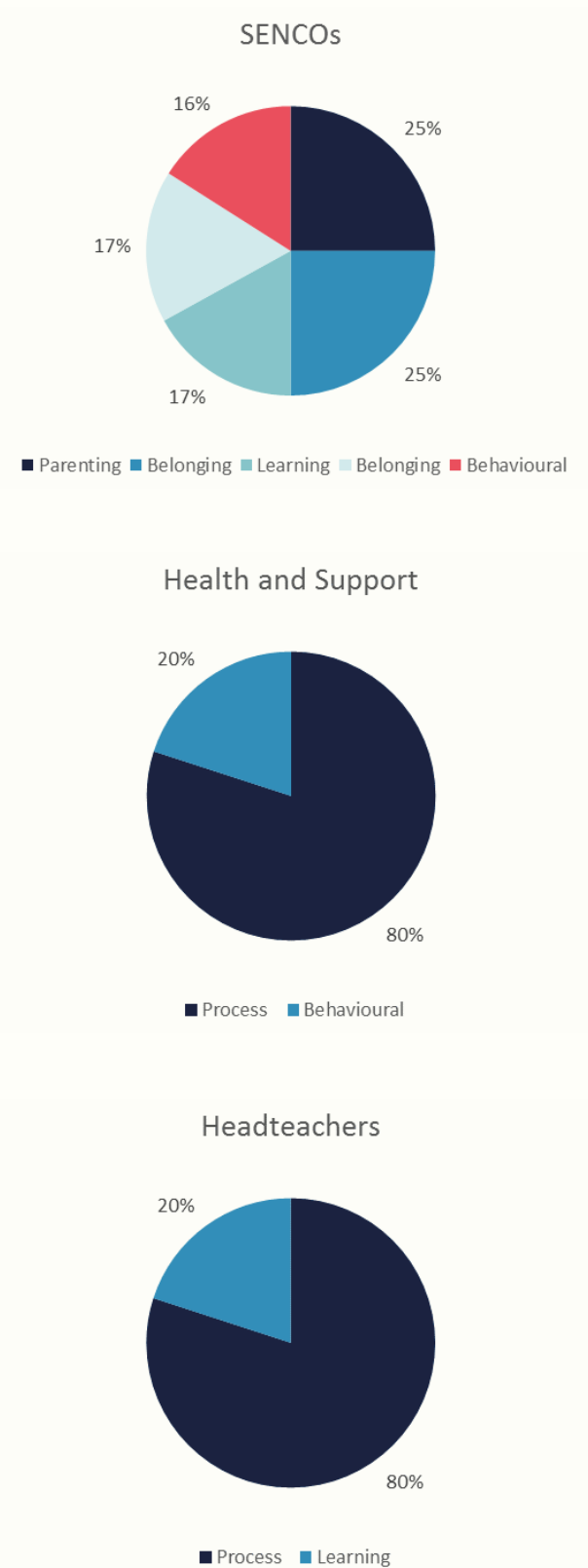


Figure: 7. Professional views on the barriers to the managed move process

**Table 18.** Professionals’ views on the barriers to the managed move process

| Theme       | SENCOs<br>(n=12) | Health and support<br>(n=5) | Headteachers<br>(n=8) | All professionals<br>(n=25) |
|-------------|------------------|-----------------------------|-----------------------|-----------------------------|
| Process     | 3 (25%)          | 4 (80%)                     | 7 (88%)               | 14 (56%)                    |
| Behavioural | 2 (17%)          | 1 (20%)                     | -                     | 3 (12%)                     |
| Learning    | 2 (17%)          | -                           | 1 (13%)               | 3 (12%)                     |
| Parenting   | 3 (25%)          | -                           | -                     | 3 (12%)                     |
| Belonging   | 2 (17%)          | -                           | -                     | 2 (8%)                      |
| Total       | 12 (100%)        | 5 (100%)                    | 8 (100%)              | 25 (100%)                   |

**3.5.1. Professionals’ views on the challenges to successful managed moves (process factors)**

Although headteachers were not asked specifically about managed moves, eight made comments about the process. Table 19 highlights that the main barrier to a successful managed move was when schools cannot meet the child’s needs **‘it just moves the problem on’** (SENCO). These comments corroborate early concerns raised by the DfES (2004b), that the practice of managed moves is problematic, as it moves the problem on to other schools rather than establishing and responding to the underlying reason. The responses from health and support services support this view **‘some schools don’t like that I will ask them to assess the child properly’** (Health and support services).

Some responses share concerns that not all schools are willing to engage in taking a child on a managed move. As one headteacher explained: **‘even now we have put in extra support, the schools are just not interested. They don’t want that child in their books. In the worst schools, they will fail within days’** (Headteacher). This could be seen to support the views of some of the caregivers and children, that there is a stigma around children on a managed move. This comment from the headteacher could indicate a reason why managed moves fail; the receiving school not being invested in the child succeeding.

**Table 19.** Professionals’ views on the barriers to the managed move process (process factors - all comments)

| Subthemes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Schools unable to meet the child’s needs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <ul style="list-style-type: none"><li>• ‘The school doesn’t want the child back, but they haven’t got grounds for permanent exclusion, they don’t want to change to meet their needs’ (Headteacher)</li><li>• ‘You’ve been to two primary schools and two secondary schools, that throw in a managed move and exclude them anyway; it’s no wonder they have trust issues and attachment issues’ (Headteacher)</li><li>• ‘Schools are trying to find a quick solution, and they are doing it without informing the Local Authority. To get respite. I think that is what they are actually doing sometimes’ (Health and support)</li><li>• ‘We’ve just taken on a child who had a managed move from another school. He was permanently excluded, and his presentation in school is ten times better than some other children we are working with. We have children whose needs are far greater. We try to work and support, we are totally committed to inclusion, and it’s interesting to see the tolerance in different schools’ (Headteacher)</li><li>• ‘Many children have gone through a managed move or two. I disagree with two; you are failing the child twice’ (Health and support)</li><li>• ‘To prevent a permanent exclusion’ (SENCO)</li><li>• I disagree that an attendance target from a new school will help a child who struggles to go to school’ (Health and support)</li></ul> |
| <b>Not all schools will take children on a managed move</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"><li>• ‘We need a fairer route for every school to take a turn (at taking a child on a managed move)’ (Headteacher)</li><li>• ‘Funding and places for them to go... We had a child who was promised a place, given a date to start and an induction, and because there was a permanent exclusion, then he didn’t get the place. So, he went totally off the rails and we had to do a managed move to another school for him because the relationship just broke down... We went for a managed move with another school, rather than the permanent exclusion’ (Headteacher)</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Lack of identification of underlying needs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <ul style="list-style-type: none"><li>• ‘Some schools don’t like that I will ask them to assess the child properly’ (Health and support)</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Caregivers feeling pressured</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"><li>• ‘We work with other schools on managed moves, and actually, one thing that might be interesting is the number of families who move. Parents under pressure for attendance or behaviour, the parents move, and they start over somewhere else. We have a lot of mobile children. That mobility needs to be looked at quite carefully’ (Headteacher)</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

### 3.5.2. Professionals’ views on the challenges to successful managed moves (behavioural factors)

The most cited obstacle to successful managed moves concerns the behaviours of the child arising from any disabilities they may have. The health professional stated **‘this child cannot change their behaviour because they are very anxious and they have underlying reasons, it is not that they don’t want to come to your school; they don’t want to go to any school’**. This supports the views of Mills and Thomson (2018), who suggested that not all children can have their needs met in mainstream education and, as a result, they are unable to cope with that environment.

Table 20. Professionals’ views on the barriers to the managed move process (behavioural factors)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Behaviours arising from disabilities</b>                                                                                                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"><li>• ‘I feel it’s failed because of an SEN, particularly children with ADHD, because of their disruptive nature and behaviours in class’ (SENCO)</li></ul>                                                                                                                                                                                                                                                       |
| <b>Lack of funding</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"><li>• ‘We accepted a child on a managed move after exclusions at another school into our year four. His family would like another managed move. But he’s going to face the same obstacles in another school. We have so much in place for him and his behaviour. CAMHS, Early Help. We feel that by moving him, he will not have that support. We have put a lot in even though it is unfunded’ (SENCO)</li></ul> |

### 3.5.3. Professionals’ views on the challenges to successful managed moves (learning factors)

Additional views expressed by professionals raise issues surrounding the ability to fund support for children during the managed move, at a time when the child is potentially given unrealistic expectations **‘it’s flawed because the children are put under far more pressure than the children currently in that school. The targets are more extreme (learning and attendance), it’s harsh, it’s unfair, it’s unjust’** (Headteacher).

Table 21. Professionals’ views on the barriers to the managed move process (learning factors)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Learning</b>                                                                                                                                                                                                                                                                                                                                                                                  |
| <ul style="list-style-type: none"><li>• ‘The support we can provide is limited as we are a small school’ (SENCO)</li><li>• ‘I think a lot of mainstream schools don’t have the teaching assistants (TAs) to support, so strategies aren’t being put in because they can’t. Sometimes they put in no support at all, including no SEN support for children on the SEN register’ (SENCO)</li></ul> |

### 3.5.4. Professionals’ views on the challenges to successful managed moves (caregiver factors)

Three SENCOs felt that some of the challenges stem from the caregivers in terms of the acceptance of their child’s SEN and the impact of home factors.

Table 22. SENCOs’ views on the barriers to the managed move process (parental factors)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Caregivers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <ul style="list-style-type: none"><li>• ‘Parents unable to acknowledge their child’s difficulties’ (SENCO)</li><li>• ‘There was a conflict between school and the parents where they didn’t want us to support him in a certain way. We know that the issues are still there and it’s quite sad. We just got a report recently where he is still displaying the same behaviour’ (SENCO)</li><li>• ‘They’ve come on a managed move, to see how they settle. They are doing really well, but the issues are still there around their home background and the family separation’ (SENCO)</li></ul> |

### 3.5.5. Professionals’ views on the challenges to successful managed moves (belonging factors)

The two comments by the SENCOs share the importance of the child having a sense of belonging but also the challenges some children have when changing schools. This echoes the DfE (2016) guidance on supporting mental health and behaviour, which acknowledges a sense of belonging as a protective factor, where children can trust and talk openly about their difficulties. Yet, for some children with a traumatic history, this is not always feasible.

Table 23. SENCOs’ views on the barriers to the managed move process (belonging factors)

| Subtheme                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• ‘The child had some attachment issues. They felt unsure in their surroundings and about where they belonged. Ultimately the child lashed out at the new school and sent another child to the hospital, so that was cancelled’</li><li>• ‘Sometimes they have been rejected by their new school. They feel rejected by us because we have put them somewhere else and then more rejection when they get sent back again. It is another failure’</li></ul> |

## **4. The proposed managed move model**

## 4. The proposed managed move model

Following analysis of the data and literature review, the following model has been created to illustrate the enablers to successful managed moves for all children (Figure 8). This is a sequential model in that it begins with the receiving school identifying a suitable member of staff (potentially the SENCO or pastoral lead) to be an advocate for the child and their caregivers. The role of the advocate is to support the transition process by securing positive and enduring relationships with staff and peers.

Once the advocate is established, they will take the lead on gathering information from the child's current school on their holistic development, strengths, interests and needs. This will include the family history and all internal and external data on the child, including attainment, attendance, reasonable adjustments, interventions, SEN support/ EHC plans and reviews over a period of time. Information on any diagnosed needs/ assessments or concerns need to be made available alongside the record of behaviour sanctions and rewards.

Once the school has the chronology of the child, a site visit can then be arranged using the information from the previous school to enable the advocate to plan the visit, ensuring any necessary adaptations are in place. For some children, a visit after school hours may be more appropriate. This should be discussed with the child and caregiver. The caregiver should accompany the child, so they can also begin to forge positive relationships with staff, familiarise themselves with the surroundings, and find out the expectations of the school and curriculum offer. Following the visit, the child needs to be given adequate time to decide if the placement is right for them. If the child and/or caregiver does not 'buy into' the move at this point, the managed move is less likely to be a success.

If the child and caregivers agree to the managed move, the process of planning the intricate details of the transition should begin with the advocate, child and their caregiver. This must include a bespoke package of learning, pastoral and behavioural support, which is agreed and signed off by the child, caregivers, advocate and then senior leaders. The transition plan needs to consider if the child needs a phased integration or reduced timetable, depending on their views, wishes and needs. One of the main reasons that managed moves fail is due to inflexibility in behaviour policies. The child and caregivers need to understand in advance of the transfer what the specific expectations of behaviour are and what a child will receive sanctions for (and the limit and consequences of reaching this). Flexibility and leniency must be adopted, given that children are moving from smaller classes with greater levels of support into larger mainstream classrooms. This will include a discussion of the need for the implementation of the graduated approach, or an application for an EHCP needs assessment where appropriate. The SENCO will then seek internal and external assessment as the graduated approach, and to support any application for an EHC needs assessment. As part of this, a communication strategy needs to be agreed to determine how best to contact the caregivers during the planning and transition phase. The support plans will be agreed and signed off by senior leaders.

The next stage is training, to support all staff to understand the importance of enabling children on managed moves to participate, learn and progress, through developing a sense of belonging and creating positive relationships.

Staff all need to be familiar with the child's support plan and, where relevant, an outline of the circumstances leading to the managed move.

The next stage in the model is for the child to have a peer or learning mentor to ensure they have a point of contact during the 12-week trial period. At this point, the placement would begin. For some children a phased return may be appropriate. Daily and weekly updates must be shared with the child and caregivers to ensure they are kept up to date, and so any early intervention for behaviour points can be openly discussed and responded to. The updates are an opportunity for the school to respond to concerns from the child and caregiver regarding

the level of work and need for additional differentiation, learning and pastoral support. This early debrief is a crucial part of the process, as it prevents any sense of unfair treatment and allows for reconciliation.

The advocate needs to monitor the placement and check that the support plan is being adhered to and, where appropriate, agree any modifications with all parties.

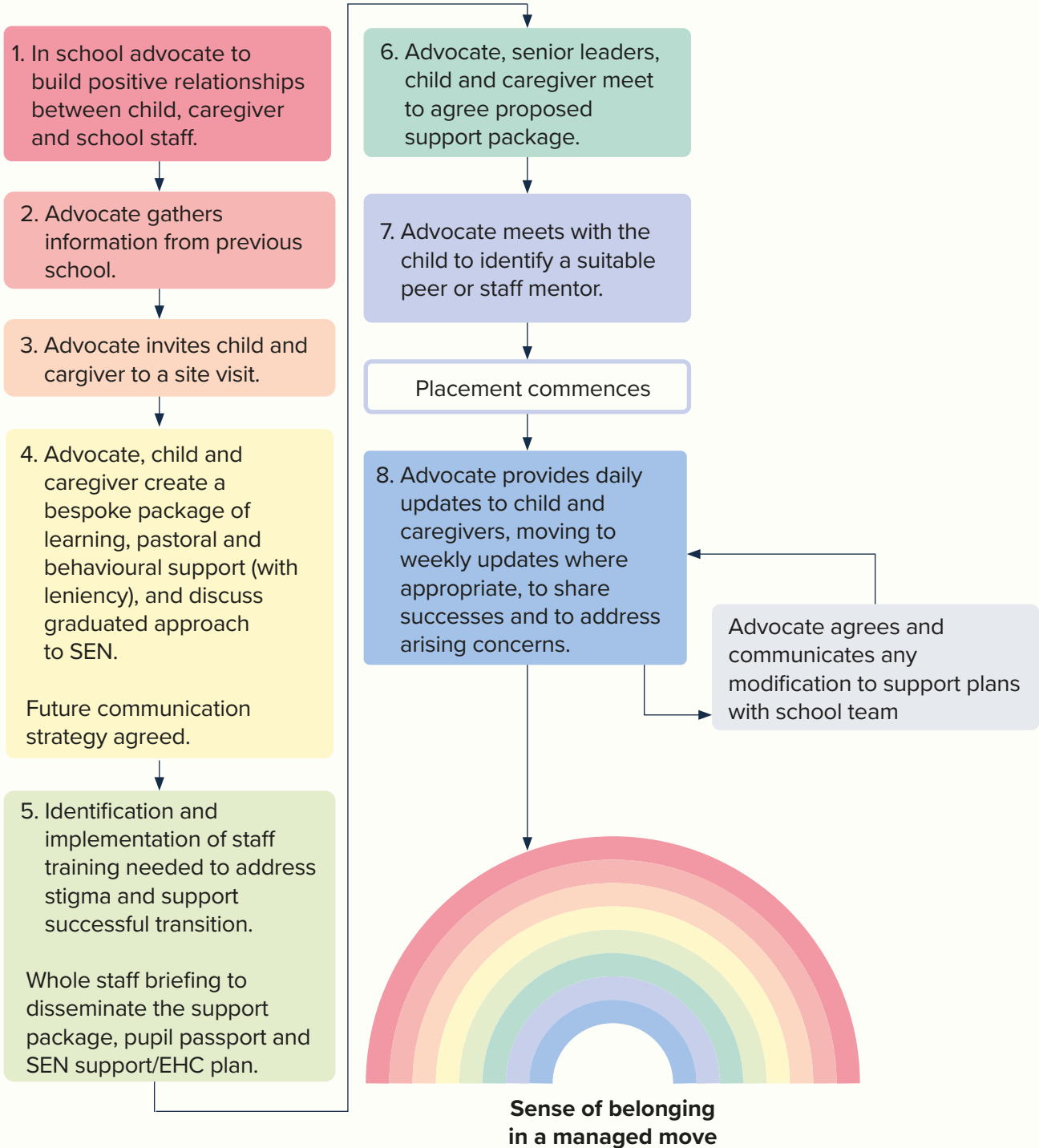


Figure 8: The proposed managed moves model



## 5. Concluding remarks

## 5. Concluding remarks

This research has explored factors that are believed to contribute to failed managed moves from the perspectives of children, caregivers and professionals. It has provided some evidence that successful managed moves rely on the building of positive relationships with the child and their caregiver. The importance of early communication of any arising issues is emphasised as a support to a successful placement. The reality is that, for these children, the managed move system did not work, and some children had multiple failed placements. There needs to be extensive planning, alongside comprehensive knowledge and understanding of the individual child's strengths, interests and holistic needs, in partnership and with buy-in from the child, their family and the school. The voices of the 20 children in this research illustrated that a well-considered transition plan and time to adjust with a familiar adult supporting them would improve the managed move process. Children and professionals also advocate additional support and the child having someone they can speak to alongside regular check-ins to monitor wellbeing and progress.

The evidence from this research could suggest that in some cases, the ceasing of some managed moves is not rational, reasonable, fair or proportionate in terms of the Education and Inspections Act (2006) and the ECHR (2010). Instead, it could be argued they were due to inflexible behaviour policies, processes and a lack of understanding of individual needs and circumstances, as suggested by Panskeep (1998).

The leading enabler to a successful managed move from the children and caregivers was leniency in behaviour sanctions. This would give the child time to adjust from moving between schools and to understand the new systems and processes. The children did not seem to know why they are getting so many behaviour points, what behaviours constitute points being allocated, and reasons for the placement terminating. Throughout the research, it became apparent that children are seeking a sense of belonging, but some know they are stigmatised due to the fact that they are involved in a managed move; they expect it

to fail. The perception from some of the children and caregivers was that the expectations of their behaviour was higher than for others in the school. This all has negative consequences for the children being able to develop a sense of belonging in the school community.

The caregivers and professionals shared that an effective managed move process includes reintegration meetings, assessment of any underlying needs, transition and support plans. However, it seems that some schools will not accept children on a managed move, and some that do, do not have a good understanding of children's bespoke needs, despite caregivers' perceptions that this information was shared. For learning and progress to occur, there needs to be access to the curriculum and quality first teaching by teachers experienced in meeting the needs of children with SEND. This can only be achieved through an ongoing package of professional learning for those responsible for the education and care of children. Children who have experienced managed moves are unlikely to have been accessing lessons in their previous school. Some may have been out of school for some time, so the curriculum offer will need to reflect their prior learning. These factors all have implications for their ability to transition into a new school and their ability to participate and learn.

The impact of a failed managed move on the children was palpable during the conversations. The notion of a 'fresh start' appears not to be felt by those who have lived the experience of having a managed move, for a range of reasons. The effects can be long-lasting and, for one child in particular, the caregiver felt it was traumatic. If managed moves are to become a realistic alternative to exclusion, there need to be improvements in the processes to ensure they consider the views, wishes and aspirations of children and their families. The suggested managed move model (Fig. 5) should be included in the LA protocol and shared with Academy Trusts as an approach to supporting children and families engaging in the process.

## **6. Research limitations and reflections**

## 6. Research limitations and reflections

The study adopted a qualitative approach, and it could be argued, that although it is the most extensive primary study on the topic of managed moves to date, it is of a relatively small size. It also has a greater focus on the lived experiences of children and their caregivers for whom a managed move was unsuccessful and did not include any children who successfully transitioned. In combination with the subjective, qualitative nature of the analysis, it could also be suggested that the potential for replication and subsequent generalisation is limited. However, by adopting a phenomenological-based methodology, the research has identified detailed accounts of experiences surrounding a managed move process across a limited range of cohorts. The study identified the homogeneity of experience, as all children interviewed had undergone a managed move that had failed, with some participants experiencing up to three managed moves. By analysing data from the participant groups' perspectives, the author was able to critically reflect on the current processes and the effect of a managed move experienced by children, caregivers and professionals to create an alternate model for implementation across local government, to prevent further managed moves from failing.

Qualitative content analysis was selected as the appropriate means to condense and analyse raw data into themes, to better understand the enablers and barriers of managed moves. Content analysis is both a quantitative and a qualitative form of analysis, as there is some level of 'word quantification' involved (Graneheim and Lundman, 2004). For this reason, it could be argued that the quantification of data creates baseline metrics and the opportunity for others to compare findings regionally, should the research be adopted and taken forward.

The children who participated were all reflecting on previous managed move(s) and were now placed (seemingly contently) in alternative provision specifically for children with SEMH needs. It is a commonly held belief that due to factors relating to their age, children and young people's memory recall of past events are not as accurate or reliable than those recalled by adults (Oates and Shrimpton, 1991). However, to subscribe to this view would undermine all research involving children's views. Additionally, in reviews of children's memory, researchers have found that while children can fabricate information and are more easily manipulated than adults, children under certain conditions can recall past events accurately (Gordon, Baker-Ward and Orstein, 2001).

For future research, it would be important to explore what the determining factors were that enabled a successful managed move, and to examine the long term outcomes on children to find evidence of whether managed moves should continue as an alternative to school exclusion. Also, further research on managed moves should investigate:

- If the model proposed in this report increases the number of successful managed moves
- How many children over the last three years took part in managed move(s) and how many of these were successful or not successful
- How many children receive multiple managed moves and what was the justification for each move
- What are teachers' perceptions in the receiving school of a child on a managed move, and what are the perceived barriers and enablers to it being successful
- From a sample of children who have had successful managed moves, what made them effective

## 7. Recommendations

## Recommendations

The recommendations are directly related to the data analysis of the interviews and literature reviews.

**Recommendation 1:** The local authority to adopt the managed move model in appendix 1, with careful consideration of the appropriateness of this approach for individual children. The model should be incorporated into protocol documentation and cascaded during training with schools. The managed move model should be monitored for impact to see if it increases the number of successful managed moves with a pilot group of children and schools.

**Recommendation 2:** Local training for senior leaders in education to make explicit the legal position for the use of managed moves. One of the recommendations of this training would be to clarify that managed moves cannot be used where a child has additional needs or a disability that the school is unable to cater for.

**Recommendation 3:** Further training for schools on the particular needs of children with SEMH and/or learning needs, to ensure effective and timely evidence-based learning and teaching approaches. The training needs to be evaluated for impact by the SENCO and senior leadership teams.

**Recommendation 4:** Early assessment and identification of any underlying special educational needs and/or disabilities before negotiating the managed move. All children need a transition plan, SEN support plan and, where required, an application for an EHC needs assessment. These must be agreed in partnership with the child and caregivers, including reasonable adjustments to support wellbeing, learning and behaviour.

**Recommendation 5:** To implement a monitoring system alongside school exclusions data records to analyse the following:

- The number of managed moves each child has attempted; the number of successes; and a narrative outlining the reasons for any failed placement. The records should include the length of time the child was in the school before the termination of the placement.
- The long-term outcomes for children who have experienced managed moves.

### National Recommendations

- To create a national system of recording managed moves, to capture the number attempted by individual children, how many succeed, how many fail, the length of time they sustained the placement and a narrative account of why they failed. This evidence will support if there is a need for a thorough review of the managed move process.
- Due to the stigma of 'pupil referral units' and 'alternative provision', the terminology should be reviewed with a consideration of the name 'school' or similar, regardless of the designation.
- To invest in further research, to investigate the long-term academic and wellbeing outcomes of managed moves, to evidence that the system is an appropriate alternative to school exclusion.

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## 8. References

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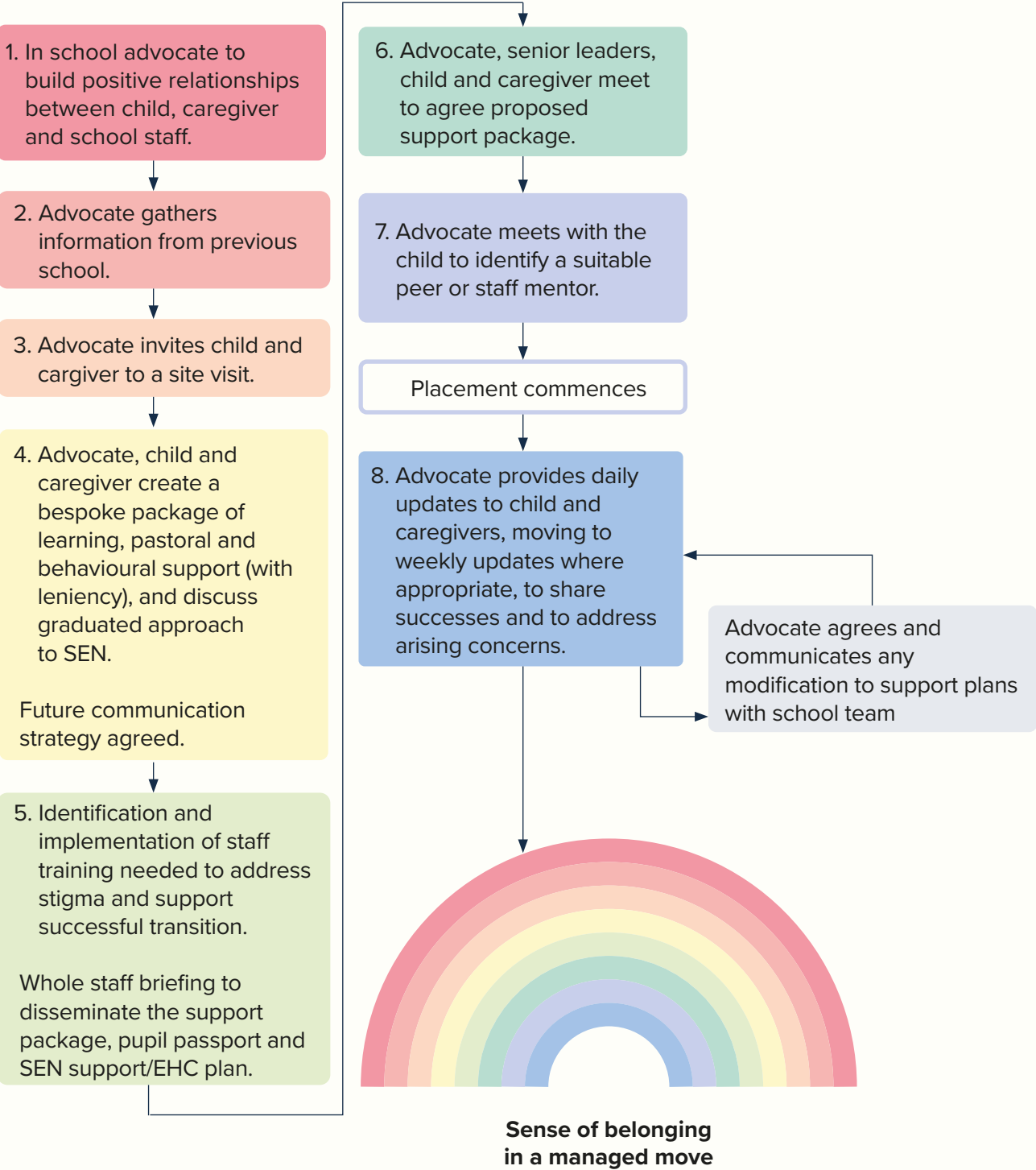
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## 9. Appendix

# 9. Appendix

## Appendix 1: A model for successful managed moves





## Appendix 2: Participant demographics

### Children

- Age and gender: 8-16 years - identifying as male or female
- Children with SEND and some whose needs were yet to be assessed/diagnosed
- Children who had experienced managed moves
- Children who currently attend a range of provisions including mainstream and/or Alternative Provision

### Caregivers

- Who have children from 8-16 years of age who had experienced edge who had experienced managed move(s)
- From a range of socio-economic backgrounds
- Foster carers

### Headteachers

- From special measures to outstanding Ofsted rating
- Experience of managed moves
- A range of years experience of headship

### SENCOs

- Across key stages 1-4
- A range of experience (new to the role, with the NASENCO award, experienced SENCOs)
- Academy Trusts, maintained, free schools

### Health and support services

- From NHS trusts, charity and support services
- With statutory and non-statutory roles
- With different levels of experience and qualifications









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# **A review of school exclusion on the mental health and wellbeing of children and young people in the City of Sunderland**

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University of Sunderland, School of Education  
Commissioned by Together for Children, Sunderland**

**March 2020**



**University of  
Sunderland**



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## Executive summary

In the Autumn of 2018, the University of Sunderland was approached by Together for Children to 'investigate the factors that impact upon social and emotional wellbeing of children and young people from 3-16 years in Sunderland, which may lead to exclusion from school'. The purpose of the commission was to provide a research-informed review of the process and impact of school exclusion through a detailed examination of the personal lived experiences of children who were excluded from school and their caregivers.

### Research aim

To investigate the benefits of school exclusion on those excluded from school and their caregivers.

Research objectives:

- To establish the impact of school exclusion on the child and their family
- To explore the effectiveness of the process of school exclusion
- To determine the drivers for school exclusion
- To explore the impact of school exclusion on caregivers
- To determine the effectiveness of alternative provision
- To produce a report with supporting evidence to inform provision planning and training for education professionals within the local area of Sunderland

165 individuals took part in the research; 55 children, 41 of their caregivers and 55 headteachers across age phases and types of provision, as well as 14 Special Educational Needs Co-ordinators (SENCOs). The evidence from those interviewed indicates that some schools need training and support to effectively identify and respond to the diverse needs of children in their care. The findings suggest that these children thrive in an environment

where there are small classes, flexible policies and in most cases, a vocational curriculum offer. This research highlights that there are significant short and long-term effects of school exclusion on children and their families. The impact on the children is that during the exclusion, they are often not doing anything purposeful with their time or being supported to understand any underlying reasons for their behaviour. Caregivers struggled to maintain employment or good mental health due to the stress of the uncertainty of their child's future.

What is clear, is that children and caregivers need to understand why the exclusion happened and to be supported to rebuild relationships within families and to re-engage with education. Headteachers and SENCOs believed that the benefit of school exclusion is not only to keep other children safe but also to fast track the excluded child to specialist support. This shows that schools need further investment to meet children's needs as soon as they become apparent. Without funding for training and staffing, it is difficult to see how the situation of rising exclusions will change. Health services have a fundamental role to play in providing prompt assessments for these children, to identify any underlying difficulties, and to support schools in understanding and providing reasonable adjustments and evidence-based approaches to learning.

This piece of research is both timely and significant, considering the Timpson Review (DfE, 2019a) publication, as it captures the voice of children, caregivers and professionals who work with or who have experienced first-hand exclusion from school. The result is a unique piece of primary research believed to be the largest qualitative study of school exclusion to date in England (see appendix 1).

## Recommendations

**Recommendation 1:** Children identified as being at risk of, or allocated a fixed-period or permanent exclusion, to be referred to health services for assessment of needs. This would determine any underlying genetic, learning disabilities or neurodiverse causes, so that reasonable adjustments are based upon strengths and difficulties. The health, functioning and wellbeing summary traffic light communication tool (Ireland and Horridge, 2016) should be considered for universal use by all health services under the direction of the paediatric disability team.

**Recommendation 2:** To extend the KS1-4 alternative provision to allow those children thriving in their care to have a permanent placement in the school. This could be in the form of an additional provision, so that the current alternative provision school is maintained for those who have recently been excluded, with a partner provision for those for whom mainstream is not a suitable or viable option.

**Recommendation 3:** To provide prompt preventative support in mainstream and other schools where children are identified as at risk of exclusion. This needs to be coupled with training for education staff, including identification of underlying SEND, person-centred approaches, supporting children with challenging behaviours, and compliance with equality duties.

**Recommendation 4:** The creation of a child, caregiver and sibling support network for those with children on the edge of, or who have been excluded from school. This will include signposting to support systems, including legal advice and access to universal services to support their mental health and wellbeing.

**Recommendation 5:** Consistent information to be provided to the caregivers by the excluding school, detailing all local and national contact numbers of support services for the child, caregivers and siblings. This must include details of education provision available in the local area and the appeals process.

**Recommendation 6:** Documentation following an exclusion needs to be given to the caregivers and the next school placement. This needs to include prior attainment, attendance, behaviour system records, statements of witnesses, caregiver and child, communication and responses, the reason for the exclusion and length of exclusion. It must include evidence of the implementation of the graduated approach with a review of progress and evidence-based approaches as part of this process.

**National recommendation 1:** DfE to update statutory guidance on exclusion to change the terminology from 'should' to 'must', to ensure schools are obligated to address any underlying causes of disruptive behaviour, including the use of a multi-agency assessment. Schools also require clarification of their duties within the Equality Act 2010, to make reasonable adjustments for those with disabilities, to prevent substantial disadvantage.

**National recommendation 2:** DfE to delegate more powers to Local Authorities to enable them to support children at risk of exclusion and to hold schools to account for their decision to exclude a child to ensure the reason is lawful, reasonable and fair.

**National recommendation 3:** To rename pupil referral units to schools, due to the stigma of this type of provision.

I would like to sincerely thank Together for Children for commissioning this research; the caregivers and children for taking the time to share your stories, and the headteachers and SENCOs for speaking honestly and openly about your experiences.

**Sarah Martin-Denham**  
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### Recent publications:

Martin-Denham, S. and Donaghue, J. (2020) 'The impact and measure of Adverse Childhood Experiences: Reflections of undergraduates and graduates in England'. *Journal of Public Health*. DOI:10.1007/s10389-020-01359-z.

Martin-Denham, S. (2020) 'A review of school exclusion on the mental health and well-being of children and young people in the City of Sunderland.' Sunderland: University of Sunderland.

Martin-Denham, S. (2020) 'An investigation into the perceived enablers and barriers to mainstream schooling: The voices of children excluded from school, their caregivers and professionals.' Sunderland: University of Sunderland.

Martin-Denham, S. (2020) 'The enablers and barriers to successful managed moves: The voice of children, caregivers and professionals.' Sunderland: University of Sunderland.

Martin-Denham, S. and Donaghue, J. (2020) 'A review of fixed-period and permanent school exclusions in children with SEN and no SEN designation in the City of Sunderland.' Sunderland: University of Sunderland.

Martin-Denham, S. and Donaghue, J. (2020) 'What is the prevalence of primary and secondary types of Special Educational Needs (SEN) in the City of Sunderland? A national comparative analysis of school census data.' Sunderland: University of Sunderland.

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# Glossary of acronyms

|                                                                         |                                                                    |
|-------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>ACE</b> Adverse Childhood Experience                                 | <b>GP</b> General Practitioner                                     |
| <b>ADHD</b> Attention Deficit Hyperactivity Disorder                    | <b>IPSEA</b> Independent Parental Special Education Advice         |
| <b>AP</b> Alternative Provision                                         | <b>KS</b> Key Stage                                                |
| <b>ASD</b> Autism Spectrum Disorder                                     | <b>LA</b> Local Authority                                          |
| <b>BERA</b> British Educational Research Association                    | <b>MLD</b> Moderate Learning Difficulty                            |
| <b>BILD</b> British Institute of Learning Disabilities                  | <b>NC</b> National Curriculum                                      |
| <b>CAMHS</b> Child and Adolescent Mental Health Services                | <b>NEET</b> Not in Education, Employment or Training               |
| <b>CCVAB</b> Children with Challenging, Violent or Aggressive Behaviour | <b>NHS</b> National Health Service                                 |
| <b>CYPS</b> Children and Young People Services                          | <b>OCC</b> Office of the Children’s Commissioner                   |
| <b>DfE</b> Department for Education                                     | <b>OECD</b> Organisation for Economic Co-operation and Development |
| <b>DoH</b> Department of Health                                         | <b>Ofsted</b> Office for Standards in Education                    |
| <b>EHCP</b> Education, Health and Care plan                             | <b>PRU</b> Pupil Referral Unit                                     |
| <b>FE</b> Further Education                                             | <b>SEMH</b> Social, Emotional and Mental Health Difficulties       |
| <b>FIES</b> Food Insecurity Experience Scale                            | <b>SEN</b> Special Educational Needs                               |
| <b>GCSE</b> General Certificate of Secondary Education                  | <b>SENCO</b> Special Educational Needs Coordinator                 |
| <b>GDPR</b> General Data Protection Regulation                          | <b>SEND</b> Special Educational Needs and/or Disability            |

## Glossary of terms

**Active listening:** Focusing entirely on what the child is saying; understanding the emotions and feelings underlying the message.

**Alternative provision:** For children of compulsory school age who do not attend mainstream or special schools.

**Care pathway:** The route a person takes through healthcare services

**Education Health and Care Plan:** Details the education, health and social care support that is to be provided to a child with SEN and/or disabilities.

**Graduated Approach:** A model of action and intervention to support children who have SEN

**Healthy Child Programme:** Supports pregnancy and the first five years of a child's life, focussing on universal preventative service with screening, immunisation, health and development reviews.

**Joint Strategic Needs Assessment:** Information, advice and support services for children and caregivers with SEN or disabilities.

**Local Authority:** Leading integration arrangements for children with SEND.

**Maintained School:** Schools maintained by a Local Authority.

**Methodology:** Describes how research is carried out, including how information is collected and analysed, and why a particular method or methods have been chosen.

**National Curriculum:** Statutory entitlement to learning for all children from 5-16 years.

**NHS England:** An independent body, to improve health outcomes for people in England.

**Official Exclusions:** These are recorded with central or local government and include temporary fixed period exclusions or permanent exclusions.

**Ofsted:** Responsible for the inspection of all schools in England.

**Prevalence:** How common a type of exceptionality is within a population, either at a point in time or over a given period of time.

**Pupil Referral Unit:** Provides education for children who would otherwise not receive suitable education because of illness, exclusion or any other reason.

**Special Educational Needs:** A child has a SEN if they have a learning difficulty or disability that calls for special educational provision to be made.

**Special Educational Needs Coordinator (SENCO):** A qualified teacher in a school or maintained nursery school who has responsibility for coordinating SEN provision.

**SEN Support:** Extra or different support that is provided in addition to the school's usual curriculum.

**Special Educational Provision:** Provision that is different from or additional to the normal provision available to children with SEN to enable them to access and participate in learning.

**Specialist School:** A school that is specifically organised to make special educational provision for children with SEN.

**Stakeholder:** An organisation/individual with interest in a topic, including public sector providers and commissioners of care or services.

**Statutory Duty:** A duty that must be complied with.

**Unofficial Exclusions:** These are not recorded as exclusions in the national data and include managed moves to a different school; a move into some form of alternative provision offsite; or illegal exclusions.

**Young Person:** A person over compulsory school age (the end of the academic year in which they turn 16 to the age of 25).

# 1. Introduction



# 1. Introduction

The House of Commons Education Committee (2018) reports that school exclusion in England is receiving attention at a national level. The use of school exclusion as a disciplinary sanction remains controversial, despite numerous attempts to reduce the practice as no solutions with evidence of effectiveness exist (Obsuth et al., 2017). Research and policy suggests early intervention can result in better trajectories, reduced disengagement, improved childhood mental health and decreasing school exclusions (DfE, 2015a; Romeo et al., 2006; Snell et al., 2013). The reality is that staff in schools need quality training in recognising neurodevelopmental and mental health needs to support children and assist them in accessing the curriculum (Ford et al., 2007). The Timpson Review supported this view, noting that more needs to be done to support schools in how to understand and respond to children with SEN (DfE, 2019a). In response, the House of Commons (2019) clarified that the Department for Education was committed to reviewing the Special Educational Needs and Disability code of practice (DfE, 2015b) by the end of 2020.

## 1.1. Rationale for the report

Together for Children (TfC) commissioned this research due to the findings of the Martin-Denham et al. (2017) publication, which identified higher than national prevalence of particular primary types of Special Educational Needs (SEN). The research reported that in 2016 the prevalence of children in Sunderland with an Education Health and Care Plan (EHCP), with Social, Emotional and Mental Health Needs as their primary type of need were +14.03% higher than the national rate. TfC wanted to find out the causal factors that may explain this rise in SEMH needs across the City. They also wanted to use research as a tool to progress and reform how services were commissioned and to reconfigure inclusion for children with Special Educational Needs and Disabilities (SEND). The findings and recommendations will be used by TfC and Sunderland City Council to inform the strategic plan for the next five years.

Packer (2016) raised a concern that there continues to be limited research that explores the views of parents of younger children who have experienced exclusion from school. This is the value of this piece of work, as it highlights the perspective of caregivers, their children, and education professionals who have a 'best endeavours' duty within the Children and Families Act, 2014, section 66, to 'secure that the special educational provision called for by the pupils or students special educational needs is made'.

## 1.2. Context

The city of Sunderland, lies on the North East coast of England and has a long and illustrious history of shipbuilding, heavy engineering and glassmaking (Short and Fundingsland-Tetlow, 2012). Overtime, Sunderland has grown from being a small trading port into a large industrial city due to rural-urban migration within the region, high birth rates and historic immigration from Ireland and Scotland (Cookson, 2015). The 2011 census (Nomis, 2019) states that the total number of residents in Sunderland was 275,506, within the City and approximately 39.9% of households had no adults in employment.

### 1.3. Research question

What is the benefit and impact of excluding a child from school?

### 1.4. Research aim and objectives

#### **The overarching aim**

To investigate the benefit of school exclusion on those excluded from school and their caregivers.

#### **Research objectives**

The objectives of the research were to:

- Establish the impact of school exclusion on the family
- Explore the effectiveness of the process of school exclusion
- Determine the drivers for school exclusion
- Explore the impact of school exclusion on caregivers
- Determine the effectiveness of alternative provision
- Produce a report with supporting evidence to inform provision planning and training for education professionals within the local area of Sunderland

## 2. Literature review

## 2. Literature review

School exclusions are used in the United Kingdom as a method of tackling the more severe forms of misbehaviour, such as physical violence or persistent disruptive behaviour (Obsuth et al., 2017). Children who go on to be permanently excluded from school are likely to have experienced a multitude of disciplinary sanctions, behaviour management strategies, such as isolation booths and attempts at alternative curriculum (Harris et al., 2008; Barker et al., 2010). As a sanction, it is the most explicit form of rejection by the education system (Munn and Lloyd, 2005).

### 2.1. Legislation and guidance on school exclusions

The Education Act (2011) is the main statute which that sets out duties of schools when excluding a child. Only a headteacher can exclude a child due to a serious breach of the school's behaviour policy and where allowing the child to remain would harm the education or welfare of other children. The exclusion must be lawful, rational, proportionate and fair (European Convention of Human Rights, 2010; Education Act 2002, as amended by the Education Act 2011, the School Discipline Regulations 2012). The Education Act 1996 places duties on Local Authorities (LAs) to 'make arrangements for the provision of suitable education at school or otherwise'. The DfE (2017a) clarifies that under the Equality Act 2010, schools must not discriminate against, harass or victimise children because of disability alongside the other protected characteristics. Schools must comply with the Equality Act 2010 in the way that behaviour policies are created and applied (IPSEA, ud). Headteachers are required to take into account any contributing factors after an incident of poor behaviour and, in addition to early intervention to address underlying causes, should also consider what additional support might be needed to reduce the risk of exclusion (DfE, 2017a). However, in relation to this, the legal basis for some exclusions has been raised by a range of organisations, namely, the Centre for Social Justice (2011) and the Office of the Children's Commissioner (Atkinson, 2012; 2013).

The DfE (2017a) statutory guidance also clarifies other legal responsibilities, that schools:

- Must take into account their legal duty of care when sending a child home following the decision to exclude (ensuring they are safe)
- Must ensure their policies and practices do not discriminate against children by increasing their risk of exclusion (for example inflexible behaviour policies and disability duties)
- They can be excluded for one or more fixed periods (up to a maximum of 45 days) in a single academic year, or permanently
- Permanent exclusion should only be used as a last resort where there is a serious breach or persistent breaches in the school's behaviour policy and where allowing them to remain in school would seriously harm the education or welfare of the pupil or others in the school
- Should, as far as possible, avoid permanently excluding a child with an Education, Health and Care Plan or with looked after status

### 2.2. Types of school exclusion

The House of Commons (2018, p. 10) share that exclusions can be:

- Permanent, where they are unable to return to their current school
- Temporary (fixed) where they are not allowed to attend school for a certain number of days
- Internal, where they are placed in isolation and segregated from the rest of the school

### 2.2.1. Permanent exclusions

A decision to formally permanently exclude can only be taken:

- In response to a serious breach or persistent breaches of the school's behaviour policy; and
- Where allowing the child to remain in school would seriously harm the education or welfare of others in the school

(DfE, 2017a, p. 10).

Unless the exclusion is overturned, the child will be removed from the school's roll (DfE, 2016a). In this situation, the LA is responsible for ensuring alternative educational provision for them in another school, a pupil referral unit, or alternative provision (Atkinson, 2017).

### 2.2.2. Fixed-period exclusions

IPSEA (ud) defines a fixed-period exclusion as when a child is formally and temporarily removed from school for a fixed period of time for disciplinary reasons. Children can be given multiple fixed-period exclusions in a year, for a maximum of 45 days (DfE, 2017a). Atkinson (2017) reported that in 2012, 97% of fixed-period exclusions were for less than a week. The latest figures from the ONS show that in 2017/18, this figure rose to 98.3%, with the average length of fixed-period exclusions across primary, secondary and special schools being two days and the (49%) lasting for one day (DfE, 2019b). DfE (2018b) state that on the sixth day of a fixed-period exclusion, schools must arrange alternative provision (AP), which is generally a form of pupil referral unit.

School exclusions are also classified as official or unofficial (Martin-Denham and Watts, 2019). Gill (2017, p.13) explains the difference between these types of exclusions as:

**Official exclusions** are recorded with central or local Government and include fixed-period or permanent exclusions.

**Unofficial Exclusions** are those that are not recorded as exclusions in the national data. These include managed moves, a move to some form of alternative provision offsite, or illegal exclusions such as off-rolling.

The Education Act (2011) sets out legal duties when excluding a child. This law clarifies that a child is either in school full time or excluded, so informal or unofficial exclusions such as sending a child home for the afternoon following an incident or to 'cool down' are unlawful (Martin-Denham and Watts, 2019).

## 2.3. How many children are excluded from school?

The data on school exclusions from state-funded schools are captured and released by the DfE on an annual basis through a statistical first release (Martin-Denham and Donaghue, 2020a). In 1990/91 there were 2,910 school exclusions in schools in England and Wales. Just three years later the number had increased threefold, to 11,181 (Frederickson and Cline, 2009), and by 1995/96 it had increased fourfold to 12,476 (Donovan, 1998). Of the six years between 1994/95 and 2002/03, five of those saw school exclusions above 10,000. Between 2006/7 and 2012/13, the number reduced by nearly half but has risen over the last three years (IPPR, 2017). The DfE (2019a) confirms that the number of fixed-period exclusions issued in schools has increased nationally, in part due to the increased rates in the North East of England. However, the DfE (2019a) reports that permanent exclusion is a rare event, with 0.1% of the 8 million children in 2016/17, equating to 40 children per day. For fixed-period exclusions, 2,000 children are excluded each day.

## National permanent exclusion rates

Figure 1 shows that permanent exclusions were declining and were at their lowest rate in 2013/14, but have since started to rise. However, the data illustrates that they are still lower now than they were between 1997/98 and 2008/09 DfE (2019b).

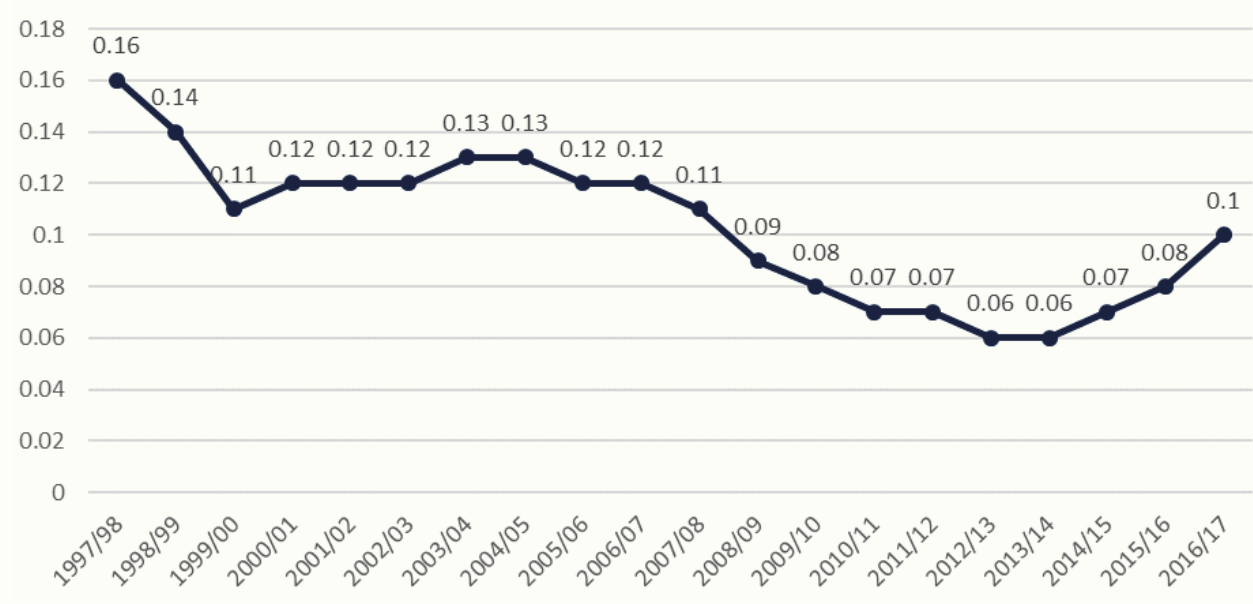


**Figure: 1.** Permanent exclusion rate for all state-funded primary, secondary and special schools (1997/98 - 2016/17) (adapted from DfE, 2019b)

The latest statistical release (DfE, 2019b) highlighted that among all regions, the North East had one of the highest rates of exclusion (0.14% of the pupil population) in state-funded primary, secondary and specialist education as of 2017/18. Figure 2 presents the rates of exclusion specific to local authorities (LAs) within the North East region and shows that Sunderland is ranked seventh for permanent exclusions in 2017/18.

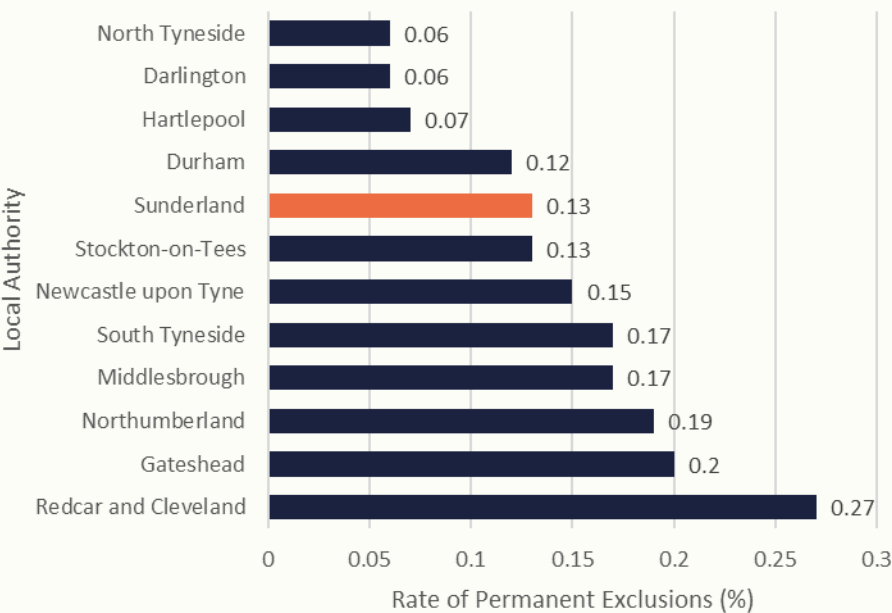


**Figure: 2.** The rate of permanent across local authorities in the North East (adapted from DfE, 2019b).

## National fixed-period exclusion rates

Figure 3 illustrates that the rate of fixed-period exclusions peaked in 2006/07 before following a downward trend towards 2012/13. Following 2013/14, the rate has steadily increased, with 2016/17, exclusion rates at 4.76% (DfE, 2019b).

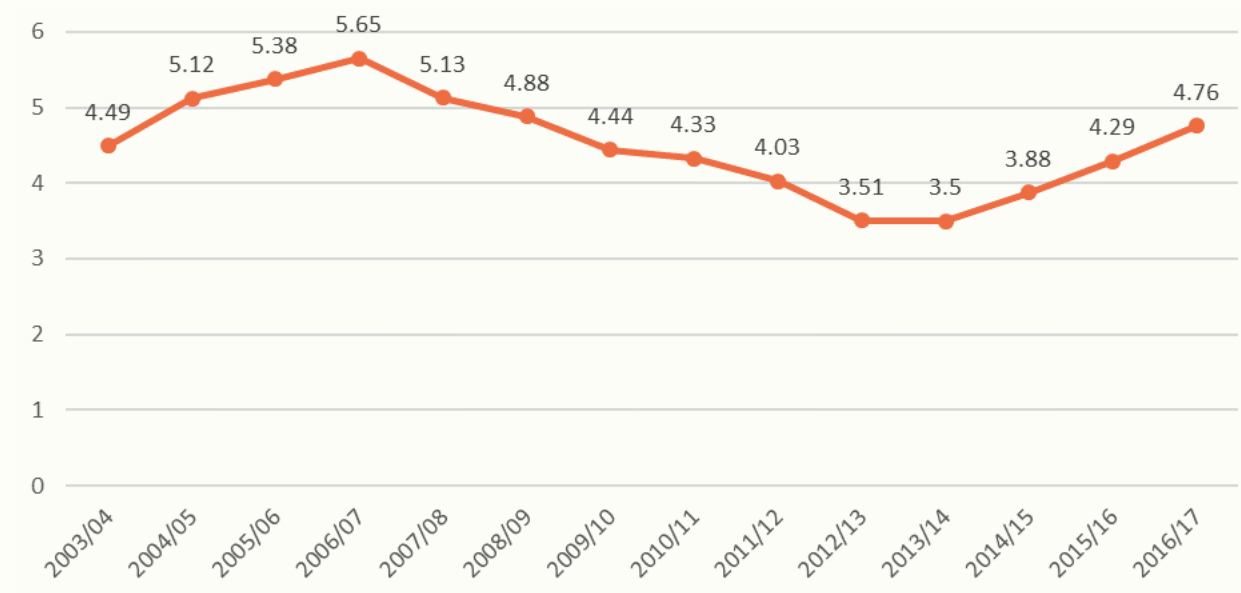


**Figure 3.** Fixed-period exclusion rate for all state-funded primary, secondary and special schools (2003/04 - 2016/17) (adapted from DfE, 2019b)

The latest statistical release commented on how the increase in the rate of fixed-period exclusions within the North East resulted in the overall increase nationally (DfE, 2019b). Currently, the rate of fixed-period exclusions in the North East is 9.34%, up from 5.92% in 2016/17. Figure 4 presents the exclusion rates for the individual local authorities and shows that Sunderland is ranked sixth for fixed-period exclusions in 2017/18.

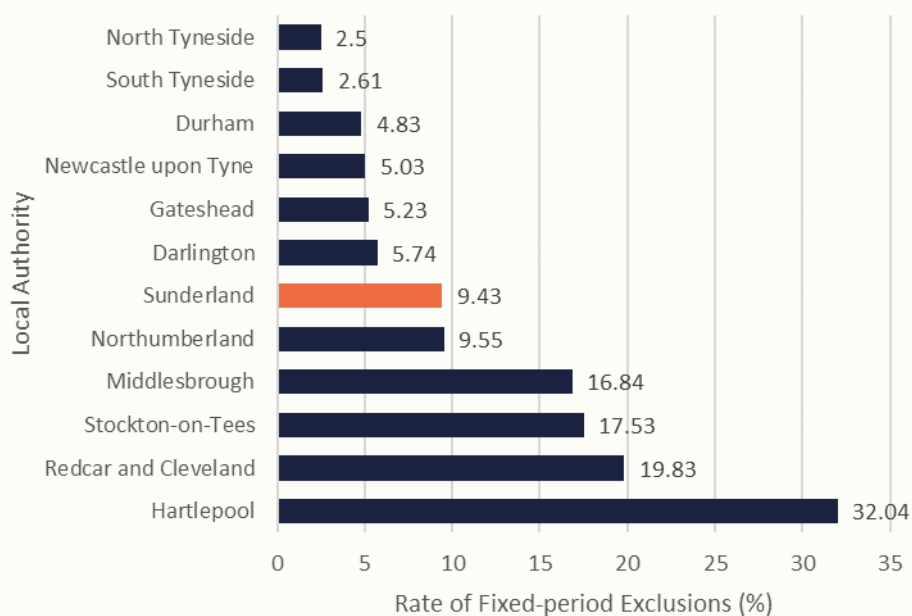


**Figure 4.** The rate of fixed-period exclusions across local authorities in the North East (adapted from DfE, 2019b).

## 2.4. Off-rolling

Off-rolling is unlawful and is described by Ofsted (2019a) as the practice of removing a child from the school admissions register for the interests of the school rather than the child. It is believed that there is a significant issue with informal exclusion practices (unofficial exclusions), particularly among children with special educational needs and disabilities (SEND) (Ambitious about Autism, 2014; Office of the Children's Commissioner (OCC), 2019; Paget et al., 2016). Off-rolling includes the practice of schools persuading caregivers to agree to a managed move as an alternative to the child having a permanent exclusion recorded on their school record (Atkinson, 2012). Another alternative to permanent exclusion is discussed by Gill (2017), who suggests that some schools coerce caregivers into signing paperwork, agreeing to enrol children in another school or to home educate. This is illegal, as schools should not attempt to persuade caregivers to educate children at home to avoid school exclusion (IPSEA, ud). Current figures reported by the Office of the Schools Adjudicator Annual Report (OSA, 2018) suggest as many as 52,770 children are educated at home, with caregivers citing school preference, avoiding exclusion under the advice of schools, child happiness, and not having their child's needs met as the reasons for educating their child at home. Staufenberg (2017) has further indicated the primary reason caregivers are electing to home educate is due to concern for their child's welfare or unresolved difficulties relating to behaviour or attendance.

Hutchinson and Crenna-Jennings (2019) state that there have been growing concerns around the practice of taking children off the school roll without formally excluding them, due to the cost of meeting additional needs and managing financial pressures in school budgets. Another factor identified by Ofsted (2017; 2018a) is believed to be attempts to improve performance tables, in particular General Certificate of Secondary Education (GCSE) examinations. This is known as 'gaming', and is when a school's decision of whether or not to exclude is influenced by the impact on the school league tables (Ofsted, 2019b). Ofsted (2017) reported that between January 2016 and January 2017,

19,000 children dropped off the school roll between years 10 and 11, equating to (4%) of all pupils. Half of these did not reappear on the roll of another state-funded school (Ofsted, 2017). Hutchinson and Crenna-Jennings (2019) highlighted that one in ten children who reached year 11 in 2017 had experienced an unexplained exit at some time during their secondary education, an increase of 1% since 2014. They believe the unexplained exits are particularly prevalent in vulnerable groups:

- Almost two in five have experienced a permanent exclusion
- Close to a third of current or former looked after children
- Over a quarter of those ever with identified social, emotional or mental health difficulties
- A quarter of children with a fixed-period exclusion and of those who were persistently absent
- A fifth of current or former children in need
- One in six children ever identified with SEND and children ever eligible for free school meals
- One in seven of those with low prior attainment and those from minority ethnic backgrounds

With similar findings to Ofsted (2017a; 2018a), Nye and Thomson (2018) examined a cohort of 553,000 children from year 7 to year 11. Of these, 516,000 finished their secondary education in mainstream school. Their chart below shows the number of children who left secondary education before the end of their schooling (approximately 20,000).



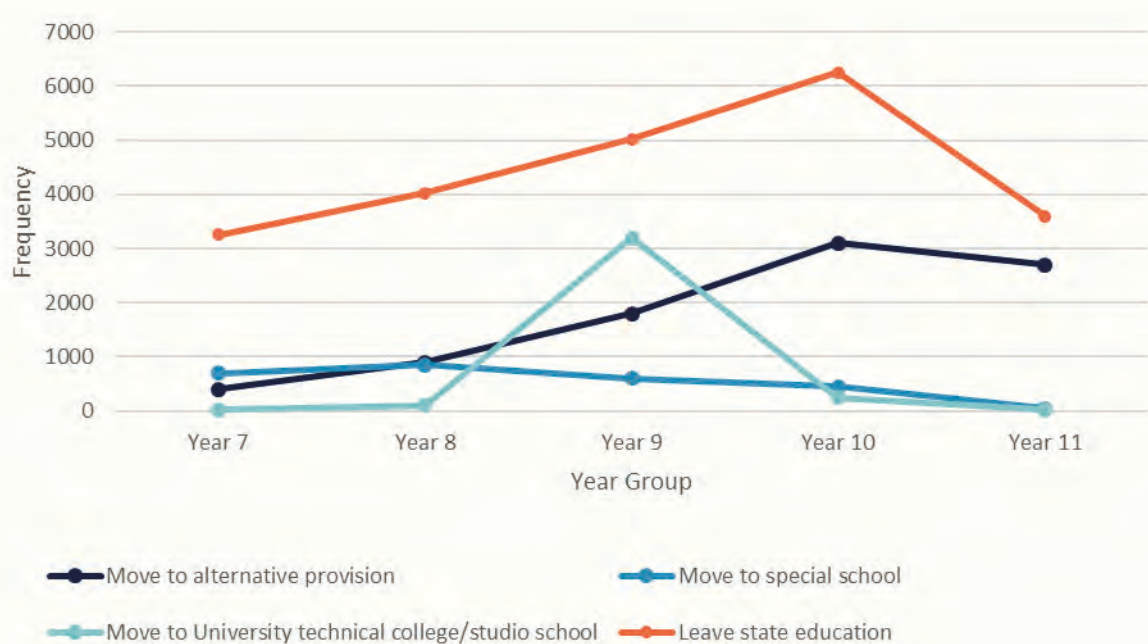


**Figure: 5.** Pupil moves by school year group and destination (Adapted from Nye and Thompson, 2018).

Hutchinson and Crenna-Jennings (2019) also examined unexplained exits from the school state system for unknown reasons. The data analysis was based on exits from secondary schools from 3 cohorts taking their GCSEs.

**Table: 1.** Number and percentage of children with an unexplained exit from the school

| Year | Total number of children in the cohort | Number of children with an unexplained exit | Percentage of children with an unexplained exit |
|------|----------------------------------------|---------------------------------------------|-------------------------------------------------|
| 2011 | 602,033                                | 47,225                                      | 7.8                                             |
| 2014 | 616,933                                | 49,051                                      | 7.2                                             |
| 2017 | 603,705                                | 55,039                                      | 8.1                                             |

The research also found that those most likely to experience an unexplained exit were those with:

- A high number of absences (two in five)
- Contact with social care (one in three)
- An official permanent exclusion (one in three) or fixed-period exclusion (one in five)
- Black minority ethnic background (one in eight)
- Lowest attainment profile (one in eight)

## 2.5. Why are children excluded from school?

The practice of excluding children from school has existed for decades (Grosenick et al., 1981). Paget et al. (2017) share that the reasons children are excluded from school are due to a range of child, family and school-related factors, of which many are present in the pre-school or early years. The following section explores some of the key factors that are believed to lead to school exclusion.

### 2.5.1. 'Difficult' behaviour in schools

Montuoro and Mainhard (2017) share that for 90 years, children misbehaving has been recognised as a source of teacher frustration and provocation. Wickman (1928, p.159) carried out one of the earliest studies and explained the phenomenon 'assails the teacher's authority, integrity, and frustrates their teaching'. The statistics from DfE (2019b) indicate this continues to be the case, as the most commonly cited reason for school exclusion is persistent disruptive behaviour (DfE, 2019b). Over the decades, there have been reports that 'difficult' behaviour is a concern for school staff and caregivers (DfES, 2006:2). However, the perception of disruptive behaviour is personalised and may vary from teacher to teacher (Thorley and Coates, 2018). Over twenty years ago, the Children's Plan also reported that the standard of behaviour continued to be a concern for teachers, caregivers and children themselves (DfCSF, 2007). The following year the National Foundation for Educational Research (DfCSF, 2008) reinforced the notion that teachers believed the behaviour of children was deteriorating and that it was resulting in teachers leaving the profession.

Negative behaviours from children interfere with teaching and learning, and are a significant cause of stress for teachers (Tsouloupas et al., 2010). This is of ongoing concern. Anderman et al. (2018) identified that violence and misbehaviour perpetrated against teachers adversely affect their wellbeing, efficacy and longevity in the profession. A large scale study

demonstrated a link between teacher burn-out, anxiety and anger in those who teach children with negative behaviours (Koutrouba, 2013).

### 2.5.2. Teacher aggression

Montuoro and Lewis (2014) and Lewis and Riley (2009) suggest that teachers may respond negatively to a child who is misbehaving using a range of direct and passive communication with the intention of passively controlling them, including the use of verbal and non-verbal attacks. It is understood that aggressive teachers distract all learners from their work (Romi et al., 2011; Montuoro and Lewis, 2017) and cause those receiving the aggression embarrassment and shame (Thomas and Montgomery, 1998). Another outcome is that it leads to peer disliking (McAuliffe et al., 2009) and damages self-perceptions (Henricsson and Rydell, 2004). In some circumstances, teacher aggression has been associated with academic difficulties (Brendgen et al., 2006) and post traumatic stress disorder (PTSD) (Hyman and Snook, 1999). For some children, aggression from the teacher can lead to an increase in problematic behaviours (Mitchell and Bradshaw, 2013) and results in the child feeling that the teacher does not care (Teven, 2013).

Trait self-control refers to a person's capacity to modify and override impulses, emotions, thoughts and behavioural responses that dominate them (DeLisi, 2015). Therefore, those with low trait self-control experience more difficulty controlling their impulses (Vohs and Baumeister, 2011) and aggression (Finkel et al., 2009). Montuoro and Lewis (2014) conclude that teacher aggression is a common teacher behaviour and is not the exception (Finkel, 2014). McCarthy et al. (2014) claim that teachers who learn how to reduce classroom management stress are less likely to utilise aggressive management techniques. However, they add that the underlying psychological mechanisms of teacher aggression remain unknown, so it is difficult to know how to reduce these responses.

### 2.5.3. Zero tolerance behaviour policies

The American Psychological Association (APA) (2008) defines zero tolerance as ‘a philosophy or policy that mandates the application of predetermined consequences, most often severe and punitive in nature, that are intended to be applied regardless of the gravity of behaviour, mitigating circumstances, or situational context.’ Advocates of this punitive approach claim that it prevents violence in schools by removing dangerous children sending a strong message to the remaining children (Gregory and Cornell, 2009). One of the key issues with zero-tolerance policies is that it does not allow for flexibility or consideration of the child’s intentions or their circumstances (Tebo, 2000). The introduction of zero-tolerance behaviour policies in school is believed to be a key factor in why exclusions from school have increased (Krezmien et al., 2006; Skiba and Sprague, 2008).

### 2.5.4. Children with challenging, violent and aggressive behaviour (CCVAB)

The term CCVAB was introduced by Thorley and Coates (2018) to encompass a wide range of previously applied acronyms for childhood challenging, violent or aggressive behaviour. The World Health Organization (2012) defines violence as ‘the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation’. Crick (1996) makes a distinction between relational (verbal assaults and non-physical actions such as shouting) and physical aggression (infliction of harm). It is believed that whether violence is experienced, witnessed or perpetrated, it adversely affects the emotional and physical wellbeing of children (Janosz et al., 2008; Mrug and Windle, 2010). Victims of violence are at increased risk of long-term behaviours such as alcohol use and suicidal ideation (Centers for Disease Control, Division of Violence Prevention, 2015). Furthermore, it is

suggested that victims and witnesses of school violence often show indicators of depression, anxiety or anger (Mrug and Windle, 2010; Shukla and Wiesner, 2015). There needs to be consideration of the impact on those witnessing aggression and the risk of them going on to be a perpetrator of violence (Kirk and Hardy, 2014). It is widely understood that high rates of violence are also related to poor school climates and structures (Espelage et al., 2014).

Research has suggested, that creating a positive school climate (Wang et al., 2013), engaging community organisations within the school and involving caregivers (Espelage, 2014) are suitable preventative measures that should be adopted to achieve a violence-free environment. However, little is known of the impact of such initiatives on reducing the number of violent incidents in a school (Lauver and Little, 2005). Indeed, research by Afkinich and Klumper (2018) found that having violence prevention programmes and collaborating with community groups actually increased numbers of violent incidents on campus. They concluded that these initiatives alone are not sufficient to reduce violence and that schools need to adopt clearly communicated school standards and procedures in response to violent events. In contrast, Nakonechnyi and Galan (2017), in their research with 210 adolescents, used martial arts to develop behavioural regulation and found the children were able to self-regulate in other situations and developed positive perceptions of others.

2.5.5. Academisation

Adams (2015) reported that academies exclude at nearly double the rate of maintained secondary schools. It has been suggested by Messeter and Soni (2017) that a possible reason for these high rates of exclusion by academies is that they are driven by a need to have good academic results to attract funding to open new schools within an Academy Trust. A further issue is that academies do not fall under local authority (LA) scrutiny; they do have the same legal duties but do not have to follow LA guidance. Interestingly, Lewis (2016) shared that there are no academies in Scotland or Wales as their Governments have rejected the academy model. The most common reason for school exclusion nationally is persistent disruptive behaviour, which amounts to 34% of all permanent exclusions nationally (DfE, 2019b).

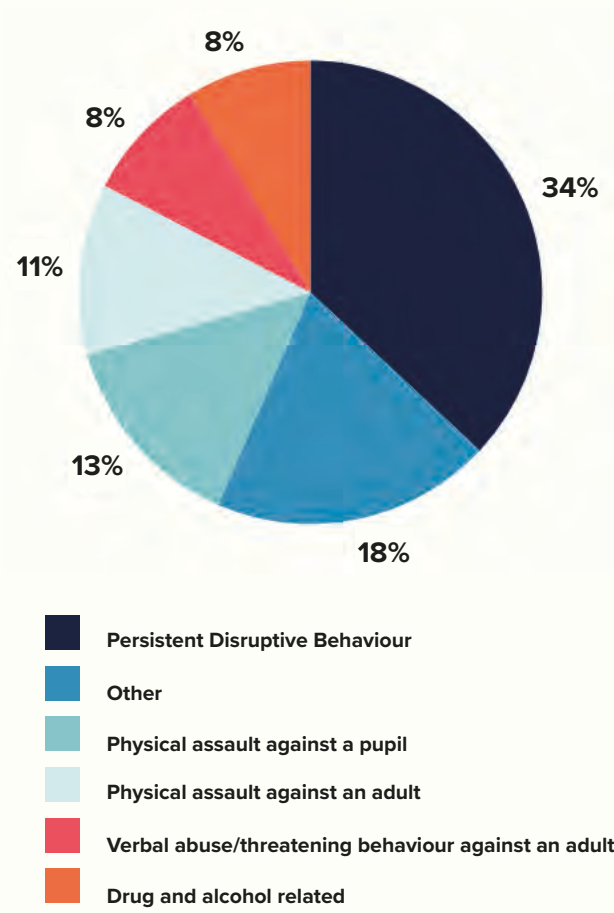


**Figure: 6.** Most frequently reported reasons for permanent exclusion in primary, secondary and specialist schools in England in 2017/18 (DfE, 2019b).

### 2.5.6. Issues with timely identification of neurodevelopmental, learning and emotional needs

Neurodevelopmental disorders (NDD) are defined as multifaceted conditions which are characterised by impairments in cognition, communication, behaviour and/or motor skills resulting from abnormal brain development (Mullin et al., 2013). They go on to state that intellectual disability, communication disorders, autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and schizophrenia are within the umbrella of NDD. Gill (2017) suggests that one reason why children are excluded from school is due to their needs not being identified by teachers. She proposes that many children do not have their needs formally recognised or that they fall below thresholds for classifications. Reduced funding for Child and Adult Mental Health Services (CAMHS) has implications for schools and increases the pressure on teachers to support children with complex needs (Association of Teachers and Lecturers, 2015).

### 2.5.7. Lack of resources to support diverse needs

The House of Commons (2018) present evidence that schools no longer have the financial resources to fund pastoral support, including teaching assistants, that would enable children to remain in mainstream school. In addition, schools reported that they exclude children so they will get the support they need in alternative provision and this will speed up the assessment of any underlying SEN. They believe the increased strain schools are experiencing in meeting the needs of children with SEND is due to greater national awareness of poor mental health and adverse childhood experiences.

### 2.6. What do children do during a fixed-period of permanent exclusion?

The reality is that when children are excluded from school, few demands are placed on them, and when they return to school, they receive minimal support (Obsuth, 2017). They further stated that schools are required to set and mark work for any exclusion that lasts for more than one day but are only required to arrange alternative provision from day six. Currently, the Department of Education does not have mechanisms in place to check to what degree guidelines for school exclusions are being adhered to (DfE, 2017a). The outcome is that what was intended to be a punishment is in fact a fully sanctioned school holiday (Dupper et al., 2009).

### 2.7. Who is most likely to be excluded?

It has been suggested that two main factors lead to exclusions: school policies and socio-cultural factors which take place outside of school (Strand et al., 2014). As Mills and Thomson (2018) report, it is the most marginalised young people who are most likely to experience school exclusion. One of the largest studies was by Logan et al. (2017) who analysed a British birth population to identify patterns in those excluded. The conclusion was that school exclusion was associated with child, family and school-related factors, which were identifiable at, or prior to, primary school age. This view has been supported in other studies, stating that other vulnerabilities include mental health issues, learning difficulties, experience of maltreatment in and outside of the home, poverty and other risk factors (Obsuth et al., 2017; Gill, 2017) such as Attention Deficit Hyperactivity Disorder (ADHD) (Zhang, 2004). Other characteristics for being at risk of school exclusion were: being male, lower socioeconomic status, maternal psychopathology, anti-social activities, bullied/ being bullied, low parental engagement with education, poor relationships with teachers, low educational attainment and SEN (Gazeley et al., 2013). Cole (2015) disputed this, suggesting that exclusion is a social issue due to disadvantage, family and societal difficulties, and a political issue due to schooling having a focus on standards. Gill(2017) agrees, expressing

that children excluded from school are the most vulnerable; twice as likely to be in the care of the state; four times more likely to have grown up in poverty; seven times more likely to have a special educational need; and ten times more likely to suffer recognised mental health problems.

**Children with SEND:** DfE (2017a) states that due to unmet educational needs, some children will find school difficult. Ofsted (2018b) reported evidence of heads of pupil referral units stating they had seen increases in the number of children with SEND, with younger children and girls being excluded in recent years. They also report that children with SEN support are five times more likely to have a fixed-period exclusion or to be off-rolled. They added that 27% of pupils with SEN support had a fixed-period exclusion last year (93,800). In alternative provision nationally, 77% have recognised SEND (DfE, 2017b).

**Mental health:** The IPPR (2017) estimates that one in two children in schools for excluded children have social, emotional and mental health needs. A recent analysis of exclusion data in Sunderland found that 49% of all fixed-period exclusions were given to children that have SEMH as a primary need (Martin-Denham and Donaghue, 2020b).

**Low attainment:** The most recent data set from the 2011 longitudinal analysis of school exclusions in England, which used the National Pupil Database, demonstrated a relationship between a child's key stage 2 result and exclusion. The lowest attaining children were 15 times more likely to receive a fixed-period exclusion than the highest attainers (Strand and Fletcher, 2011).

**Poverty:** Gazeley (2010; 2012) identified that there is over-representation of children from working-class backgrounds in school exclusion processes. It is understood that 55% of 5-10-year-olds and 40% of 11-15-year-olds in schools for excluded children are eligible for free school meals, compared to 14% of the general population (DfE, 2017b). The evidence suggests that poorer children are on average, four times more likely to be excluded than other children (DfE, 2017c).

**Gender:** National data shows that for every girl permanently excluded, three boys will be in the same position (DfE, 2017c).

**Ethnicity:** Some groups of children are disproportionately more likely to be excluded compared to the whole school population (DfE, 2019a). The DfE (2018) clarifies that black Caribbean children are three times more likely to be permanently excluded than those who are white British. They add that white Irish traveller and Gypsy Roma children have by far the highest rates of both fixed and permanent exclusions. Children in ethnic minority households are much more likely to be living in relative poverty (living in households below 60% median income) than children living in households headed by a white person (Shaw et al., 2016; Bhopal, 2018). White British children are over-represented in PRUs (70%) and black Caribbean children are taught in PRUs at four times the expected rate given their proportion in the national population (DfE, 2017b).

**Adopted children:** Children who have been in care are twice as likely to be excluded compared to those who have not (DfE, 2017d). Adoption UK (2017) conducted a UK-wide survey asking adoptive caregivers about their children's experiences of school with a focus on school exclusion. The results, based on 2,084 participants, confirmed that adopted children are more likely to be excluded for either a fixed-period or permanently compared to their non-adopted peers. The survey highlighted:

- **29%** had changed schools as a result of unmet needs in school
- **23.5%** had been illegally informally excluded
- **23%** of children had received a fixed term exclusion
- **14.5%** had been excluded more than 10 times in their school career
- **12%** were home educated due to unmet needs in school
- **4.7%** of adopted children had been permanently excluded.

**Figure: 7.** Adoption UK survey findings (2017)



## 2.8. The exclusions process

When a headteacher excludes a pupil, they must let parents know the type of exclusion and the reason(s) for it without delay (DfE, 2017a). They must also provide parents with the following information in writing (this can be by email if caregivers agree):

- The reason(s) for the exclusion
- The length of a fixed-period exclusion or, for a permanent exclusion, the fact it is permanent
- The parents' right to make representations about the exclusion to the governing board and how the pupil may be involved in this
- How many representations should be made, and
- Where there is a legal requirement for the governing board to consider the exclusion, that parents have a right to attend a meeting, to be represented at that meeting (at their own expense) and to bring a friend

(DfE, 2017a, p. 12).

Parker et al. (2016) and Hodge and Wolstenholme (2016) queried whether sufficient information about exclusion and referral is provided to caregivers and whether they are adequately supported through the process (see also Gazeley 2012). The House of Commons (2018) add that navigating the exclusions process is difficult for parents who often do not understand the system and feel the odds are stacked against them.

## 2.9. How are exclusions recorded?

Official records are kept for permanent and fixed-period exclusions in the UK, though it is widely understood that historically they have not been systematically monitored with many being unrecorded (Osler and Hill, 1999). The Office for the Children's Commissioner (2013) has reported that this continues to lead to underestimates in the number of school exclusions and the issuing of 'illegal' and unrecorded exclusions, which complicates the ability to understand the full extent of their use. Mills and Thomson (2018) report that there is an issue with a lack of shared understanding of the reasons for exclusion.

In addition, the problematic nature of the use of the category 'other' in the school census data was revealed in a study by Martin-Denham and Donaghue (2020b). They reported that 37.01% of all fixed-period and 16.04% of all permanent exclusions issued to all children in 2017/2018 were recorded as 'other', illustrating that the category is not being used as intended. This is despite the guidance from DfE (2017e) stipulating the 'other' category should only be used sparingly. The increased use of the miscellaneous exclusion category compounds growing concerns about the unreliability of exclusions data, as some exclusions are not recorded because they are illegal (OCC, 2012, 2013; DfE, 2013). The Institute for Public Policy Research (2017) calculated that 1,570 children sat their GCSEs in PRUs, who were not reported as being permanently excluded. They added that this was equivalent to 23% of the entire reported number of permanent exclusions. Gill (2017) agrees that there are children excluded from mainstream school who are not captured in any Government data sets.

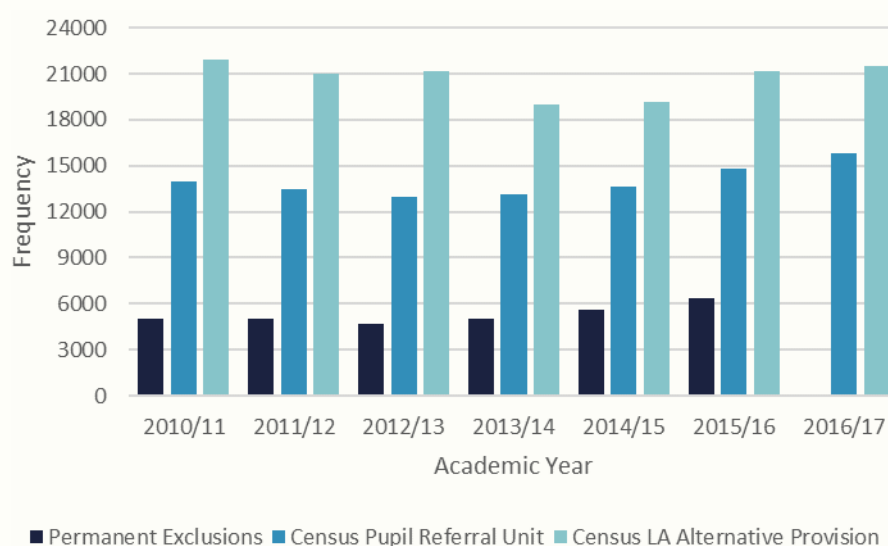


**Figure: 8.** Comparison of the number of permanent exclusions and the number of pupils enrolled in pupil referral units (PRUs) and alternative provision (AP) between 2010/11 and 2016/17 (adapted from Gill et al., 2017)

An added concern is that if schools use alternative offsite provision, it is not counted as an official exclusion, even though it is believed 23% of schools nationally use this as full-time provision for an entire academic year or longer (Smith et al., 2017). They add that schools are not obliged to report children taught offsite, so there is no way of knowing how many children are excluded through this loophole. Gill (2017) estimates this would be approximately 2,556 children.

## 2.10. Appealing permanent exclusion

Caregivers can dispute the decision of a governing body ‘not to reinstate a permanently excluded child’. They can do this by asking for the decision to be reviewed by an independent review panel (DfE, 2017a, p. 6). The statutory guidance clarifies that caregivers can also make a claim for disability discrimination to the first tier tribunal if they allege discrimination in accordance with the Equality Act (2010). The panel is not able to direct the school to reinstate but only to ask for reconsideration (Atkinson, 2017). DfE (2017a) guidance also confirms that caregivers have the right to an SEN expert at a review meeting to provide impartial advice to the panel.

## 2.11. What are the benefits of excluding children from school?

It is not clear in current research if, and to what extent, school exclusions are effective, as there is a lack of rigorous evaluation (Obsuth et al., 2017). Historical research by Skiba (2000) found that exclusion practices did not improve problem behaviours. Research by Theriot et al. (2009) and Bowman-Perrott et al. (2013) also found that exclusion is not likely to reduce disruptive behaviour as it does not identify the child’s underlying difficulties. Furthermore, many children experience multiple school exclusions. The DfE (2012) guidance supported that exclusion should trigger a holistic assessment of the child’s needs to identify and mitigate contributory factors. This continued into the current (DfE, 2017a) guidance, but the statutory duty says ‘should’, not ‘must’, allowing schools to avoid their duties. The reality is that it is unclear how often and how effectively such assessments take place (Paget et al., 2017). Gill (2017) clarifies that exclusion can be preventative (to access therapeutic or specialist education) or punitive (to punish a child, to disincentivise repeats of negative behaviours).



## 2.12. What are the consequences of excluding children from school?

Historical research has shown that school exclusion is associated with adverse consequences for both the child and the society in which they live (Parsons et al., 2001; Bagley and Hallam, 2016). Research by Humphreys and Lewis (2008) highlights that exclusion can have long term consequences for young people's life trajectories with damage that is wide-ranging and long-standing (Parsons, 1999; Munn et al., 2000; Manstead, 2014). Obsuth et al. (2017) believe that exclusion can weaken an already fragile relationship with schooling as it removes the fear of punishment and makes children feel rejection. They add that the reality is that exclusion should be a signal that the child and/or the school need help. Other research has highlighted short term consequences as a result of school exclusion, including psychological and practical impact on the child and their family (McDonald and Thomas 2003; Quin and Hemphill, 2014; Paget et al., 2016).

In the longer-term, school exclusion is associated with mental and physical ill health, substance misuse, antisocial behaviour, crime, low educational attainment, unemployment and homelessness (Daniels and Cole, 2010; Pirrie et al., 2011; Hemphill et al., 2012). A further consequence of school exclusion is linked to County Lines. The National Crime Agency (2020) use these terms to describe when drug gangs exploit children and others with vulnerabilities to sell drugs. They confirm that children excluded or disengaged from school can be targeted. In summary, those who experience school exclusion are more likely to be already disadvantaged, and exclusion further reduces life chances (Manstead, 2014).

### 2.12.1. The escalation in negative behaviours and shame

Skiba (2000) highlighted that past exclusion from school could predict future exclusion, suggesting 40% of those excluded will repeat the behaviours they were excluded for. It is believed that children who are excluded may show escalations in the behaviours that led to their exclusion, when they believe that exclusion was unfair (Piquero et al., 2004). They add that children may feel stigmatised due to the exclusion and deny feeling shame about what has happened. There is also the risk that the children will identify with labels assigned to them, leading to a self-fulfilling prophecy, as they continue the behaviours that led to the exclusion (Bernburg and Krohn, 2003).

### 2.12.2. Disengagement with schooling

Atkinson (2012) reported that there are significant consequences of being permanently excluded, which have ongoing implications. Some of these have been reported for several years, such as school disengagement (Reschly and Christenson, 2006), academic failure (Brown, 2007) and school dropout (Christle et al., 2005). We know from research that the long-term consequences of exclusion are significant; they are an obstacle to the 'education ladder of opportunity and social justice' (House of Commons, 2018, p. 3). Importantly, it is also acknowledged that school exclusion does not reduce disruptive behaviour as it does not identify and address underlying difficulties (Bowman-Perrot et al., 2013).

### 2.12.3. Attainment

School exclusion has featured in debates about the impact on attainment and achievement, both in the UK and internationally, and is also believed to limit a child's educational opportunities (Gazeley, 2010; Cole et al., 2013; Thorsborne and Blood, 2013). The Prince's Trust (2007) raised the concern that many children who have been excluded are known to have SEN and their disadvantage is further compounded by missing significant time in school due to exclusion. This is supported by Gill (2017), who shared that only 1% of children in 2014/15 who were excluded from school achieved five good GCSEs, including Maths and English. Perry and Morris (2014) found that children who attend schools that exclude are more likely to suffer academically, regardless of whether they themselves are excluded. This finding contradicts the argument that the disruption caused to other children is unfair and risks their educational achievement (Nogeura, 2003; Perry and Morris, 2014).

Research by the DfE (2016) highlighted that in 2013/14, 51.5% of children with no absences from school achieved level 5 or above at key stage 2 compared to 25.7% for those children who missed 10-15% of lessons. They also reported that at key stage 4, there was a decline from 78.4% of those who attended fully to 35.6% with 10-15% absence achieving five or more A\* to C grades. The Institute for Education Sciences notes the relationship between non-attendance at school and subsequent poor behaviour (Faria et al., 2017).

### 2.12.4. Employment and training

As discussed above, there is a link between low levels of qualifications and absences from school (DfE, 2016). The highest numbers of young people 'not in education, employment or training' (NEET) are in the North East of England (Powell, 2018, p 9). The Organisation for Economic Co-operation and Development (OECD) (2016) defines NEETs as people between 15 and 29 not in employment, education or training, with around 40 million NEETs across OECD countries. There are a number of reasons why a person is categorised

as NEET, including disability (physical and psychological), caring responsibilities, lack of qualifications, bouts of precarious (self) employment, lack of opportunities and school exclusion. However, others may be in the situation due to a choice of some kind, e.g. travelling or pursuing an interest (Furlong and Cartmel, 2007).

Powell (2018) agrees, citing the DfE (2011b), which claims that young people were more likely to be NEET if they had their own child; had been excluded from school; had not achieved 5+ A\*-C GCSE grades and those who were eligible for free school meals. Atkinson (2012) reports that 40% of 16-18-year-olds who were categorised as NEETS had been previously excluded from school. Furthermore, the DfE (2011b, p. 34) found that 'Young people who had either been permanently excluded or suspended from school in Year 10 or Year 11 were more likely to have experienced three or more spells of NEET between ages 16 and 19 than those who had not (13% and 8% compared with 2%)'. The evidence suggests a negative correlation between school exclusion and future ability to find employment, education or training. Children and young people who are excluded from school are more likely to find it difficult to get a job or training or further education, and therefore are more likely to be reliant on benefits and experience poverty.

### 2.12.5. Crime

HM Inspectorate of Prisons (2011) shared that more than half of young offenders in custody have at some point been excluded from school. Hayden (2003) and Pirrie et al. (2011) both highlighted that exclusion from school is associated with adverse outcomes, including anti-social behaviour and offending. This could be due to the exclusion itself, giving the child time and opportunity to spend time in environments conducive to crime (Wikstrom et al., 2012). Ofsted (2019b) recently discussed the criminalisation of young people carrying knives to school and whether it was a criminal offence when there was clear evidence of the child being at risk on a journey to or from school. Their research found that police officers use an inconsistent approach and that school leaders are biased in terms of who they would and would

not report. Some would be criminalised and others would not, even within the same school. The report clarifies that permanent exclusions are a necessary and important sanction, but schools should consider the best interests of the child at risk of exclusion alongside the need to maintain safety. The impact on and the risks to the child being excluded need to be considered, especially when their behaviour is not a risk to others.

### 2.13. Caregivers' views of school exclusion

Daniels (2011) acknowledges that the impact is also on the family who must deal with the consequences of exclusion and the stigma associated with it. Parker et al. (2016) found that caregivers reported similarities and differences in their experiences of school exclusion. They added that the exclusion was not experienced as a one-off event but as crisis following a time of fluctuating difficulties. McDonald and Thomas (2003) concluded that caregivers felt they were judged to be unworthy parents and that they were simply observers to the exclusion decision even though it had implications for their child's future education. More recently, Smith (2009, p.95), who interviewed caregivers of teenagers who had been excluded from school, reported their feelings of powerlessness, of being talked down to, criticised and labelled.

## 2.14. Alternative approaches to school exclusion

A core principle underpinning the Code is the notion of early identification and intervention to support better outcomes for children by reducing disengagement and any mental health challenges (DfE, 2015b).

### 2.14.1. Good practice in reducing school exclusion and supporting mental health

The House of Commons (2018) advocates the need for whole-school programmes such as personal, social, health and economic education (PHSE) alongside early intervention and treatment from CAMHS and health professionals.

Mills and Thomson (2018) identified two approaches to preventing school exclusion; changing the child or changing the school. They also found that support strategies to prevent exclusion focussed on addressing poor behaviour rather than identifying the root cause and underlying difficulties. Schools have varying approaches to how they manage behaviour; the effectiveness of these tends to be measured by the level of exclusions (Martin-Denham and Watts, 2019). Valdebenito et al. (2018) carried out a systematic review of school-based interventions, which were designed to reduce exclusions in mainstream schools. This was based on children aged four to 18 and considered 37 randomised controlled trials, 3 from the UK, 33 from the US and one undetermined.

**Table: 2.** Systematic review: Evidence-based approaches preventing school exclusion

| Outcome                                                                                                                     | Approach                                                                                                                               | Researchers               | Number of research studies reviewed/dates |
|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------|
| School-based interventions cause a small and significant reduction in exclusion rates, but effects are not always sustained | A focus on the child (enhancing academic skills, counselling, mentoring and monitoring) and a focus on the school (training for staff) | Valdebenito et al. (2018) | 37/2003-2014                              |

Although useful, Valdebenito et al. (2018) concluded that school-based interventions cause a small and significant drop in exclusion rates but added that care needs to be taken around making conclusions, due to the small number of studies involved.

2.14.2. Communication with caregivers

Ofsted (2019a) clarify that the extent to which caregivers care about and are involved in their child’s education is undisputed. Embeita (2019, p.19) adds that families and schools are ‘intimately interlinked for a considerable period in the family’s development cycle and enter a dynamic two-way relationship. Dowling and Osbourne (2003) apply general systems theory to understand interactions with caregivers. They outline that schools operate in either ‘open’ (constant exchanges) or ‘closed’ (resisting change and little exchange of information) ways. For mutual understanding and collaboration, Rendall and Stuart (2005) suggest that systems must be permeable. The problematic relationships begin when boundaries become resistant, particularly during conversations about school exclusion as interactions are often framed by conflict (Embeita, 2019). However, communication with caregivers is fundamental for them to understand why their child has been excluded (Parker et al., 2016). Unsurprisingly, the literature all points to developing respectful and trusting relationships between schools and families (Mowat, 2009; Flitcroft and Kelly, 2016). However, the House of Commons (2018) and a study by Parker et al. (2016) highlighted that caregivers often felt ignored in their experiences of school exclusion. From the limited research involving interviews with caregivers, it is understood that successful

reintegration into education is facilitated by positive relationships between teachers and caregivers (Lown, 2005). Indeed, a positive school ethos and learning environments to reduce school exclusion have been the subject of research, which argues for a greater focus on children’s voices in curriculum design, teaching methods, school policies and employment of staff (Nind et al., 2012).

2.14.3. Class sizes

Blatchford et al. (2011) carried out systematic observations of 686 children in 49 schools and found that in primary and secondary education smaller class sizes resulted in children having increased individual attention from teachers. Other studies have reported that smaller class sizes, introduced at school entry with the youngest children, has a positive effect on academic attainment (Blatchford et al., 2003; Finn et al. 2003; Hart et al. 2011) and in improving communication and interaction with teachers (Gavalda and Qinyi, 2012). Research by Mills and McGregor (2016) and McGregor et al. (2017) supports these views, noting that children complained that they were lost or ignored in large mainstream classrooms.

2.14.5. Restorative justice

The restorative justice approach aims to address and repair relationships following negative social actions (Liebmann, 2007). Harold and Corcoran (2013) explain that it is based on the principle that actions can violate another’s rights and impact on social and community relationships. They believe the greatest asset of the approach is that it

allows schools to develop links between their disciplinary procedures and pastoral care. The focus is on how relationships can be restored, rather than the need to punish an individual (Restorative Practices Development Team, 2003). The approach asks key questions, such as ‘who has been hurt?’, ‘what are their needs?’, and ‘who is obliged to address these?’ (Zehr, 2002).

Sanctions for poor behaviours may be used (Thorsborne and Vinegrad, 2008) but should be negotiated by all parties (Galvin, 1999). This would ensure a balance between care, control, individual, community, accountability and support (Morrison, 2007). However, this approach is at odds with zero-tolerance policies, so introducing such programmes would require a paradigm shift to challenge embedded notions (Hopkins, 2004).

#### 2.14.6. Alternative provision

Alternative provision includes education arranged by the LA for pupils, who due to exclusion, illness or other reasons would not otherwise receive a suitable education. Dual placements and part-time alternative provision can also be arranged by schools for those on a fixed- period exclusion or for sending pupils off-site to improve their behaviour (Ofsted, 2018b). Research by The Prince’s Trust (2016) and Thomson and Pennacchia (2017) show that schools see part-time and short-term alternative provision as respite for the child and school. They also add that alternative provision would allow the child to learn new skills and re-evaluate their motivations and aspirations. However, other studies have identified that schools can use AP as an ‘out of sight out of mind strategy’ (Barker et al., 2010; Gilles 2016).

Thomson and Pennacchia (2016) used evidence from seventeen case studies to argue that the most effective alternative provision involves joint planning between the current mainstream school and the alternative provision provider. The most effective alternative provisions address both social and academic outcomes (Ofsted, 2017; Gill et al., 2017; Shaw, 2017). Embeita (2019) interviewed caregivers following their child’s successful reintegration into

alternative provision and reported the receiving school seeing their child as a whole, listening to their views, committing to the process and providing regular communication. This echoes the view of Smith (2009) that caregivers need to feel that their circumstances and opinions are heard, valued and reviewed.

#### Types of alternative provision

The term alternative provision (AP) is used to describe a wide range of schools, including pupil referral units (PRUs), AP academies and free schools, hospital schools, and AP delivered by charities and other organisations such as independent and unregistered schools (House of Commons, 2018). These are for children of compulsory school age who do not attend mainstream or special schools for a range of reasons, including:

- Behaviour that has resulted in permanent or fixed-period exclusions, or an offsite direction by schools
- Health reasons including physical or mental health needs
- Where a child is awaiting placement in mainstream school

(DfE, 2018e)

Thomson and Mills (2018) share that children attend for a wide range of reasons including fixed and permanent exclusions, illness, pregnancy, complex SEMH needs and to improve behaviour. AP is different from mainstream schooling in that it has smaller class sizes and personalised tuition to meet individual needs. The House of Commons (2018, p.5) describes AP as ‘the forgotten part of the education system, side-lined and stigmatised as somewhere only the worst behaved pupils go’.

#### 2.14.7. Nurture groups

Nurture groups are popular in schools to support the development of social skills in preparation for accessing learning (Kourmoulaki, 2013). The evidence base is not secure on the positive impact of nurture rooms, especially in secondary

education (Hughes and Schlosser, 2014). Ecclestone and Hayes (2009, p.36) argue that nurture groups are a form of in-school exclusion, as they remove children with behavioural difficulties from mainstream classrooms to provide routines and developmental strategies to improve organisation skills, self-control and awareness. Norwich (2014) adds that policies such as these are motivated by a perceived negative impact on school and cohort attainment in national assessments.

The next section describes the methodological approaches used to answer the following research aim and objectives:

### Research aim

To investigate the benefit of school exclusion on those excluded from school and their caregivers

### Research objectives

The objectives of the research were to:

- Establish the impact of school exclusion on the child and their family
- Explore the effectiveness of the process of school exclusion
- Determine the drivers for school exclusion
- Explore the impact of school exclusion on caregivers
- Determine the effectiveness of alternative provision
- To produce a report with supporting evidence to inform provision planning and training for education professionals within the local area of Sunderland

## 3. Methods



### 3. Methods

This section presents the approaches and procedures adopted when the research was carried out. The subsections cover the author’s philosophical perspective, data collection methods, sample information, sample recruitment, ethics, data preparation and analysis.

#### 3.1. Paradigm

The term paradigm was believed to be first used by Kuhn in 1962 to describe a philosophical way of thinking. Paradigm from an educational research standpoint is a term used to share a researcher’s ‘worldview’, a perspective, school of thought or set of beliefs that are used to interpret meaning from research data (Guba and Lincoln, 1985; Mackenzie and Knipe, 2006; Kivunja and Kuyini, 2017). A paradigm can be divided into four components: epistemology, ontology, methodology and axiology, that ultimately link research philosophy to practice and output (Newby, 2014). For research that involves a level of interpretation, it is important for the researcher to disclose their underlying philosophical perspective, as this directly impacts how the data are collected, analysed and presented (Kivunja and Kuyini, 2017). The aim of the research was to investigate the nature of school exclusion on those who had been excluded from school and their caregivers. In order to better understand these individual experiences, an interpretivist perspective was employed, which aligns itself to the assumption that phenomena have multiple, subjective interpretations (Guba and Lincoln, 1994). To capture these subjective experiences, qualitative data collection methods were used, as it is typical in interpretivist research (Silverman, 2000; Nind et al., 2012).

#### 3.2. Methodology

Methodology is described by Crotty (1998) as the strategy or plan of action which lies behind researchers chosen methods. It is concerned with why, what, from, where, when and how data is collected and analysed (Scotland, 2012). Similarly, Keeves (1997) states methodology is a term which refers to the research design, methods, approaches and procedures used to find something out. This includes how data is to be gathered, the selection of participants, the methods to be used, the approach to data analysis; these are all under the umbrella term of methodology. As the research seeks to understand the nature of school exclusion from an individual’s perspective in relation to factors that impact on mental health and wellbeing, interpretative phenomenological analysis (IPA) was chosen (Smith and Osborn, 2015) (see Fig. 9). The assumptions of IPA are that individuals are limited by their present conditions but can make choices, known as situated freedom (Webb and Welsh, 2019).

Characteristics of IPA are as follows:

- Significance of the phenomena of interest
- Strong consideration of the researcher’s philosophical position
- Qualitative data collection methods and analysis
- Yielding a rich description of the phenomena of interest (Cresswell and Cresswell, 2013)

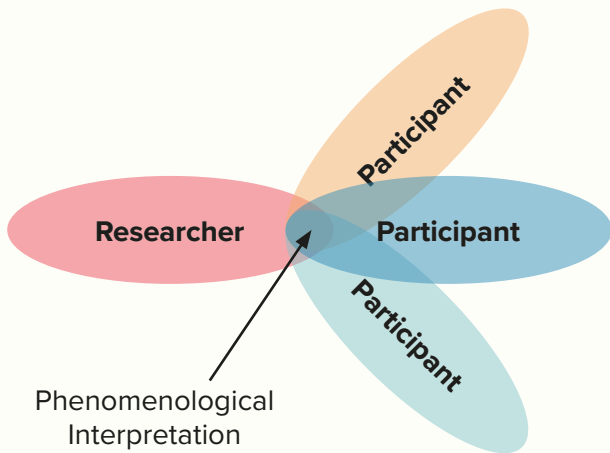


Figure 9: Phenomenological interpretation



Figure 10 presents the stages that informed the procedure for this research.

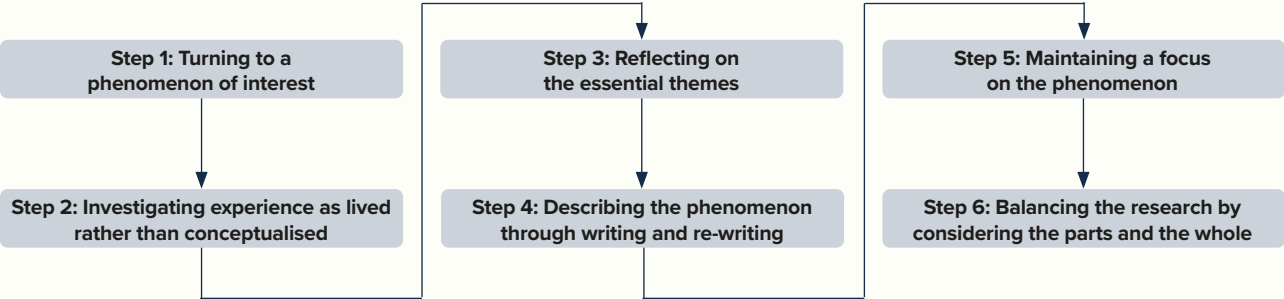


**Figure: 10.** Phenomenological investigation steps (adapted from van Manen, 1997)

### 3.3. Methods

Researchers use a variety of techniques and methods to investigate how individuals interpret and construct their reality; these include observations and interviews. This research used a series of semi-structured interviews on a one-to-one and group basis. Semi-structured interviews rely on a set number of questions and a flexible, adaptable style to allow for sufficient breadth to be explored (O’Leary, 2004). The term ‘conversation’ was used in place of interviews when conducting discussions with children and young people. All interviews were recorded using a Dictaphone and transcribed (verbatim), excluding identifiable information.

### 3.4. Participants

The final sample consisted of 165 participants. These included 55 children and young people, 41 of their caregivers, 55 headteachers across types of provision and 14 special educational needs co-ordinators (SENCOs). A summary of the participant sample is given below.

**Table: 3.** Participant sample summary

| Group               | Number    | Group                   | Number    |
|---------------------|-----------|-------------------------|-----------|
| <b>Children</b>     | <b>55</b> | <b>Professionals</b>    | <b>69</b> |
| KS1                 | 20        | Nursery headteachers    | 4         |
| KS2/3               | 15        | Primary headteachers    | 28        |
| KS4                 | 20        | Secondary headteachers  | 9         |
| <b>Caregivers</b>   | <b>41</b> | Specialist headteachers | 4         |
| Caregivers of KS1   | 4         | ARP/AP headteachers     | 10        |
| Caregivers of KS2-3 | 16        | SENCO                   | 14        |
| Caregivers of KS4   | 21        | Health and Support      |           |

3.5. Participant recruitment

Purposeful sampling was used to recruit participants, and is defined as the identification and selection of participants who are experienced or knowledgeable on the research subject of interest (Palinkas et al., 2015). Before any recruitment began, the principal investigator met with gatekeepers and informed them of the research. This was so that headteachers could brief school staff on the purpose of the research and allow staff to share information with children and adult participants. Letters were sent to caregivers to provide further information and explanation of the research process, ethics, rights and analysis. These were followed up by phone conversations from either the school or research director. All participants were given an opportunity to take part and were informed of the requirement for their voluntary consent and their right to withdraw within six months of the interview taking place (British Educational Research Association, 2018). The interviews were conducted between September 2018 and June 2019.

The children were recruited from alternative provisions within the City of Sunderland, following a gatekeeper’s permission. The children’s ages ranged from 5-16 years and, other than key stage 1, all had been permanently excluded, although many also had fixed-period exclusions. Two of the children in key stage one had permanent exclusions. The remaining children in this cohort were identified by their mainstream school as being at risk of school exclusion. None had education, health and

care plans and none of the caregivers reported that their child was on the SEN register during their time in mainstream school. At the time of holding the conversation with the children in their alternative provision, they were on the SEN register and some had diagnoses of autism, ADHD and SEMH..

The caregivers were recruited from the same alternative provisions, and all caregivers and children were invited to be part of the project. The headteachers and SENCOs were invited by the funder and the University research team to take part. This ensured a balance of high and low excluding schools, and a range of Ofsted rated schools were included as part of the sample. When schools did not consent to take part in the research, replacement schools were sought.

3.6. Ethical procedures and compliance

All research, especially social research where the focus is on a sensitive issue, needs to be ethically grounded and gain ethical approval. This research was subject to rigorous ethical scrutiny and gained full ethical approval from the University of Sunderland’s Ethics Committee in March 2018, a body well-versed in the complexities and issues involved in such research. Alongside this, the BERA ethical guidelines (2018), the NSPCC research ethics committee guidance for applicants (2012) and the Economic and Social Research Council (ESRC) Framework (2015) for guidelines on good research conduct were used, to ensure best practice in the research design, delivery and safeguarding of all participants. The sections

below presents the process of gaining informed and voluntary consent from participant groups.

### 3.6.1. Caregivers voluntary and informed consent

BERA (2018) instructs that it is fundamental research practice to obtain voluntary informed consent before any research is carried out.

1. The information sheet and consent form were shared with the gatekeepers and school staff, who then shared it with caregivers. They also gave a verbal explanation of the research, its purpose and the requirement of voluntary informed consent.
2. Before the interview was carried out, written and verbal consent was confirmed.
3. After the interview, caregivers were asked if they would consent to their child participating in the research. This involved sharing the list of questions children would be asked so that the caregivers could make an informed decision. The caregivers also had the option of being present during their child's conversation building trust and cooperation (Greene and Hill, 2005). For children who were designated as 'looked after', consent was sought from their foster carer and social worker.

### 3.6.2. Children's voluntary and informed consent

The difficulty with this research was in ensuring that children and young people had accessible age and developmentally appropriate information to make an informed choice to take part. School staff were responsible for sharing the purpose of the research with all children and for gaining initial consent from them. Consent was also sought prior to the conversation taking place with the researcher, to provide further opportunity for the children to change their mind, as participation is not based on a singular decision (NSPCC, 2012). A detailed process for informed consent is outlined below.

1. Following gatekeeper and caregiver consent, school staff explained the research, including its purpose, to the children and young people. A list of children who were interested in taking part was created and kept on school premises. If the caregiver consented to their child taking part but the child did not want to, they did not participate in the research.
2. The location of the conversation was agreed as the child's school in each case.

On the day of the conversation, the researcher reiterated the purpose of the research and related information to the child and any adult who was present. This included, but was not limited to, confidentiality, conversation length (20-30 minutes), their right to say 'stop' at any time, and their right to not answer any question they felt was difficult to talk about. Formal informed consent was sought using a comic strip that used emoji faces with 'yes' 'no' next to them, to allow children to indicate their decision.

3. The inclusion of words next to the emojis was important, as it allowed children who were not able to identify with the emotions depicted on the emojis, to still inform the researcher and caregiver of their decision.

All children were given the opportunity to ask questions about the research, process and nature of the conversation. This was important,

as it gave them time to reflect on their previous decision to take part during discussions with gatekeepers and school staff. Children who did not consent to either their caregiver or researcher did not take part. For children in the early years and key stage one, a member of staff from their school led the conversation, acting as a safe and familiar adult.

**4.** The dates and times of the interviews were flexible, allowing children to participate while not affecting the attendance of their favourite lessons and/or activities. Gibson (2012) suggests that the interviewer should engage in activities with the children prior to any interview, to promote the enjoyment of the process and to also create a partnership that fosters trust while reducing the power differential. This is especially important in adult-dominated places such as schools, where children have less control (Punch, 2002) and particularly important, given the nature of the research, to build a relationship with the child to enable valid and reliable data. Therefore, the researcher engaged in activities with children in key stage 2 before the conversation took place.

### 3.7. Specific ethical considerations for the conversations with children

Careful consideration was given to how children and young people could safely be involved in the research. Avoiding personal and/or social harm to participants and those conducting research is the key aim of published ethical guidelines (NSPCC, 2012). These guidelines acknowledge that causing harm or upset during the research process can never be prevented. However, for the current research and in liaison with schools, ‘aftercare’ was discussed and protective processes were implemented for any child needing support following the conversation. The following main risks were identified during the ethics application process:

- Evoked traumatic memories or feelings about school exclusion

- Questions asked could uncover suppressed or new feelings
- Child protection
- The child could worry about what was said during the conversation

It was extremely important to get an insight into the views and experiences of children who received a school exclusion. For the children to feel safe when participating and to mitigate the outlined risks above, among others, the following processes were put into place:

- A caregiver or familiar adult, such as the designated officer for safeguarding, was in attendance during each conversation with children
- Protocols were in place with schools and researchers, should there be any disclosure of child protection concerns or other safeguarding issues relating to adults in the study (NSPCC, 2012)

Discussions were held with the schools prior to any conversation with children on the protocols if a child became distressed during the interview. If the questions are of an appropriate nature for the research and the distress is not deemed excessive, the conversation can be considered ethical if they agree (NSPCC, 2012). The questions during the conversation were ordered in such a way that the more

- Sensitive questions on school exclusion were halfway through the interview and a positive discussion about their achievements and aspirations was included at the end
- Aftercare protocols for children and caregivers were put into place and were available following the interviews and conversations. This included schools asking the children how they were feeling and whether they had any support needs

### 3.7.1. The ‘conversations’ with children

During the earliest conversations with gatekeepers, it was agreed that children in key stages 2-4 would be suited to conversations with the research team but those in early years and in key stage one would have their views captured by alternate means with the school staff. This was agreed as young children would have likely been more wary of strangers (Gray and McIlmoyle, 2004). Additionally, it was important to adhere to questions, consent and information to the children’s developmental ability, understanding and communication competences (Gibson, 2012). This ensured that the children voluntarily agreed to participate following caregiver and gatekeeper consent.

### 3.7.2. Upholding children’s rights

Along with BERA (2018) and NSPCC (2012) guidelines, the principal investigator also ensured the research was in accordance with Articles 3 and 12 of the United Nations Convention Rights of the Child (UNCRC) (1989) for conversations with participants who were under the age of 18 (see Fig. 11).

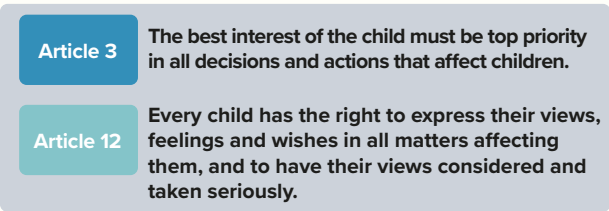


**Figure: 11.** Articles 3 and 12 from the United Nations Convention Rights of the Child (UNCRC, 1989).

### 3.7.3. Withdrawing consent

Participants were notified of their right to withdraw from the research during or up to six months afterwards via the information sheet, consent form and discussion with school staff and the research team. Processes were put into place for any participant who wished to withdraw from the study. For example, it was agreed that school staff would inform the principal investigator should a child wish to withdraw their consent (BERA, 2018). There were some children changed their minds on the day and were therefore not interviewed.

One child decided during the conversation that he did not want his voice recorded on the Dictaphone and instead chose to draw what he enjoyed about his new school. No participants withdrew consent following the interviews and conversations.

### 3.7.4. Ethical dilemmas

One specific ethical consideration involves ethical dilemmas which are: non-predictable events that can occur during the research (Kutrovátz, 2017) and can be described as ‘ethically important moments’, or ‘micro-ethics’ (Guillemin and Gillam, 2004, p. 265). In relation to the current research, ethical dilemmas refer to possible situations during conversations with children that may arise. These could include body language signs (head down and eyes to the floor) or verbal language indicators such as utterances of ‘mmm’ or inability to form sentences that would suggest the child was feeling uncomfortable (Phelan and Kinsella, 2013).

There were two instances of ethical dilemmas when children were asked about their experiences of school exclusion. One child froze completely, and the other child looked away. In these instances, it was immediately decided that it was not in the best interest of each child to continue with the research questions. Both children instead led discussions on topics they enjoyed, which included Christmas and a new therapy dog. These instances demonstrate how formal ethics approval is not always enough in managing unpredictable events, and highlights how it is sometimes down to the researcher’s judgement, with the child and a safe adult, as to whether conversations proceed. A key factor when judging a situation or critiquing research as a whole, is the notion of reflexivity. Guillemin and Gillam (2004) suggest that ‘adopting a reflexive research process means a continuous process of critical scrutiny and interpretation; not just in relation to the research methods and the data, but also to the researcher, participants and the research context’ (p. 275). For the research to remain ethical, a combination of good ethical practice, reflexivity and formal ethical procedures were employed (Christensen and Prout, 2002).

### 3.7.5. Disseminating research findings

It is important to consider disseminating research in the most relevant and beneficial way to a range of audiences (BERA, 2018). This was discussed with caregivers and children, and it was decided that an additional two freely available versions of the report would be produced by April 2020.

### 3.7.6. General Data Protection Regulation (GDPR)

GDPR concerns how data are acquired, held, used and applied to countries within Europe. The legislation came into force on 25th May 2018, replacing the Data Protection Act 1998, and introduced increased expectations of how organisations process data. A key difference from prior legislation was informed consent and increased transparency regarding the use of personal data. These new standards were not designed to impact negatively on research but to enable and reflect good practice and safeguards (NHS, 2018).

Considering this, the necessary steps were taken to maintain GDPR compliance. Participants were provided with information including the purposes for processing their personal data, retention periods for the data and who it will be shared with, known as privacy information (Information Commissioner’s Office, 2019). The participants were informed of where and how the audio recordings would be stored, and the process of anonymisation. They were advised of when the original recordings would be deleted and the timeframe for the publication of the reports. It was made clear that although the original recordings would eventually be deleted, the transcripts would be retained for future publications by the principal investigator. The right to withdraw, with time frames in accordance with BERA (2018), was also made explicit. All information sheets and consent forms used in the research were also GDPR compliant in that:

- They were concise; they used clear, plain language; and were easy to understand

- They were adapted to each audience
- They were provided by appropriate means; for example, were participants who could not access the written form, verbal consent was obtained

### 3.8. Analysis strategy

Qualitative analysis follows a similar analytical process of seven steps: creating the research question to be explored, selecting the appropriate sample to analyse, defining the categories to be applied, planning the coding process and reviewer training, carrying out the coding process, evaluating the trustworthiness and analysing the data (Kaid, 1989). The data analysis sections outline the strategy employed. Summative content analysis was used to analyse data and involves counting and comparing keywords within the data, followed by the interpretations of the underlying meaning (Hsieh and Shannon, 2005). The process began by reading and rereading every transcript to immerse and become familiar with the data (Tesch, 1990). Coding then followed for each participant subgroup, which involved, highlighting passages of text and attributing a suitable name to each (Miles and Huberman, 1994; Morgan, 1993; Morse and Field, 1995). The qualitative analysis program, nVivo 12 Pro, was used to code and arrange data into emerging themes (see Fig. 12).

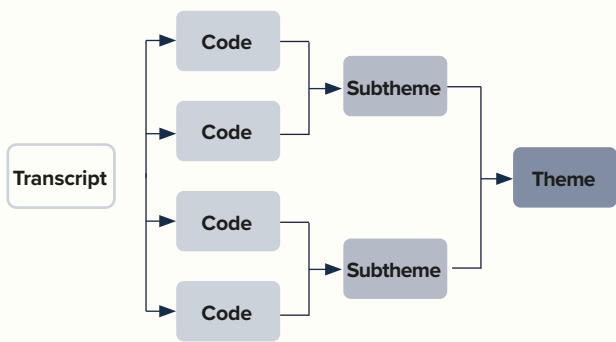


**Figure: 12.** Example of the coding process used in the content analysis.

Transcripts were coded by participant group using a continuously updated coding list. A coding list limits cognitive load and maintains reliability when analysing many transcripts (Morse and Richards, 2002). Codes emerged from the data and were continuously revised, merged, split and reviewed in preparation for analysis. Examples of the emerging codes are given in the figure below.

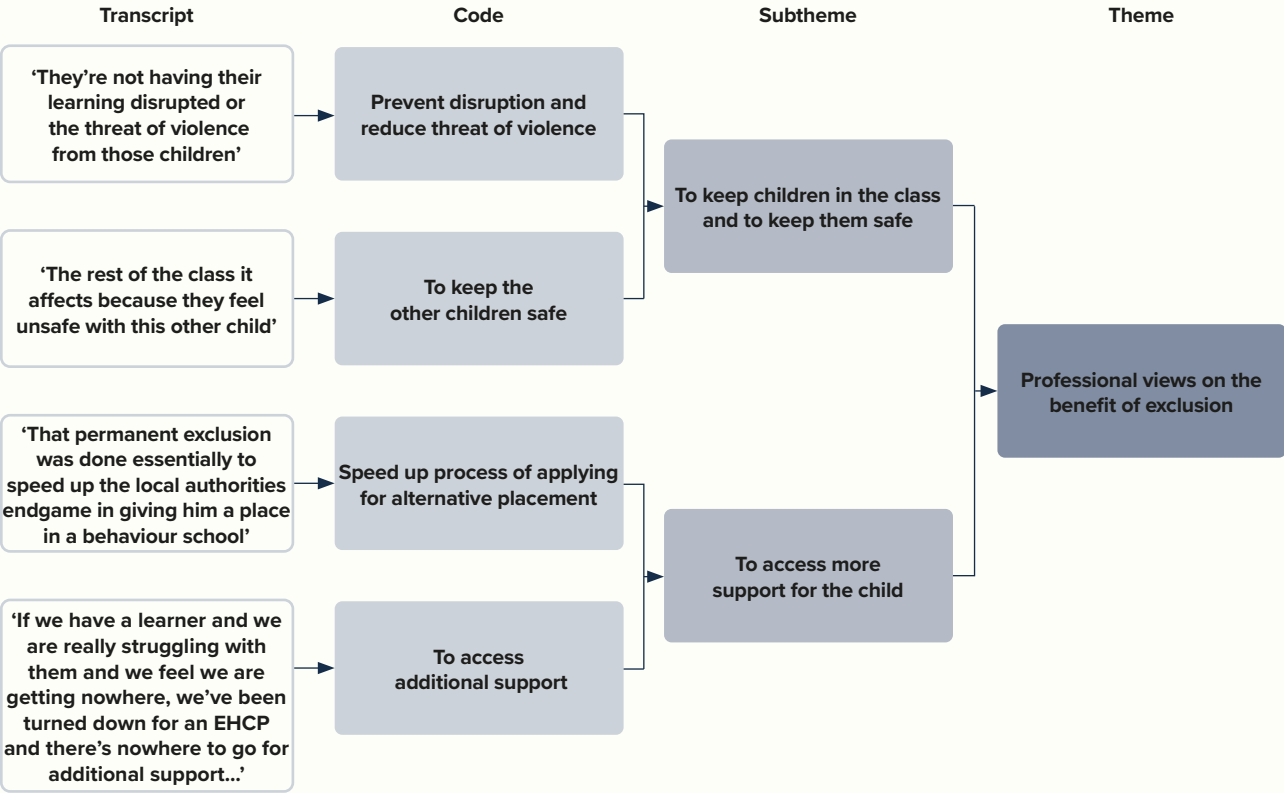


Figure: 13. Example of the coding process with transcript excerpts, codes, subthemes and theme.



### 3.9. Limitations

It can be argued that the research team would have reflected on their own meaning when coding and analysing data. However, controls were put into place to allow for codes and themes to emerge from the data rather than being imposed. This was to keep descriptions as true to the participants as possible. To achieve this, researchers carried out what is known as 'bracketing', where preconceptions are held throughout the research process to minimise influence. Quality assurance was carried out with separate members of the research team on all transcripts and at all stages of analysis. This limited interpretation bias, helping to maintain accuracy overall. Although this study is large in comparison to research on similar topics, discretion should be held before generalisations are made, as the research represents the voices of those who participated. Further limitations include:

- The sample is not representative of children across the UK who have experienced exclusion from school
- The sample does not include children who had no experience of school exclusion as a point of comparison
- The participants were all selected from one City as the governing authority commissioned the research. While some participants had moved into the local area from other areas across the UK, only direct experiences of education in Sunderland were reported on

### 3.10. Strengths

This research study elicited views from a reasonably large group of caregivers and professionals from education and health services. It is not realistic to claim generalisability of finding beyond the voices of those interviewed, but it is believed aspects of this research would be transferable to other local areas in England. The research team ensured the open-ended questions allowed all participants to share their experiences without any restriction on the length of the interview. It is hoped the findings of this study will contribute to our understanding of the impact of school exclusion on children and their families.



## 4. Analysis

## 4. Analysis

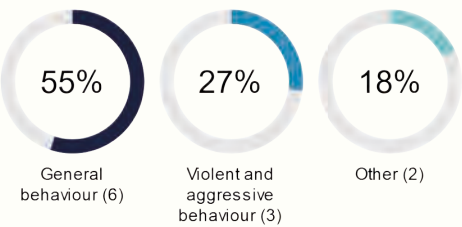
This section presents the analysis of data collected from children and their caregivers who experienced exclusion from school. It also includes the voice of education professionals who have supported children and families during this time. The children in KS1 were predominantly on the roll of a mainstream school but accessing alternative provision on a temporary basis (only two had been permanently excluded). All the children in KS2, 3 and 4 were taught in alternative provision (AP), following fixed and/or permanent exclusion from school. For some, this was a temporary arrangement for 12 weeks, after which, if a place was available, they would return to mainstream school or another provision. For ease of reading and where there was substantial data, themes were broken down into constituent sub-themes in order to present the content in an accessible manner.

### 4.1. Children’s perceptions of why they were excluded from school: KS1-4

Thirty-six children responded to this question on why they were excluded from school, generating 62 references:

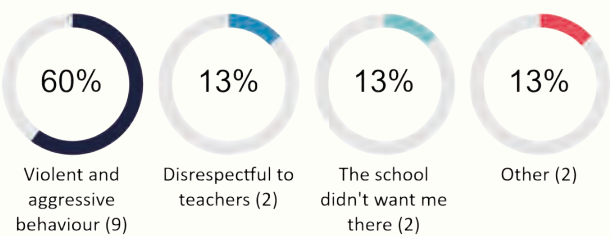
- 11/20 children in KS1 (11 references)
- 11/15 children in KS2-3 (15 references)
- 14/20 children in KS4 (36 references)

#### 4.1.1. Children’s perceptions of why they were at risk of exclusion from school: Key stage 1



Of the 11 responses from KS1, over half articulated what could be described as low-level behaviours such as **‘being naughty, not following instructions’** and **‘because I would be silly’**. Within the comments, the children perceived they were unable to be in mainstream school because of their behaviour. Some of the children were able to share their feelings as they reflected on mainstream schooling as **‘I was sad’** and **‘I was having problems’**. Three children said they could not stay in mainstream school due to them **‘hurting people’** or **‘because of my anger issues’**. The remaining two felt they could not stay in mainstream school **‘cos it’s too tricky and the teachers are mean’** and not knowing why **‘no, I don’t know why I was excluded’**. The challenges the children encountered could be indicative of early signs of unrecognised or unmet learning needs as suggested by Parker et al. (2016). All of these children were accessing support from a key stage 1 alternative provision, which shows that they were identified by the mainstream school as requiring specialist support.

4.1.2. Children’s views on why they were permanently excluded from school: KS2-3



Eleven children from KS2-3 out of a possible 15 who shared their recollections of why they were excluded from school. The most common reason related to aggressive and/or violent behavioural responses such as **‘flipping tables and being angry’** and **‘fighting and fracturing a teacher’s wrist’**. This contrasts with KS1, where the prominent reason was perceived to be due to general low-level behaviours. In KS2-3, three of the responses related to fighting, three related to what they described as **‘kicking off’**, the remaining responses were **‘biting’**, **‘assault’** and **‘anger’**. The children used language to describe the reasons such as **‘the new head wound and wound me up until I kicked off so he could get me out’** and **‘I used to kick-off, they couldn’t handle me’**. One child described how she got into fights in response to the actions of others and to advocate for or protect others saying **‘I had fights 10 with boys and three or four with girls, because one tossed a bottle off my head, another called me a slag, one was laughing about cancer’**. During the conversations with the children, it was apparent that they found aspects of mainstream school difficult and the physical aggression was the outcome of frustration built up over time. Clearly, there could be a detrimental impact on those children who

perpetrate and witness these acts of violence in school as suggested by Janosz et al. (2008), and Mrug and Windle (2010). These behaviours support the need for embedding whole school approaches through PHSE, as advocated by the House of Commons (2018), and coupled, where appropriate, with early assessment and intervention from health professionals. This would allow for understanding the root cause of underlying difficulties, whether they are health or education-related factors (Mills and Thomson, 2018).

Two children said they were excluded from school for being disrespectful to teachers **‘I didn’t like them screaming at other people, so I would scream at them, then they would scream at me, so I got myself into it more’** and **‘I was really horrible to teachers’**. Two children felt the school did not want them there **‘just for being me, they didn’t like me, I didn’t like them’** and **‘to be honest, they just wanted me out, they really didn’t want me there’**.

The children shared their responses of shouting and non-physical actions (relational aggression as described by Crick, 1996) but felt their behaviours were justified as they felt they were provoked. From these comments, it could be suggested that these teachers may have challenges with managing and regulating their own behaviour, which may have contributed to the increase in challenging behaviours from some of these children. It may be of benefit to provide targeted training that is specific to supporting children with challenging, violent and aggressive behaviours (CCVAB). The children also described how they felt the teachers did not like them and did not want them to be in the school. Both perceptions were echoed by the caregivers in their interviews (see section 4.4.2).

### 4.1.3. Children's views on why they were permanently excluded from school: KS4

Fourteen out of 20 KS4 children shared why they were excluded from school, with 58 references. Most of the reasons were markedly different from the other key stages. The predominant reason children in KS1-3 recalled for being excluded from school was challenging, violent and aggressive behaviours, whereas in KS4 it was low-level disruption or not adhering to school rules. Fourteen of the children said they were excluded for general behaviours, categorised as follows:

|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Making others laugh        | <b>'Yeah, I was trying to make people laugh cause everyone was bored. It was inappropriate'</b>                                                                                                                                                                                                                                                                                                                                                         |
| Hood up when outside       | <b>'The head would make us stand outside for 20 minutes to have uniform checked; we would put our hoods up... we would be taken out of the line if you had your hood up'</b>                                                                                                                                                                                                                                                                            |
| Wearing makeup             | <b>'One time was because I refused to take my makeup off. They took me to the headteacher's office. I was trying to plead to her 'would you want your makeup wiped off?' They would literally put baby wipes to my face, and they would wipe my makeup off my face. They wouldn't let me wear it. I was crying'</b>                                                                                                                                     |
| Multiple factors           | <b>'False tan, make-up. Nails. Not correct shoes. Refusing to wear their shoes. General behaviour. I was really naughty in Year 9, but then in Year 10, I started sorting myself out a bit. But by then, the teachers just didn't like me at all. I used to be in the corridors for every science lesson. Teachers would tell me to put my earphones in and go to sleep on the desk'</b><br><br><b>'Uniform, makeup, forgetting pencils and rulers'</b> |
| I hated teachers           | <b>'I just hated the teachers'</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |
| My behaviour               | <b>'I got kicked out of my first Secondary because I was just turning into a little shit'</b>                                                                                                                                                                                                                                                                                                                                                           |
| Walking out of lessons     | <b>'Kicking off. Walking out of lessons. There were different reports. If you were bad, you would get an 'X'. If you got a certain amount of 'X's, you would get punished. I think I got excluded for that'</b>                                                                                                                                                                                                                                         |
| Not going to lessons       | <b>'Not going for a lesson'</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Swearing                   | <b>'Swearing and doing loads of shit. Isolation, as well. Because I didn't like people. I didn't like some teachers'</b>                                                                                                                                                                                                                                                                                                                                |
| Having my mobile phone out | <b>'I think it was because I had my phone on me truthfully. I was in isolation and I had my phone on me and I had it out. I refused to give it to the staff. So they kicked me out for that'</b>                                                                                                                                                                                                                                                        |

My sibling did not behave

**‘My siblings... when they were in that school, they were naughty. My cousins as well. So, they thought I was like that. So, they picked me out straight away. My sister was kicked out for something she didn’t do... They started blaming me for things, so I thought I would give them something to blame me for’**

Unsure of the reason

**‘I didn’t even know what I was doing then. I was just finding my feet’**

The reasons recalled by the children appear to contravene the Education Act (2011), which states that the headteacher can only exclude a child due to a serious breach of the behaviour policy and where allowing the child to remain would harm the education or welfare of other children. Based on the children’s views, it is hard to see how these would be justified reasons for giving a child a fixed or permanent exclusion as they are not rational, proportionate or fair, as dictated by the European Convention of Human Rights, 2012. In addition, some of the caregivers and the children themselves were able to share the contributing factors that led to these low-level behaviours, which, rather than indicating a need for exclusion, demonstrate a potential need for bespoke support (such as body dysmorphia or neurodiversity).

## 4.2. Children’s views on how permanent exclusion made them feel: KS2-4

Children in KS1 were not asked the question, however 11 children across KS2-4 responded with 13 references:

- 7/16 children in KS2-3 (7 references)
- 6/20 children in KS4 (6 references)

### 4.2.1. Children’s views on how permanent exclusion made them feel: KS2-3

Four children said that they wanted to leave mainstream school. Two felt sad at leaving their friends and another child described their feelings as being **‘in the middle’**.

- **‘I wasn’t bothered. I said I wanted to leave from the start’**
- **‘Happy’**
- **‘Glad... Glad to be back. Anywhere would have been better than there’**
- **‘At the time, I wanted to leave’**
- **‘I was there for quite a long time. But then I left all my friends. I was a bit sad’**
- **‘I miss my friends; they were a big part of my behaviour; they would help me and tell me to stop acting up’**
- **‘In the middle, I couldn’t really tell’**

These results indicate that these children, overall, wanted to leave mainstream school, but they felt sadness at leaving established relationships with peers.

### 4.2.2. Children’s views on how permanent exclusion made them feel: KS4

Six children out of 20 children from KS4 shared how their school exclusion made them feel. Their views generally reflected children in KS1-3 and their comments are shown below.

- **‘I was disoriented like no tomorrow. I was like Tom Hanks in Castaway. I had no one’**
- **‘It was the best day of my life. I hated it there. It was crap’**
- **‘Getting kicked out was mint, exclusions are boring though’**
- **‘I forgot how to read and write, how to add and takeaway, it was hard when I started my next school. I wouldn’t do any work... I still can’t read properly yet’**
- **‘I didn’t see it as a punishment. I don’t get how giving a couple of days of school is a punishment’**
- **‘Relieved’**

The responses from children were mixed, with one child reporting feeling a sense of abandonment and others describing relief. A child who talked about being unable to read and write spoke about how he was sent home from school with a computer and did not return for two and a half years but remained on the school roll. He felt his inability to read and write was likely to be a direct result of not attending school; his anger at this was palpable during the conversation. This child’s comments support findings that there are adverse consequences associated with school exclusion, including low educational attainment (Daniels and Cole, 2010).

### 4.3. What children did during their fixed and permanent exclusions: KS4

This question was asked of the children in KS4 only, with half of the 20 children responding with 13 references overall.



What children do with their time during exclusion is currently an under-researched area. Three children described how they would sleep all day to help the time pass. Equally, three children talked about having to complete work sent by the school **‘I just started doing work online, tests and stuff, to keep myself busy’** and **‘my mum was strict...she made me sit and do school work in the house’**. A further three children talked about playing on the computer, games console and/or phone doing non-school related activities. This could suggest that they either did not have school work to do or chose to do other activities. Two children cited doing nothing with their time and one child said they **‘just went out with people who don’t go to school’**. Another child was part of an academy of schools and recalled going out of the area to another school during their exclusion. What became apparent was that many appeared to be unsupervised during their exclusions, as their caregivers were employed during the school day. These findings indicate that during a school exclusion, these children were largely bored and unstimulated, which could perpetuate disengagement with schooling. These experiences appear to support research that school exclusion limits a child’s educational opportunities (Gazeley, 2010; Cole et al., 2013; Thorsborne and Blood, 2013).

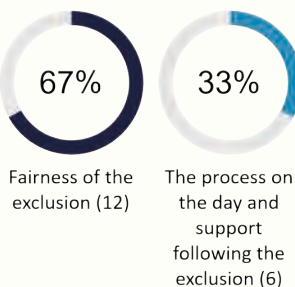
## 4.4. Caregivers’ views on the fairness of fixed and permanent school exclusions and the exclusion process

Twenty-eight caregivers shared their views on the fairness of school exclusion, with 67 references:

- 12/20 caregivers of children in KS1-3 (18 references)
- 16/21 caregivers of children in KS4 (49 references)

### 4.4.1. Caregivers’ views on the fairness of the fixed and permanent school exclusions and the exclusion process: KS1-3

Overall, 12 of the 20 caregivers of children in KS1-3 responded to this question and shared their experiences on the fairness of the school exclusion and process, creating 18 references.



#### 4.4.1.1. The fairness of the exclusion: KS1-3 caregivers

Of the 12 caregivers who spoke about the fairness of exclusion, all felt it was unfair. One of the main reasons was that they felt their mainstream school should have been more accommodating of their child’s needs, **‘they gave it ten days and got rid, he has autism and was in crisis, he was saying things like I want to live in heaven where I can be away from all the nastiness of school. Autism outreach had just been in the day before and put a comprehensive plan together. The day after - gone’** and **‘if he’d had the support, he**

**wouldn’t have been excluded... he grabbed a couple of kids because he was overwhelmed. They said it was for safety; I just thought it was wrong’.** One caregiver felt that the child should have been supervised and how the limited supervision led to the exclusion **‘he was meant to be supervised during unstructured times and he wasn’t and was permanently excluded’.** These comments suggest the importance of adhering to agreed plans for support (DfE, 2015b). It could also indicate that mainstream schools need an increase in staffing resources and funding to ensure that children are supervised when that is the agreed arrangement.

Some caregivers felt there was a lack of communication between home and school perceiving this as the reason their child ended up being excluded **‘they said he was like an animal, attacking teachers and swearing, the head said he’d rang us loads. I said you only rang today. I can show you the phone records; he got permanently excluded’.** Another caregiver said they were never informed of the reason why their child was excluded from school and they felt this was not fair **‘they said they wouldn’t discuss it over the phone, I was at work, so my mum had to collect him. They said they would let us know why he was permanently excluded. I tried ringing but he wouldn’t speak to us’.** In these cases, the caregivers perceive the schools did not adhere to their statutory duties of informing the caregiver without delay of the type of exclusion and reason for it (DfE, 2017a).

Two caregivers felt the exclusion was unfair as **‘they put him on report and he tried his best. They said he would have a clean slate after half term, he came back and they permanently excluded him’** and **‘these children are being marginalised and treated in a way that is unlawful, someone has to stop it from happening’.**



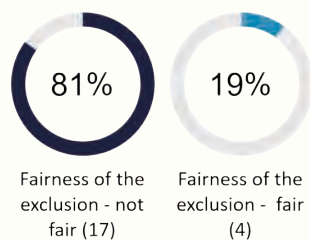
### 4.4.1.2. The process on the day of the school exclusion: KS1-3 caregivers

Caregivers were asked to describe the process on the day of the fixed or permanent exclusion. Two of the six responses referred to the difficulty of being called at short notice to collect their child **‘I understand I have to come and get him; they have to give me time. I can’t just drop everything’** and **‘when I got the call to say he was excluded, I thought what am I supposed to do, I am at work’**. It is understandable that schools who make the decision to exclude a child want them removed from the site as soon as possible but there is a sense that this has negative implications for caregivers, particularly when they are at work. This supports the findings of Quin and Hemphill (2014), and Paget et al. (2016) that school exclusion has a practical impact on the family.

The caregivers talked about the difficulties they encountered following the fixed-period or permanent exclusion in terms of knowing where to go for support. Only one of the six caregivers recalled receiving a letter from the school explaining the process following a permanent exclusion **‘we didn’t know what to do; we got a letter with a number on it but she wasn’t in the office. On Monday we had to ring round to see what to do, it was stressful and hard’**. The caregivers’ responses indicate that they need more support from the excluding school on the options available to them when their child is permanently excluded, as some seemingly had to seek out support independently **‘we had to ring schools; his school did nothing and no one rang us to see if we needed help’**. These views support the suspicions of Parker et al. (2016), and Hodge and Wolstenholme (2016), that in some instances, caregivers are given insufficient support to guide them through the school exclusions process.

### 4.4.2. Caregivers’ views on the fairness of the fixed and permanent school exclusions and the exclusion process: KS4

Sixteen out of 21 KS4 caregivers responded to this question and shared their experiences on the fairness of the school exclusion, generating 24 references.



#### 4.4.2.1. Fairness of the exclusion - not fair: KS4 caregivers

Similar to the views of the KS1-3 caregivers, 13 of the 21 KS4 caregivers spoke about how they thought the exclusion was unfair, creating a total of 17 references. The main reason cited was they felt the exclusion was an over-reaction to their child’s behaviour **‘on a daily basis, I would get phone calls to go and take him home from school because they couldn’t cope with his behaviour. Sometimes it was nothing. He had shouted at the wrong time. Someone would ask him to take his top off and he didn’t want to take his jumper off’**. The additional example below shares the perception of the caregiver that the teachers’ response to their child’s behaviour might have exacerbated the situation, which led to school exclusion.



**'We had a big meeting, somebody from the hospital came. There was a plan for them not to get in his face. My son came in and he was bright red in the face and his arms were bright red. I said, 'What's wrong?' and he said 'A teacher pinned me down and ripped my blazer off me.' 'Why?' 'Because I had a fag in my pocket'. His blazer was in shreds, all the arms were ripped. He said, 'Three teachers grabbed hold of me and ripped it apart'. He had marks all over him. He was wrong to have a fag in his pocket but ask him for it. Don't surround him, pin him down, rip his blazer off him. He would have kicked off and got kicked out. He smashed the door and smashed the glass. So, I got charged for the glass. He got permanently excluded'**

In this case, it could also be surmised that the recommendations from the hospital were not adhered to and the outcome was that the child inevitably went into crisis. If there was aggression from adults, this would likely lead to further problematic behaviours, as suggested by Mitchell and Bradshaw (2013). It is understood that perceived negative behaviours from children are a significant source of stress for teachers, due to the impact on learning and teaching, and teacher wellbeing (Tsouloupas et al., 2010; Anderman et al., 2018). So, support needs to be in place for school staff as well as the child and family. The example below is similar, in that the child's mental health needs could indicate the requirement for reasonable adjustments being applied in accordance with the Equality Act (2010).

**'She had a thing for make-up and she had a huge problem with how she looked. They talked about body dysmorphia with her as well. Because she has this real view of how she looks, and her make-up was her mask almost, and you try to explain to teachers and say that... Then they used to get her into school and then they would make her wipe the make-up off in school and it would just cause her so much anxiety. I get it; I understand that they have rules and they have to adhere to the rules, but you know just the difficulty...'**

A recurring theme among the caregivers was that there were insufficient adjustments in place to accommodate the diverse needs of the children. A possible explanation for this could be the needs of children not being identified promptly (Gill, 2017) or a resource issue in schools (Martin-Denham and Watts, 2019). These findings indicate that reasonable adjustments were necessary to prevent substantial disadvantage and to reduce the risk of both fixed and permanent exclusion from school.

Another reason why caregivers deemed the exclusion to be unfair was that they felt their child was provoked by other children in the school. **'So, there were quite a few children in school who knew which buttons to press. They knew how to provoke a reaction out of him. It was always him that was excluded. Never the child that provoked him. He thinks the teachers wanted them to do it' and 'he got excluded because a group of Year 11s goaded a Year 10 with learning difficulties into attacking him when he was in Year 7—blamed for the behaviour of another child'**. It could be hypothesized that these children were unable to modify and regulate their emotions, impulses, thoughts and behavioural responses, and need to be given support to reduce stress (McCarthy et al., 2014).

A caregiver also reported provoking behaviours from some teaching staff, a view shared by some of the children:

**'A teacher shouldn't show aggression. It's just going to provoke. Which it does. I think my son and this teacher were face to face and the teacher said 'I'm going to get your mum in'. My son didn't want to upset me. He didn't want me to come in. He gets very emotional, angry and crying. Frustrated. Everything. His only way to deal, or the only way at the time, was to lash out'**

This view further supports the need for identifying early indicators in both teachers and children who are potentially becoming dysregulated to provide strategies for controlling impulses (Bohs and Baumeister, 2011).

As with KS1-3, KS4 sub-themes indicated that caregivers perceived a lack of support. Caregivers described their view that, if enough support had been in place in school, their child's conduct would not have led to exclusion, **'rather than just say that the answer is to exclude him. Not to get to the bottom of what was the root cause of the anger and outbursts'**. The caregiver who made this comment confirmed their child was not on the SEN register. This implies that local training may be beneficial to ensure all school staff have the confidence to implement the graduated approach (DfE, 2015b). The comment below implies that the child had a recognised disability and the caregiver acknowledged this impacted on their behaviour.

**'When he is anxious, his conduct becomes a bit questionable. I begged for them to give him a chance. To let me get him medicated, which is something I'd never wanted to do. I never wanted to do that. But he was becoming too much, with his anxiety. So, I said, 'let me try and get him medicated over the six weeks, give it a chance to kick in, see if that calms him down' Which we did. We went to his doctor at CYPS and we got him on medication. By the end of the six weeks, it was agreed that the medication was only working to a certain point during the day. So, we had his medication upped shortly after going to school in September. But they didn't really give him the time to let that get into his system, for it to work. It was very quick just to exclude him'.**

Some caregivers perceived that their child's school was dishonest about the extent of their child's behaviour, **'I used to think there is no physical possibility that in the time it has taken me to get home he could have been at that point where you need to remove him'**. Two caregivers went as far to say they thought their child's school had lied in order to exclude, **'they lied that he did something in a lesson. They didn't say that until the meeting for permanent exclusion... I checked all of his behaviour points and it wasn't recorded'** and **'Not really. I think he did worse things than that. I don't know why that triggered them to permanently exclude him. He didn't actually**

**threaten the teacher. The teacher wasn't even there'**. This strengthens the need for schools to keep detailed records that are shared with caregivers on a frequent basis to ensure a shared understanding and transparency of what is recorded in terms of negative behaviours and applied sanctions.

Other caregivers perceived that their child was treated unfairly, **'if another child had called him a name and he had retaliated or called him something back, it would be him that was removed from the classroom on every occasion'**, or there was a lack of supervision, which led to the school exclusion, **'staff saw my child run through school in distress followed by the older child. He pinned my child to some lockers to stop him. My child hit him. He got excluded for that because he used 'physical violence' but it was self-defence'**. Again, this highlights the importance of schools maintaining and sharing records of behaviours with caregivers following events to ensure there is an opportunity for all parties to discuss their views and to raise concerns. This will protect schools and ensure caregivers are formally kept up to date with events in school as and when they events occur.

#### 4.4.2.2. Fairness of the exclusion - it was fair: KS4 caregivers

Unlike KS1-3 caregivers, a greater proportion of the KS4 caregivers felt that the school exclusion was fair.

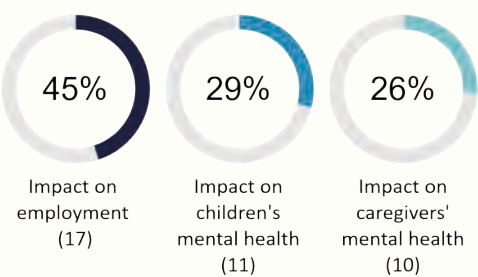
- **'They did try to get him support when you read back over the notes even that wasn't enough to keep him'**
- **'They had no choice but to permanently exclude ... I think given the circumstances; I can see that isn't the publicity that the school wants'**
- **'Some of the things he's done, I did agree'**
- **'Some, yes'**

## 4.5. Caregivers’ views on the impact of the lead up to and the school exclusion on the child and family

Thirty-two caregivers responded to this question, with 161 references:

- 12/20 caregivers of children in KS1-3 (38 references)
- 20/21 caregivers of children in KS4 (123 references)

### 4.5.1. Caregivers’ views on the impact of the lead up to and the school exclusion on the child and family: KS1-3

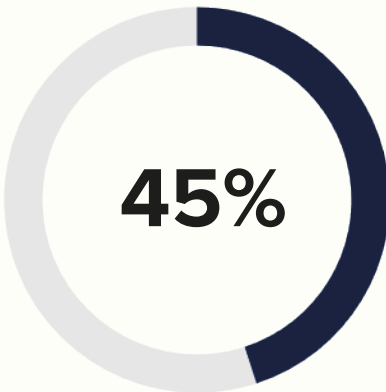


Overall, 12 of the 20 caregivers of KS1-3 children shared how school exclusion affected their family and child, with 38 references in total. The most common theme discussed was the impact of school exclusion on their ability to continue their employment. This was followed by the repercussions on the child’s and caregiver’s mental health. These are presented and analysed below.

#### 4.5.1.1. Impact on employment: KS1-3

The most common theme related to being unable to maintain employment, education or training due to having a child at risk of exclusion from school. The caregivers talked about getting phone calls at work to collect their child, which, they said, caused them stress, **‘usually I get a telephone call. I’m at work and that dreaded number would come up and I knew, my heart starts racing’** and **‘it was completely embarrassing as I’d just started, and I was running an office of sixteen people. I had to take my employer to one side and say my son is being excluded because of his behaviour. I was in shock during the times he was excluded. The amount of stress was untenable’**. Caregivers reported how it was not possible for them to collect their child urgently from school because of work commitments, suggesting they had practical barriers to collecting their child. This issue is widely recognised in other research such as McDonald and Thomas (2003), and Quin and Hemphill (2014). **‘I just can’t fly my car from Stockton to Sunderland. I can’t do that, and they weren’t very happy about it’** and **‘if they couldn’t get in contact with you, they would phone and phone and phone. Sometimes I’m in a meeting and I can’t take my phone’**.

Some caregivers shared that they had to resign in order to be available to respond to phone calls about their child. **‘I don’t work at the moment because I was getting phone calls all the time’** and **‘I had to resign my job’**. For those caregivers who continued to work, they felt there was a direct impact on family life **‘we were called in that much, we had to make sure one of us was always available; she works 12 hours and I work 12 hours (night work)... we had to do this to hold down jobs and to bring money in’**. One caregiver talked about how the experience prevented them from achieving their aspirations **‘I want to go to university to be a nurse. Obviously, I’ll have to get him settled and sorted before I do anything’**. The overarching views of caregivers were that if they have a child on the edge of exclusion, it was extremely challenging to remain in employment, education or training due to the requirement to collect their child at short notice or to answer phone calls. The anticipation of the telephone ringing while at work was a cause of significant stress for some caregivers. Their views echo those of Daniels (2011) that it is the family who must deal with the consequences of exclusion.

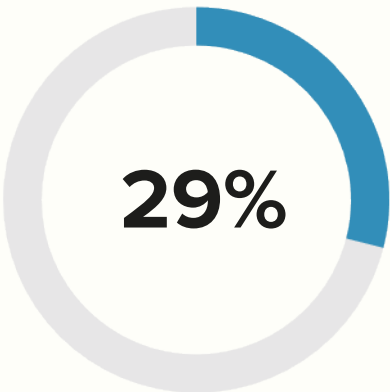


Impact on  
employment (17)

4.5.1.2. Impact on the child’s mental health: KS1-3

With 11 references, the impact on the child’s mental health was the second most prevalent theme reported by KS1-3 caregivers. Two caregivers said their child wanted to end their life **‘when your son says he wants to die that is hard to listen to. How do you get to react?’** and **‘he was saying things like ‘I want to live in heaven where I can be away from all the nastiness in school’ he was in pieces, it was dreadful’**. This correlates with research that identified associations between school exclusion and mental ill health (Daniels and Cole, 2010; Pirrie et al., 2011; Hemphill et al., 2012). These findings suggest a possible link between children encountering difficulties accessing mainstream education and mental health difficulties. One caregiver described how she felt she had to remove her child from mainstream school to safeguard his mental health. She considered homeschooling him as he had exclusions on and off for five years, but felt **‘he wouldn’t learn from me, he would learn the wrong way’**.

A few caregivers were concerned that there would be no suitable provision that would be able to meet their child’s needs and that returning to mainstream school would make the situation worse. **‘ultimately inside you’re almost dying inside cause I’m sending him somewhere that’s not able to meet his needs’** and **‘I’ve been at meetings with my child with tears in his eyes because of the lies. He’s been looking at me - shaking’**. Some caregivers also perceived how past exclusions could predict future ones as their child’s needs remain unmet, a view supported by Skiba (2000) and Bowman-Perrott et al. (2013).

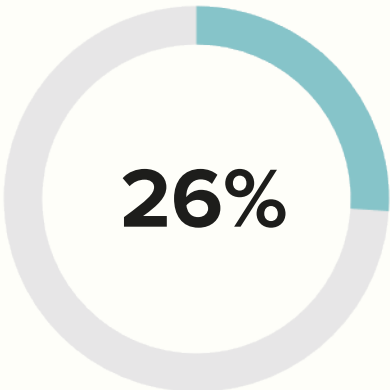


Impact on children’s mental health (11)

4.5.1.3. Impact on caregivers’ mental health: Key stage 1-3

The third most prevalent theme with ten references concerned the perceived impact of school exclusion on the mental health of some caregivers. They talked about the situation being a strain on their mental health and having no one to talk to **‘I haven’t got anyone. He’s not as bad at home as he was, but if anything happened, I’ve got no one to ring’** and **‘the best thing would be help for parents - you just feel alone’**. These views demonstrated the potential adverse consequences of school exclusion on psychological well-being (Quin and Hemphill, 2014; Paget et al., 2016). Others talked about the impact on their social life. This was particularly evident for caregivers with pre-school children who felt they could not go out and make friends due to how others may negatively perceive their child’s behaviour.

One caregiver, who was a single parent, felt particularly affected by having a child with difficulties at school. She reported relying on extended family **‘so my mum has to watch him’**. Two caregivers with children with challenging, violent and aggressive



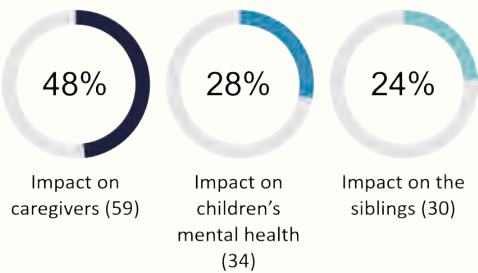
Impact on caregivers’ mental health (10)

behaviours expressed the impact on their intimate relationships **‘this situation has split me and my partner up and he just couldn’t cope; my child was hitting him’** and

**‘I used to have big earrings. He pulled them out of my ear, I’ve been hit with a belt, punched, kicked, I’ve had things hurled at me from 15 months of age... now he is in the right place, it is reducing, the kick-offs are less and less, he does have the odd bad one where he hits me, sometimes I have to restrain him... I was told by the social worker to let him trash the rooms and keep out the way, my house is rented. I would be evicted. I can’t have holes in the doors, but social services say that’s what I should do. It is hard as a parent’.**

This caregiver reflected that she initially raised concerns about her child’s behaviour and development with a health visitor at his two-year progress check. She described how she was told it was due to her parenting. This indicates that there needs to be consideration of how concerns are recorded and how this information is cascaded to other multidisciplinary professionals. The results indicate that in these cases, challenging, violent or aggressive behaviour (CVAB) in the early years could be an indicator of future school exclusion.

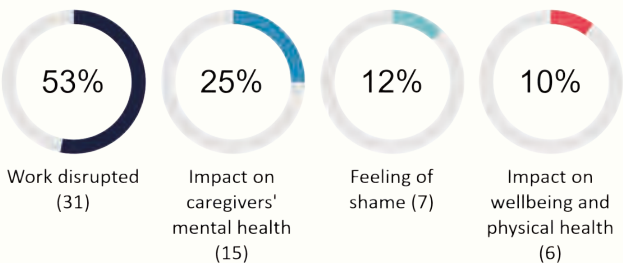
4.5.2. Caregivers’ views on the impact of the lead up to and the school exclusion on the child and family: Key stage 4



Twenty-one caregivers of KS4 children shared how school exclusion affected their family and child, with 123 references in total. The most common theme discussed was the impact of school exclusion on the caregivers, followed by the impact on the child’s mental health and the impact on the excluded child’s siblings. For ease of reading, and due to the volume of data, each of the three themes were broken down into sub-themes and analysed below.

4.5.2.1. Impact on the caregivers: KS4

The impact of school exclusion on caregivers themselves was the most reported theme representing almost half of 123 references made.



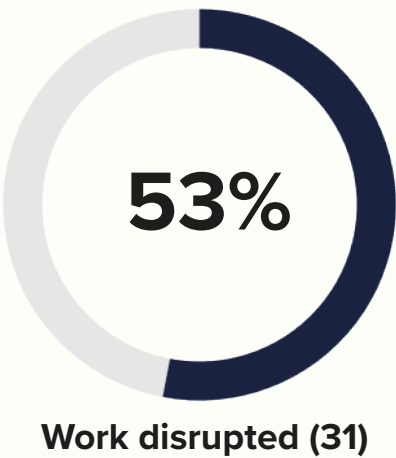


### Impact on KS4 caregivers: Work disrupted

Similar to the KS1-3 findings, the main repercussions reported by the KS4 caregivers (53%) in the lead up to, during and after school exclusion, was the disruption caused when they were at work. Some caregivers reported that both anticipating or receiving phone calls from school negatively impacted on their ability to focus while at work. **‘I work for myself, which is good, but I’ve had to take a lot of time off work. Going out of work, having to pick him up from school and bring him home’ and ‘I would be up to my eyes in work and my phone would go’ and ‘I couldn’t concentrate. I would be upset’.** Others recalled that they had a sense of dread of their phone ringing and when checking their phones at break times, using language such as **‘stressful’** and **‘dread’**. There was a reliance on supportive employees, which two of the caregivers felt they had **‘I work full time. Luckily, work has been very supportive. But obviously, I don’t want everyone at work to know what my circumstances are, so it has been quite difficult’.** One caregiver, despite having an understanding employer, now works from home so she can be available should the school contact her. Another caregiver reflected on her sense of shame about having a child with difficulties stating, **‘I just put a brave face on’.**

Thirteen of the 21 caregivers interviewed reported they had to leave employment to be available to respond to phone calls from school or to collect or discuss their child during the working day. Two of these described having to leave professional roles due to the contact from school. They said **‘you need to get back to work and I can’t give them a date. I’m very upset. It’s a huge chunk of money to lose’** and **‘I’m going to claim benefits once I get my P45. I am living on nothing lending off my dad. I have no other income apart from the child tax credit for my other son’.** One caregiver shared that she had to retire from work due to stress and the difficulties their children were having at school.

**‘The family was broken, we were broken. Our family has been broken. We are putting it back together a little bit, but it’s been horrendous, absolutely horrendous. We were always such a happy family, tried our best, hard workers, grafters. We wanted for nothing, kind and generous to less fortunate people. An ordinary family. Things just got worse and worse, to the point I couldn’t believe it, it was almost daily’.**



These findings support research that identified practical consequences for the family when a child is excluded from school (McDonald and Thomas 2003; Quin and Hemphill, 2014; Paget et al., 2016).

One caregiver reported that having a child at risk of exclusion caused a decline in their physical and mental health, resulting in them visiting their General Practitioner (GP)

**‘I thought I was getting Alzheimer’s; I went to the doctors. He said no, it is tremendous stress and anxiety. I’m not giving you medication, it is circumstantial... But I would go to work and the phone would be ringing about my son, I just couldn’t concentrate. I wanted to throw the towel in. I had to retire’.**

As with the caregivers in KS1-3, the KS4 caregivers’ views demonstrate the detrimental impact of having a child on the edge of exclusion or receiving an exclusion. It is likely that being unable to work would impact the whole.

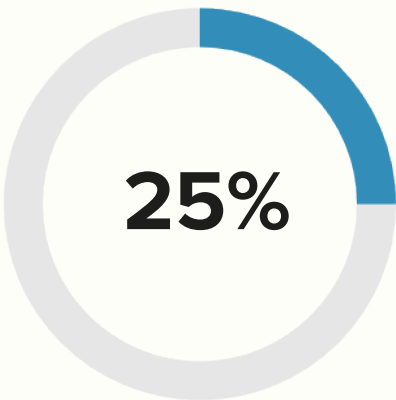
**Impact on KS4 caregivers: Mental health**

There is limited research on the impact of school exclusion on the mental health of caregivers. In this research, 15 caregivers made reference to the stress leading up to and during the school exclusion, saying it caused them mental ill health. This included one report of feeling suicidal.

**‘My husband left me a suicide note last year. We had an incident with my son that morning. We had to call the police. I got home and I asked my son ‘where is he?’ My son said he had gone to the shop, but he hadn’t, he had left me a suicide note. I had my son to look after, a husband and my other children. It was just impossible’.**

There were three reports of feeling worried about their child and their future, being anxious, depressed, with some being prescribed antidepressants.

**‘I was on Sertraline (antidepressant) because I felt like I was going to have a heart attack. I said to my Dad, I felt like I wasn’t going to wake up on a morning. That is how hyped I was about it all. That was how stressed I was—thinking about what was going to happen to him. I knew he was a good child. He just needed someone to spend a little more time with him, explain things to him. Not to pull him up for things that he can’t help. He can’t help the way his brain works, the same as anyone else. If he needs to tap, he needs to tap. He isn’t harming anybody. Honestly, my anxiety went up’.**



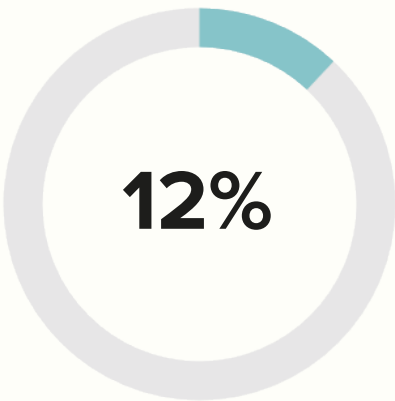
**Impact on caregivers’ mental health (15)**



The impact of the lead up to and the school exclusion on caregivers was evident, as many were visibly upset during the interview. Some talked about how they have had a low mood for many years and there was a sense that they could not take any more **‘I wanted to throw the towel in’ and ‘it doesn’t just affect him, or me and his dad. It affects the whole family. His grandparents, they adore him, it’s heartbreaking for us all. Seeing him being failed and punished over and over. But when we look back now, that was a horrible few years. Full of anxiety’**. This reinforces the need to ensure that there are support systems in place for families, including legal advice and universal services to support their mental health and wellbeing as soon as they, schools or other professionals raise concerns. It needs to be acknowledged that as families are living through this time, there are likely to be other children in households who need support.

**Impact on KS4 caregivers: Feeling of shame**

Seven caregivers reported feeling ashamed, questioning why their child was having difficulties in school **‘I was so ashamed at the time. No one wants to hear, they just run a mile’ and ‘I was embarrassed. Because this isn’t what I’m trying to bring him up to be’**. The impact of this on the caregivers was palpable in the interviews, with one describing how she wanted to just leave home **‘I considered getting on a one-way train. Never come back. I couldn’t understand it all. Have I been a bad parent? I couldn’t do anymore’**. What was evident from four of the caregivers was that they directly questioned if their child was having problems because of something they had done **‘What did I do?’ ‘What could I have done differently?’ ‘What can I do? You exhaust yourself whilst trying to put food on the table’ and ‘What have I done wrong as a parent? I just didn’t understand why’**. One caregiver described how questioning her own parenting ability in front of professionals was embarrassing, and thought that because she took ibuprofen during pregnancy, she was responsible for current difficulties **‘I couldn’t keep her safe. I couldn’t protect her from herself. Because there was nobody else. There was nobody else’**. These responses overall support the view that there is a sense of shame associated with school exclusion (Piquero et al., 2004; Daniels, 2011).



**Feeling of shame (7)**

## Impact on KS4 caregivers: Wellbeing and physical health

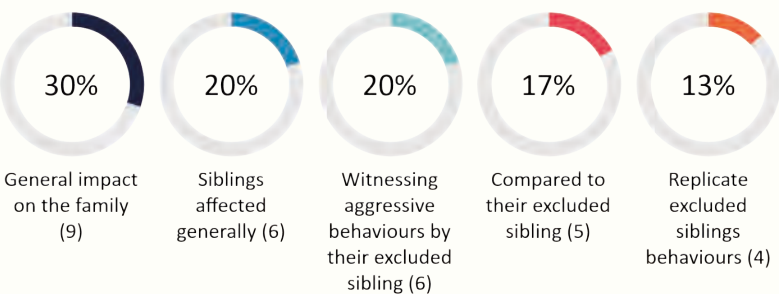
The remaining sub-theme related to the perceived impact of the lead up to and school exclusion on the general well-being and physical health of the caregiver(s). This included reports of a general feeling of exhaustion, feelings of having no support and increased states of anxiety. Some caregivers spoke about getting used to the stress and battling to get support from services. There was also a sense of resilience in the responses **‘every day I wake up and say ‘what is today?’ Don’t get me wrong I’m on antidepressants, heart medication and god knows what else. But I keep going because I have to’ and ‘I will try and keep him on the straight and narrow, to keep him on the right track but you have to give a thought for those children who don’t have that at home. That’s the frustrating thing I’ve had with him. He’ll tell me he hates me. But I’m doing my best for him’.** The data reported here and above, appear to reiterate the importance of providing support, guidance and advice for families and children when a child is having difficulties at home or school. This needs to include signposting to health services.



Impact on wellbeing and physical health (6)

### 4.5.2.2. Impact on the siblings: KS4

The impact of school exclusion on the child’s siblings was the second overarching theme, with 34 references, divided into the following sub-themes.



## Impact on the KS4 siblings: General impact on the family

The most prominent sub-theme, with nine caregivers, was on how life with a child on the edge of exclusion, and their subsequent exclusion, affected the whole family. Though little is currently written about this, caregivers spoke of the strain on the family unit, giving a sense of the family falling apart and causing a breakdown in relationships.

**‘He dabbled with drugs... our world fell in. I don’t even know how we are still a family. We were devastated. This was the beginning of a very rough ride... We thought it ‘didn’t happen to us’ but it does by the way. I felt stripped of my dignity and my**



General impact on the family (9)

pride, I have none left. We have had a really horrible two years, but we think he has turned the corner. He has crucified the family. We have been totally broken; it was a living nightmare. But he has turned a corner; he wants a future. He knows that drug-taking is a mug's game. He had worked hard behind the scenes, even on his own. So, I need to give him a chance, he is my son, I don't give up on anybody. It's interesting how I want to skip those last 18 months... It's probably too painful'.

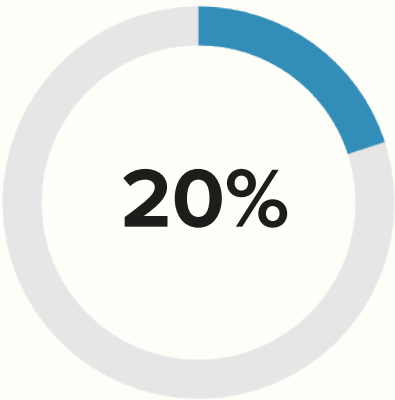
Some caregivers reflected on the lead up to and the exclusion, and shared their feelings at this time. One described her low point **'you feel like your life is just falling to bits and there is nothing that you can do. There's nothing that you can say; you can't offer anything... just nothing works'**. There was also a sense of feeling alone, even when they are part of a family. One example was the consequence of having a child being excluded from school on the caregiver's ability to socialise face to face **'most of my friends have children with disabilities, so we chat on Facebook and text... we don't get a chance to meet up'**.

Impact on the KS4 siblings: Siblings affected generally

A small number of caregivers shared the negative impact of the lead up to and during the school exclusion on other siblings or foster children in their care. There is no available research on the impact of school exclusion on siblings at this time, however, this research has shown that siblings can be overlooked when the attention is on the child who has been excluded from school. One caregiver raised the concern that when a child had experienced difficulty at school and at home, the attention moved away from their (non-excluded) siblings; **'my poor daughters just drifted'**. This caregiver felt there should be plans in place to support any siblings who remain in the excluding school.

Impact on the KS4 siblings: Siblings witnessing aggressive behaviours

There were six references from caregivers who reported on the impact of one child with challenging, violent or aggressive behaviour (CCVAB) on the other children within the household. The behaviours displayed at home included **'smashing something every day', 'domestic violence from the child to the caregiver', 'kick-offs', 'crying' and 'wobbles'**. Research tells us that whether violence is experienced, witnessed or perpetrated, it adversely affects the emotional and physical wellbeing of children (Janosz et al., 2008; Mrug and Windle, 2010). There were reports from two caregivers of siblings carrying out restraints of siblings to protect their mother **'she has held him back. He never fought against her if she ever went to restrain him'** and **'there are many times where my older sons had to restrain him. To stop him getting at me. Or me to stop him getting at his brother. He**



Siblings affected generally (6)

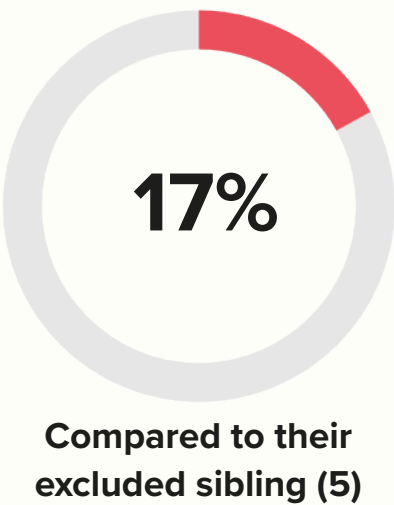


witnessing aggressive behaviours by their excluded sibling (6)

**will pull at me to get to him. He would just get a mist. He would lash out’.** The comments indicate the caregivers had concerns about keeping the siblings safe and talk of strategies such as ‘sending them to a safe place in the house’ when their child was in crisis. This supports the justification for having support in place for all household members when there are children with CVAB.

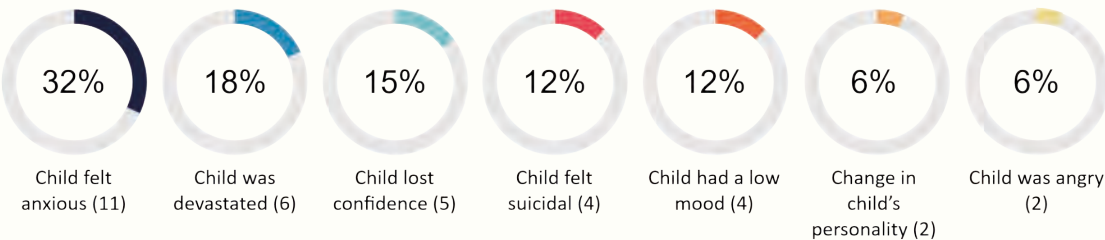
**Impact on the KS4 siblings: Compared to their excluded sibling in the school**

Five caregivers shared that when they had a child permanently excluded from school, the remaining siblings were affected by their reputation. One commented that teachers had said **‘you wouldn’t believe you are related to him’** and **‘my daughter found it embarrassing’**. Four caregivers stated that the impact of the child’s behaviour caused behaviour changes in the other siblings in the household. It was felt that this might have been because the children wanted to get excluded to be reunited with their siblings in the new school. Another felt the reason their child was replicating behaviours was that they were jealous of the attention the other sibling gained within the household. These findings support those of Thorley and Coates (2018), that CCVAB is an indicator of exclusion in school. They proposed that often these behaviours are overlooked until school age with no support, compounding the risk of school exclusion. Support needs to be in place for children who remain in the mainstream school that their sibling was excluded from.



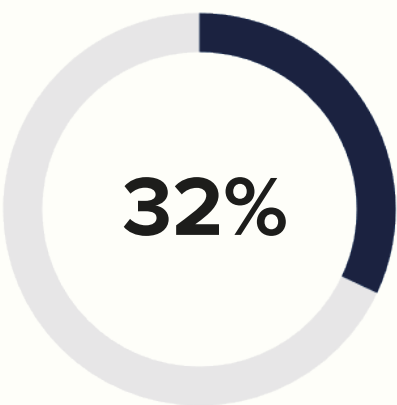
**4.5.2.3. Impact on children’s mental health: KS4**

The third overarching theme from KS4 caregivers was the impact on the children’s mental health and contains 30 responses. These have been characterised into sub-themes, analysed below.



Impact on KS4 children’s mental health:  
My child felt anxious

Some KS4 caregivers talked about the level of anxiety the child had in mainstream school **‘he ended up having a panic attack. They phoned an ambulance’** and **‘the child had difficulty getting into school due to their anxieties’**. . Four caregivers talked specifically about their child’s social anxiety; refusing to eat, going to get advice from the GP, and a consultant saying the anxiety their child experienced was stress-related. One comment related to the child being anxious in anticipation of going to mainstream school **‘the anxiety would start on the Saturday or Sunday, school holidays were ruined because she was so worried about going back’**. Another comment related to the child’s heightened levels of anxiety after school **‘when he would come home from school, his anxiety was always through the roof’**. It was evident from these comments that the level of anxiety the children experienced was a barrier to accessing and participating in school and could have been a contributing factor to the subsequent school exclusion. These children did not have any identified neurodevelopmental/neurodiverse, learning or emotional needs at this time which could indicate needs not being identified for referral to health services (Gill, 2017).



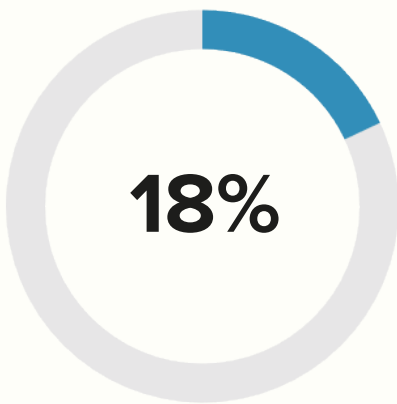
Child felt anxious (11)

Impact on KS4 children’s mental health:  
My child felt devastated

Following the permanent school exclusion, six caregivers used the term **‘devastated’** to describe their child’s feelings of having to leave mainstream school. They predominantly felt that the rejection from school profoundly affected their child’s confidence and mental health **‘we found him in bed, fully dressed, shoes and backpack still on. He was devastated. He became depressed. He slept for two hours, crying when he woke up’**. The caregiver shared that this was her son’s third attempt at a managed move and she recalled getting home from work and finding him in bed, still in the school uniform. Another caregiver commented:

**‘Irreparable damage has been done. He has lost education, lost all those life skills. He has a record now. The school rang the Police; they didn’t legally have to. He had paid the price, the ultimate sacrifice, he was permanently excluded. He was devastated; he had feelings in all of this. He couldn’t help himself; he cried. Sometimes he showed that he was upset by rebelling. He would get angry and upset’**.

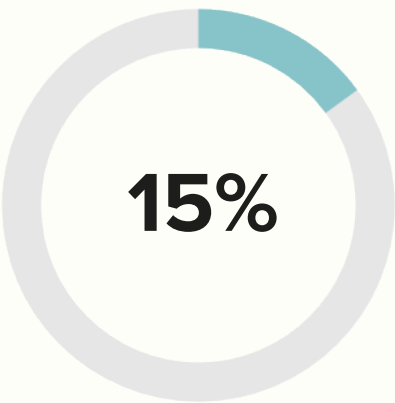
These reflections imply that school exclusion may have been an important factor contributing to the mental ill health of these children



Child was devastated (6)

Impact on KS4 children’s mental health:  
My child lost confidence

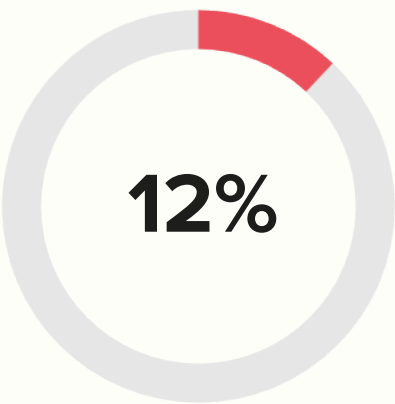
Some caregivers spoke about the long-term impact of the permanent school exclusion on their child’s confidence. All five reports suggested that the effect was ongoing, including **‘I am scared for his future, because of the scars, the damage. It’s going to take him a while to shrug that off. If he ever does’**. Caregivers reported how their child’s low confidence continued into alternative provision, with one suggesting **‘the teachers have said that he has no confidence. They will give him something to do; he will say he can’t’**.



Child lost confidence (5)

Impact on KS4 children’s mental health:  
My child felt suicidal

Four caregivers described how their child felt suicidal following their permanent exclusion from school, with one caregiver reporting their child attempted to end their life, **‘the overdose was just before he started here (alternative provision). When he wasn’t really in education. He had no routine’**. In addition, two caregivers reported how their children spoke of their desire to end their life **‘he wanted to kill himself. He actually drew pictures on a piece of paper of him wanting to die, of him shooting himself, him stabbing himself’** and **‘it reached its peak when he wrote on a piece of paper that he had had enough’**. It is possible that the attempts on life and wishing to end life were related in part to the challenges these young people encountered in mainstream school during and after exclusion. However, there is limited literature in this area to reliably infer any direct link (Whear et al., 2014).



Child felt suicidal (4)

Impact on KS4 children’s mental health:  
My child had low mood

The early indicators of mental health difficulties were commented on by four caregivers following permanent exclusion. Two referred to the child having ‘low mood’ and refusing to get out of bed. One caregiver reflected that her son might have had depression.



Child had a low mood (4)



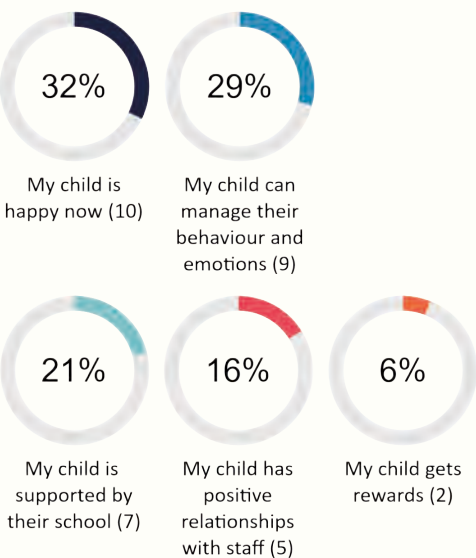
## 4.6. Caregivers’ views on the enablers to alternative provision

Thirty-one caregivers shared their views on the enablers to alternative provision, creating 100 references.

- 10/20 caregivers of children in KS1-3 (33 references)
- 21/21 caregivers of children in KS4 (67 references)

### 4.6.1. Caregivers’ views on the enablers to alternative provision: KS1-3

10 out of 20 caregivers of KS1-3 children shared their views on the enablers to alternative provision (AP).



It is important to note that the comments from the ten KS1-3 caregivers were entirely complimentary about their experiences of alternative provision in Sunderland.

#### 4.6.1.1. KS1-3 caregivers: My child is happy now

All ten caregivers talked about how their child was happy now they were in an alternative provision that meets their diverse needs **‘he runs into school. If we get here 5 or 10 minutes early, it’s a struggle to keep him in the car. He does run into school, so, yes he does enjoy school’** and **‘I’ve genuinely never seen him more settled than he is now’**. The caregivers talked about their children thriving, socially and academically. They also talked about the reality that the alternative provision where their child was placed was temporary. This is clearly very concerning for the caregivers and was palpable in their responses **‘if I could keep him here I would. I really would. My real worry is when he leaves here, he will want to come back, undoubtedly. This is a very happy environment for him and if I could, I would keep him here’** and **‘if he stopped here, I will be happy because he will come on in leaps and bounds ready for Junior School’**.

It is clear from the caregivers’ responses that the alternative provision was meeting the holistic needs of the KS1-3 children. It needs to be explored if this can become a permanent school for those children and in the best interests of the child to remain in the care of the school. This could be in the form of an additional provision, so that the current school is maintained for those who have recently been permanently excluded, with a partner provision for those for whom mainstream is not a suitable or viable option.

#### 4.6.1.2. KS1-3 caregivers: My child can manage their behaviour and emotions

The strength of the alternative provision is that the staff are seemingly able to turn around children’s behaviours and support them in self-regulating their emotions. This is achieved by listening to the child’s voice, understanding their strengths and limitations, and using this intelligence to plan for and meet their diverse needs. All of the caregivers talked about how the provision understood their child and worked with them to understand their emotions to

learn how to manage them, citing **‘they taught him how to understand his belly bubble, meaning he’s going to have an explosion, so he can manage it. This is what I needed. The difference is immense; everything is built on the rewards and understanding yourself. The groups are smaller’** and **‘in the school, they help the children to understand themselves and their problems’**. The evidence suggests that the alternative provisions have the expertise to implement the graduated response effectively, assessing and planning for children’s needs (DfE, 2015b). The support for these children is also commended by the caregivers, including how effectively the school communicates with them and the role of the effective support systems and processes. It would seem logical for the alternative provisions to be leading continuous professional development in schools, to enable the sharing of good practice within the constraints of mainstream school budgets and large class sizes.

#### 4.6.1.3. KS1-3 caregivers: My child is supported by their school

When reflecting on the support the children received from the alternative provision, some key themes arose. For example, one caregiver valued the amount of knowledge and understanding the AP had of their child

**‘The first day we came in to speak to the headteacher about moving him to the school. The headteacher knew everything about him. So, he obviously read the care plans. They made him feel very welcome. Again the staff at the gate, who don’t necessarily teach him, if we’ve got any appointments, they already know about it’.**

The wider teams who supported children were also acknowledged as a protective factor **‘the behaviour team from the school is the best service. They give great advice about parenting and processes’**. It was also discussed by a caregiver that the AP supported them in gaining an EHCP for their child and in accessing wider support for the whole family. There was a clear sense of the caregivers

feeling gratitude for the guidance from the APs , with one caregiver stating **‘he finished at the school two years ago, but I still come back to help them out as much as they help me. They kept me on the straight and narrow there’s not much help out there’**. The comments suggest caregivers valued having their views listened to and the level of support in meeting their child’s needs (Smith, 2009; Embeita, 2019).

Other enablers to AP cited by the caregivers were: supportive learning, positive relationships with staff and effective approaches to promoting positive behaviours. One caregiver suggested that they only received positive feedback from teachers about achievements and successes through certificates and other meaningful rewards from the AP; **‘that they build on reach for the stars. Every week he comes home with a certificate. He’s never had a certificate in his life you know, so he can celebrate that at home as well’** and **‘rewards are real. He got trampoline lessons last week because his house got so many points’**.

Some caregivers reported that the enablers to learning in the AP were that there was a mixed ability group and their child was challenged to do more advanced work. The option to attend subject-specific after school clubs allowed their children to catch up on missed learning. The overarching view was that the children felt empowered to ask for support with learning and it is through this that their confidence grew. **‘Here he’s got the confidence to ask for help if he does need it, whereas before he just...he would rather flip the tables, so he got took out. That was just his way of saying that ‘I’m not gonna ask for help’**. Some caregivers talked about the detrimental impact on their child’s self-esteem resulting from ‘failing’ in mainstream education. One caregiver talked about how the varied curriculum, with practical focus has enabled their child to re-engage with learning.

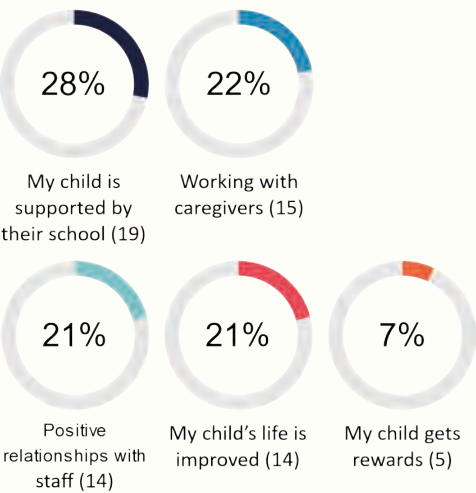
Five of the caregivers noted the importance of building enduring relationships with teachers as an enabler to AP. They described receiving positive phone calls to touch base, home-school diaries and the importance of being welcomed into the school **‘this school is**



**much nicer. The staff are just lovely. You're welcomed the minute you walk in the door. I don't think they've been welcoming in any school ever'**. The firm, fair and consistent approach to supporting positive behaviour is commended by caregivers, as they acknowledge that their children need to be safe. The approaches to managing challenging behaviour were agreed and have the full support of caregivers, which seems to have also been a significant factor in creating the positive relationships forged with the caregivers in this study. The development of trusting and respectful relationships between the school and family has been key to the success of these placements (Mowat, 2009; Flitcroft and Kelly, 2016). One caregiver summed up their feelings on AP in Sunderland:

**'I love this place. As a parent, when you are looking at an AP, this is where all the kids go who are feral; actually, that's wrong. I was wrong to think that. It's a really great placement for kids who are struggling in their behaviours, you know. I wish he could stay; I know but he can't but it's a shame. But it's a great place and I'd tell anybody, 'don't be frightened of the AP'. It isn't what you think. It hasn't got bars on the windows like you think like prison. In fact, it's the opposite'.**

**4.6.2. Caregivers' views on the enablers to alternative provision: KS4**



All 21 KS4 caregivers shared their views on the enablers to alternative provision, with 67 references. The evidence was similar to KS1-3 caregivers in that it was completely complementary about the alternative provision in Sunderland. Caregivers spoke about how their children would go to school without complaint, with increased confidence and how they are happier in themselves. The most prominent theme, with 19 references, was **'my child is supported by their school'**. This theme has been further broken down into the following subthemes.

**4.6.2.1. KS4 caregivers: Enabler to alternative provision**

Seven caregivers were pleased about the option for their child to follow vocational pathways in their AP, as it supported their child's interests and gave them options for their future **'they are going to get him into placements. Because they know that is something he is interested in. More hands-on work than classroom work' and 'he does a bricklaying course on Friday'**. Opportunities for apprenticeships were commended, particularly when they were working towards a qualification, an approach supported by Martin-Denham (2020a).

One of the main enablers to AP, cited by four caregivers, was the smaller class sizes compared to those in mainstream schooling; this has been found to be a positive aspect of AP (Thomson and Pennacchia, 2016; Tate and Greatbatch, 2017). Other caregivers reported access to additional support as an enabler **'it's as if he gets that extra help now... But he's a lot more confident in what he's done' and 'he passed a Year 11 test in Year 10. He is ahead of his work than what he would be if he was in mainstream. Because he is getting the support in this school'**.

The key difference between the caregiver perceptions of communication between mainstream and AP, is that the caregivers reported they were given positive feedback about their child's progress and behaviour **'here I get a phone call if he's naughty. They tell me what happened. But I also get a phone call when he's been good. When he's getting on with his work'** and

**'They have very good communication with the parents. I think when your child is doing good, they ring you and tell you. They give praise when they are being good. When they first rang me to say he's had a really good day, he's done good work and been laughing. It's nice to hear when all those years all you've had negatives. When this school rings I'm not just thinking 'Ohhh no'. That's what I felt like when the other schools would ring. They wouldn't ring to praise him. I think it makes all the difference as well. Because then I can say to my son 'Well done, you've been really good'.**

Another positive factor highlighted was how effective the APs were at negotiating referrals and supporting the EHCP process. One caregiver described the APs as **'this school has been the best service'** while another reported **'since coming to the AP however, it has been absolutely brilliant. They've been so understanding and helpful and supportive'**. The caregivers only had positive comments about the staff in the AP, reporting they are non-judgemental, nurture focussed, friendly, firm and fair. This is illustrated in the following comment.

**'I think here they have more time in the day for them. And here they know how to deal with a pupil, depending on their brain stage, they deal with things a lot more. I think they're more laid back here as well. Not letting them do whatever they like. Saying 'if you don't work, it's only affecting you' then eventually they will bring themselves back around to do some work. But to me personally, they know how to deal with children a lot more compared to mainstream'.**

Other positive factors offered by the AP were home tutoring and flexible school days. This included the ability of caregivers to opt for shorter school days, starting later in the morning and an activity-based curriculum during afternoons.

#### 4.6.2.2. KS4 caregivers: Positive relationships with staff

As with the KS1-3 caregivers, the KS4 caregivers valued the relationships they had with the school staff. Ten comments related to the view that the staff in the APs were knowledgeable about the multi-faceted needs of their children.

**'I take my hat off to the school and staff. The amount of work they put in and how they cope with the children is unbelievable. I used to find it hard coping with my son on his own. Never mind a class with a fair few of them. They know the children and the signs of each child. How they react. They know what's up with them. I like it here'.**

The evidence suggests that the positive relationships with caregivers were created due to a range of factors, such as being non-judgemental of their parenting; being empathetic towards the child's circumstances; being knowledgeable; and having time to understand their child's abilities, learning and mental health needs. They described how decisions on how to manage challenging behaviour are made collaboratively, so that they feel part of the process. This was described by one caregiver who was supported by the AP when her child was taking drugs: **'I'd gotten a few phone calls saying that he was on drugs, saying that his eyes were glossy. I phoned this school and I said 'Can he do afternoons here... just him by himself on an afternoon?' They said 'Yeah, of course'. Here they work with me. At his last secondary, they worked against me. It was all his fault. Or my fault'.**

4.6.2.3. KS4 caregivers: My child's life has improved

Unique to the KS4 caregivers was how they reflected on how their child's life had improved since attending AP. They shared that their children were now happy to go to school **'he is a lot happier at home. I don't even struggle to get him out of bed on a morning now. He's up and ready'** and **'he doesn't moan about it. He gets up and goes to school; before he was refusing. He's happy since he started here, I've seen a change in him. He never complains. He has good days. Progressively over time, he is getting more happy'**. Some caregivers described how their child has grown in confidence **'he has more confidence. He is passing exams. He has gone from strength to strength'** and **'he is determined to do really well. Since he has come here, his confidence has gradually been going back up'**.

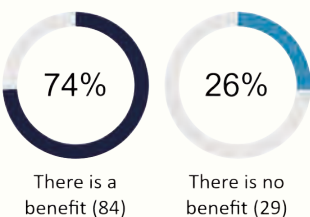
4.6.2.4. KS4 caregivers: My child gets rewards

Similar to KS1-3 caregivers, the KS4 caregivers cited the importance of rewards to raise their child's confidence. Trophies, letters from the headteacher to celebrate academic successes, activities in the afternoon, certificates and gift cards were all described as important factors in the AP placement being a success.

4.7. Education professionals' views on the benefits and challenges of school exclusion

Forty-nine professionals reflected on the benefits and challenges of fixed and permanent school exclusion, creating 113 references.

- 18/32 primary and nursery headteachers (37 references)
- 9/9 secondary headteachers (25 references)
- 4/4 specialist headteachers (5 references)
- 8/10 alternative and additionally resourced provision headteachers (22 references)
- 11/14 SENCOs (24 references)



Overall, the majority of educational professionals who spoke of the benefits and challenges of school exclusion believed there were benefits. For ease of reading and to provide a more developed analysis, each theme is presented by sub-theme or participant group where applicable.

### 4.7.1. Professionals’ views on the benefits of fixed and permanent exclusion

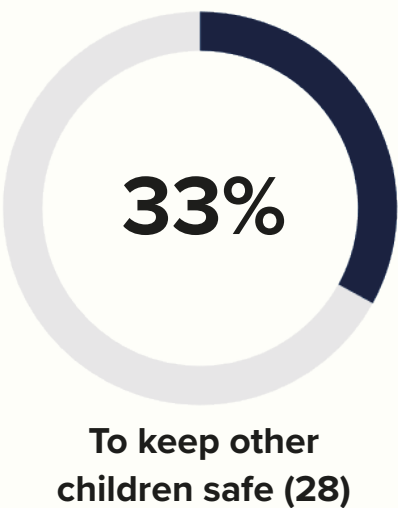
This section shares the views of the benefits of exclusion from headteachers and SENCOs. There were very few differences between participant groups, so each professional group was combined and analysed. The section begins with the most commonly held view across all professionals on the benefit of school exclusion.



#### 4.7.1.1. Professionals’ exclusion benefits: To keep children in the class and to keep them safe

The most common justification for excluding children on a fixed or permanent basis was to keep the children in their care safe and to prevent them from witnessing CCVAB. This view was similar across all participant groups, with comments such as:

- ‘The only benefit is the impact on the other children who are frightened of him. The class were very anxious, when they were told he was going on a part-time timetable, the children almost cheered’
- ‘I think that for the other children who are seeing that happening; who are seeing that level of violence’
- ‘They’re not having their learning disrupted or the threat of violence from those children’
- ‘It can create a calm atmosphere within the school, particularly within the class that that child might be working in, to allow them to get on with their work’
- ‘If you have a learner who is particularly disruptive, obviously it does affect everybody’s learning and sometimes it is for the good of the majority’
- ‘The rest of the class it affects, because they feel unsafe with this other child, plus they get confused about what is acceptable behaviour and what is not’

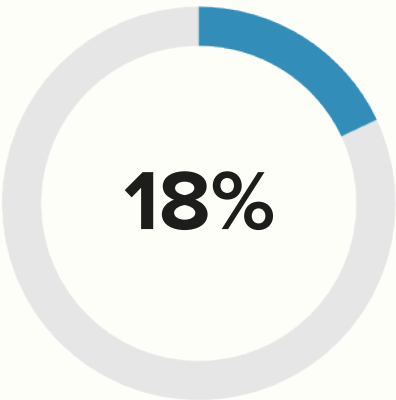


From the comments above, it could be suggested that the children displaying challenging, violent and aggressive behaviours had unmet needs. This could indicate a need for localised training to support school staff in implementing the graduated approach (DfE, 2015b) to identify and respond to children's behaviours. Two comments referenced how the professionals make decisions as leaders and governors because of limited support from external agencies:

**'If you are not getting the help, as a school, from those other professionals that you need from the outside, talking about the training, or the behaviour intervention, or people coming out and saying have you tried this or have you tried that? ... If that is not happening on a regular basis or quite a quick basis, those barriers are going to get bigger and bigger and this is what happens, the kids get into the process and the pattern of an exclusion'.**

**4.7.1.2. Professionals' exclusion benefits:  
To access more support for the child**

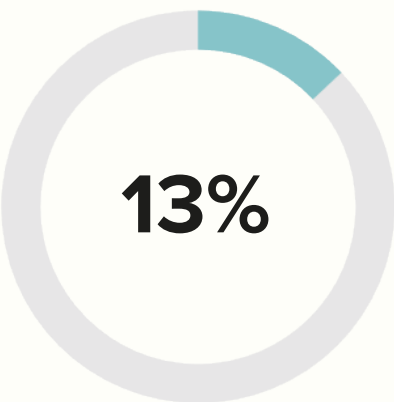
The comments in this sub-theme suggested permanent exclusion was used as a means for the child to access external support **'if we have a learner and we are really struggling with them and we feel we are getting nowhere, we've been turned down for an EHCP and there's nowhere to go for additional support. CAMHS and CYPS are engaging but perhaps taking forever to get support; sometimes I think we do feel that an exclusion is the only way for something to happen, for them to accept that this learner needs support'** (SENCO) and **'that permanent exclusion was done essentially to speed up the local authority's endgame in giving him a place in a behaviour school'**. There was a sense from the education professionals that, unless a child was permanently excluded, the school could manage, particularly if they have not had any previous exclusions. Therefore, both fixed-period and permanent exclusions were used by schools to get access to a new provision, to strengthen the case for an EHCP and to gain access to health service assessments. This may be due to the perception that excluding a child would trigger a holistic assessment of their needs, as advocated in the DfE (2017a) guidance. However, as Gill (2017) clarified, the exclusion could be a barrier to accessing therapeutic or specialist education and it is unclear how often any assessments take place.



**To access more support  
for the child (15)**

4.7.1.3. Professionals’ exclusion benefits:  
To make caregivers realise their child’s  
behaviour is unacceptable

Eleven education professionals suggested that a benefit to school exclusion was to make caregivers realise their child’s behaviour was unacceptable. The majority of those who held this view were primary school headteachers (70%), followed by secondary school (20%) and alternative provision (10%). Four participants reported that a benefit of exclusion would be the caregiver realising the gravity of the situation, so that they will work with the school on improving the child’s behaviour **‘it would normally be two to three days to get through to the parent, the child and the class, yes that really upset and hurt you all and that behaviour cannot happen in school, and start thinking about that this is not behaviour that is normal and can be condoned’**. This comment raises concerns, as it refers to ‘normal’ with no regard for the reason for the behaviour. The idea that an exclusion will make the caregiver take responsibility is an ongoing theme, as some professionals felt it was the only way to make the point that the situation could not continue **‘it makes the parent reflect on their child’s behaviour, because actually what I am saying is: I’m sorry, I can’t have your child in this building for their own safety and the safety of the children and you need to take some responsibility for your child’s actions. At the end of the day you, are the parents of that child’**. The perception of these headteachers was that the caregivers were not bothered **‘I was excluding for one day or two days and the parents were going right: that’s great, I’ll just get a lie-in’ and the kids were just getting a couple of days off, coming back to school and just doing exactly the same thing all over again’**. It is not clear what the headteachers expected the caregivers to do with their child during a school exclusion. They do not seem to consider the fact that many caregivers had to work and so could not be with their child all day. Additionally, there is also the consideration that caregivers are not teachers and may not feel able to support learning at home.

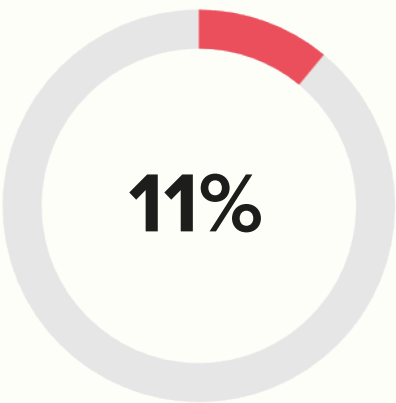


To make the  
caregiver realise their  
child’s behaviour is  
unacceptable (11)



4.7.1.4. Professionals’ exclusion benefits: To give the child time to reflect on their behaviour

The fourth most prevalent benefit for school exclusion reported by professionals was that the exclusion allowed the child an opportunity to reflect on their actions. **‘a bit of time to reflect on their actions; whether they do or not, I don’t know’** and for others to see there is a consequence for negative behaviours **‘I would use it; also it’s for other children to see. This child has punched this child and that child knows we have dealt with it’**. The language used in these responses suggests they acknowledge that this does not change behaviour in all cases **‘Whether or not they do reflect I don’t know’** and **‘it can be a wake-up call’**. These views are not supported in research, suggesting that school exclusion does not improve problem behaviours (Skiba, 2000; Theriot et al., 2009; Bowman-Perrott et al., 2013).



To give the child time to reflect on their behaviour (9)

4.7.1.5. Professionals’ exclusion benefits: For the benefit of the staff

Of the eight responses, two referenced staff getting justice for a prior assault **‘you feel a sense of fairness if that student is gone’**. One of the main threads running through the comments from the headteachers was that it gave staff a signal that the leadership team were supporting them and looking after their mental health and wellbeing **‘as staff, I think all you need is to know that leadership are supporting you and taking it seriously’**. There was a sense that a further benefit of a fixed-period exclusion was that it gives staff a break, particularly when they are dealing with the child every day **‘staff were becoming quite scared and I felt I needed to regroup. I didn’t exclude because it was going to be permanent; I wanted to give the staff space to re-group’**.



For the benefit of the staff (8)

The remaining comments on the benefits of exclusion related to giving other children the message that negative behaviours will not be tolerated; to give the child a fresh start; and to benefit the school community. Headteachers wanted to ensure that other children appreciate what is and is not acceptable, and that there are consequences for actions. This would support the view of Gregory and Cornell (2009) that to prevent violence in schools, ‘dangerous’ children are removed quickly to send a strong message to the remaining children. It was mainly secondary education professionals that felt it was important that permanent exclusion was an option to maintain order. Alternative provision professionals felt that a benefit of permanent exclusion was that it draws a line under events and allows the child and their caregivers to have a fresh start. There was also an acknowledgement from secondary headteachers that permanent exclusion was necessary, as they reported **‘the school isn’t right, and they need to go to alternative provision for specialist support’**.

#### 4.7.2. Professionals' views on the challenges of fixed and permanent exclusion

While 74% of education professionals interviewed reported the benefits of exclusion, 26% suggested there were no benefits to exclusion. This section presents those views across the different participant groups, starting with secondary headteachers, followed by SENCOs, nursery

##### 4.7.2.1. Secondary headteachers' challenges with exclusions

The largest group believing there was no benefit to school exclusion was the secondary headteachers, with ten references. Interestingly, this group said they did not see the benefit but admitted their statistics would show they do use them. This supports recent research that found no evidence to show that school exclusions are effective due to a lack of rigorous evaluation (Obsuth et al., 2017). Three headteachers felt they were not effective, as children just wanted to have a fixed-period exclusion to have time off, to be with caregivers, and one suggested to care for siblings **'it pains me to exclude some children because I know that that's what they want; they want to go home and have two to 10 days with their parents' and 'we are trying to cut down on our fixed-period exclusions because I think that's what they want; they want a day off school. Their parents are letting them on their Xboxes but at least if they're here they're doing something'**. One head said that they used exclusions because they do not have anything else. Another head suggested that they use fixed-period exclusions because of the mindset of the staff **'some staff here are of the mindset that this will fix everything; I am of the mindset that I don't want to send them home to play on their Xbox for three days because we will have the same battle when they come back in'**.

##### 4.7.2.2. SENCOs' challenges with exclusion

The seven SENCOs were unanimous that excluding a child on a fixed or permanent basis just moves the problem out of the school and does not deal with the underlying issues of why children were unable to manage in mainstream (Skiba, 2000; Theriot et al., 2009; Bowman-Perrott et al., 2013). **'if we're excluding them then we are just moving the problem opposed to dealing with what is behind that behaviour'**. One SENCO supported the view from an AP that **'sometimes they want to be out of school'** adding that **'this can mask a whole load of issues we could support them with'**.

##### 4.7.2.3. Alternative and additionally resourced provision challenges with exclusion

The six comments from alternative provision were that school exclusion does not benefit children, as they do not have an opportunity to start afresh in another mainstream school. They also said that mainstream school leaves them so negatively affected, they have no fight left, so they feel the education system is unjust. **'By the time the children get to us, those children are so damaged; emotionally, mentally. They are just beaten. They have nothing left to fight for. So, they just want to fight the world, literally'** The comments reflected that children saw a fixed-period exclusion as a reward as they received days off school, **'what would be the point you don't wanna be here, so you get two days off? Then the next time you don't want to be here, you create, then you get two days off, it's a bit like 'oh yes, a reward'**.



#### 4.7.2.4. Nursery and primary headteachers' challenges with exclusion

There were six comments (including one from nursery). The views were closely aligned to those of the SENCOs, that school exclusion is of no benefit as it does not deal with the underlying challenges that children may have. Participants felt school exclusion compounds difficulties and can leave caregivers without support. One school said exclusion was **'an admission of failure; you failed that child'**. There was an understanding among those against exclusion, with one stating **'why put a child out when they are desperately in need? I know behaviours are challenging and I totally understand about the safety aspect but whatever age of that child, they are communicating in that way, they are desperate, then putting them out, how can that help? How can it help anybody? We don't and I believe we have had some very challenging children and very challenging parents coming through'**.

These findings support those in research, that children need to have a full assessment of their needs to determine their challenges and strengths and to identify and agree on reasonable adjustments. The participants' own accounts show that the DfE (2012) guidance did not go far enough in ensuring assessments were carried out for all children where there were concerns. The current statutory guidance (DfE, 2017a, p. 6) is vague in the use of the term 'should' in relating to duties. It could be argued that until this is resolved, the situation for these children and others in their position is unlikely to change.

**'Disruptive behaviour can be an indication of unmet needs. Where a school has concerns about a pupil's behaviour, it should try to identify whether there are any causal factors and intervene early in order to reduce the need for a subsequent exclusion. In this situation, schools should consider whether a multi-agency assessment that goes beyond the pupil's educational needs is required'**.

## 5. Concluding remarks

## 5. Concluding remarks

The purpose of this research was to investigate if there were any benefits to excluding a child from school. The study has identified that both fixed and permanent exclusions have a detrimental impact on children and their wider family in terms of learning, mental health, employment and wellbeing. These findings provide insights into school exclusions in a city in the North East of England and are presented in order of the objectives of the research.

### The impact of fixed and permanent school exclusion on the child and family

This research has indicated that there are harmful short- and long-term effects of school exclusion on children, their siblings and caregivers. The current statutory guidance on school exclusion (DfE, 2017a) is a key part of the problem as it does not make it explicit that schools ‘must’ identify underlying causes of disruptive behaviour or ‘must’ consider the use of a multi-agency assessment, which conflicts with the actions dictated in the SEND code of practice (DfE, 2015b).

This study has raised important questions about the nature of mainstream schools and their role in the education and care of children who have multi-faceted abilities and needs. The children who were permanently excluded did not have the opportunity to say goodbye to friends, to repair and rebuild relationships, or to acknowledge any harm caused to others and themselves. Some of the reasons given for their exclusion did not appear to be rational, proportionate or fair, but were suggestive of inflexible policies and a potential lack of understanding of equality duties. As early as key stage one to the end of key stage four, it was clear that children encountered significant barriers to accessing mainstream schooling. The reasons were multidimensional, including unidentified learning, neurodevelopmental and mental health needs, which become increasingly apparent as they began formalised education. Some were unable to meet the

demands of the curriculum, to cope in large class sizes, to maintain positive relationships with teachers, or to meet the expectations set out in stringent behaviour policies. From the interviews with caregivers, it was apparent that once their child was in alternative provision, with identification of needs, support plans, small classes and positive relationships, they began to thrive. The children themselves articulated that in their new provision, they were happier and engaging in the opportunities they were given. None of the children wanted to return to mainstream school.

Both caregivers and the children reported that the reason for the behaviour difficulties was multifaceted. Often due to unidentified, assessed or diagnosed learning, physical or mental health needs. This was then compounded by a lack of funding for schools to effectively meet the diverse needs of children. This study has shown that exclusion from school has serious implications for children and their households emotionally, financially and academically. However, the caregivers were animated and positive when talking about how alternative provision has been a ‘lifeline’ in equal measures for the child and the family.

### The effectiveness of the process of excluding a child from school

The evidence suggests that most caregivers did not feel their child’s exclusion was fair; many talked about a lack of recognition of disabilities, even when guidance was provided from professionals external to the school. This study highlights issues regarding the communication between schools and caregivers during the exclusion process, with caregivers citing a lack of relevant information in relation to the reason for exclusion; an absence of adherence to agreed support for their child; and unclear next steps.

## The drivers for school exclusion

It seems that headteachers are using school exclusion as a means to keep other children safe; to get more support for the child; to gain access to a new provision; to strengthen the case for an EHCP; and to gain access to health service assessments. The findings also suggest that exclusion was deemed to be beneficial as it sends a message to other children and caregivers that there are consequences to negative behaviours.

## The effectiveness of alternative provision

The evidence of the alternative provision success in Sunderland was striking. This research has highlighted areas of effective practice across this local area, with the data showing that alternative provision is leading the way in responding well to children's SEMH needs. The children and caregivers all reported that once settled, the children were happy to come to school and participation in learning significantly increased. The move from mainstream to alternative provision was seemingly the best outcome for these children. The sad reality is that they had to 'fail' or 'be excluded' to get to a provision most able to meet their diverse needs. It is clear from the interview data that the success of the alternative provision is attributed to the relationships with the staff, the smaller class sizes, and finally the 1:1 pastoral and academic support that is available on demand.

The reduced curriculum offer (focusing on Mathematics, English and Science) alongside functional skills and vocational skills also appear to work well for these children. It must be asked if curriculum demands – particularly in secondary education, where over 10 GCSEs are studied – are partially to blame for children's inability to succeed in mainstream schooling. A vocational route for some children may be more feasible, as these children were all looking forward to post-16 opportunities in employment, education or training.

## Considerations for provision planning and training

One recurrent theme in the interviews was a sense that there were insufficient adjustments in place to accommodate the diverse needs of the children. Also, in some cases, when the children did have SEN support or behaviour plans in place, the agreed reasonable adjustments were not adhered to. These findings suggest several courses of action for the local area in terms of training to improve evidence-based provision and practice, as set out in the recommendations.

## Considerations for national policy

In agreement with the House of Commons Education Committee (2018), this research supports the view that the government needs to place a greater emphasis on providing a strategy for dealing with some of the root causes of child mental health problems. The research suggests that there is a conflict between the rights afforded to children in the Equality Act 2010 and the issuing of fixed and permanent exclusions, where reasonable adjustments have not been agreed or adhered to, as there is a clear tension between these two priorities. There is also a lack of regulation and accountability, particularly of academy schools who remain outside of local authority control.

## 6. Recommendations

## 6. Recommendations

These recommendations are intended to enable the local area to develop expertise and capacity in schools to allow children to thrive emotionally and socially. Some schools need to challenge their current policies and practices, working alongside caregivers, children and multi-agency professionals to better understand the holistic needs of those children. The implementation of the recommendations will require a shared commitment to implementing the findings of this research

The following recommendations relate to the data analysis and literature review.

**Recommendation 1:** Children identified as being at risk of, or allocated, a fixed-period or permanent exclusion, to be referred to health services for assessment of needs. This would determine any underlying genetic, learning disability or neurodiversity causes, so that reasonable adjustments are based upon strengths and difficulties. The health, functioning and wellbeing summary traffic light communication tool (Ireland and Horridge, 2016) should be considered for universal use by all health services under the direction of the paediatric disability team.

**Recommendation 2:** To extend the KS1-4 alternative provision to allow those children thriving in their care to have a permanent placement in the school. This could be in the form of an additional provision so that the current alternative provision school is maintained for those who have recently been permanently excluded with a partner provision for those who mainstream is not a suitable or viable option.

**Recommendation 3:** Improve preventative support in mainstream and other schools where children are identified as 'at risk of exclusion' at the earliest point of concern. Training for school staff on evidence-based interventions to enhance academic skills. This needs to include identification of any SEND, person-centred approaches, supporting children with CVAB, equality duties, and reasonable adjustments,

which should be coordinated and led by the alternative provision schools and lead health professionals in the city.

**Recommendation 4:** The creation of a child, caregiver and sibling support network for those with children at risk of, or who have been excluded from school. This will include signposting to support systems, including legal advice and access to universal services to support their mental health and wellbeing.

**Recommendation 5:** Consistent information to be provided to the caregivers by the excluding school, detailing all local and national contact numbers, support services for the child, their caregivers and siblings. This must include details of education provision available in the local area and the appeals process.

**Recommendation 6:** Documentation following an exclusion needs to be given to the caregivers and the next school placement. This needs to include prior attainment, attendance, behaviour system records, statements of witnesses, caregiver and child communication and responses, the reason for and length of the exclusion. It must include evidence of the implementation of the graduated approach with a review of progress and evidence-based approaches as part of this process.

**National recommendation 1:** DfE to update statutory guidance on exclusion to change the terminology from 'should' to 'must', to ensure schools are obligated to address any underlying causes of disruptive behaviour, including the use of a multi-agency assessment. Schools also require clarification of their duties within the Equality Act 2010 to make reasonable adjustments for those with disabilities, to prevent substantial disadvantage.

**National recommendation 2:** DfE needs to delegate more powers to Local Authorities to enable them to support children at risk of exclusion and to hold schools to account for their decision to exclude a child, to ensure the reason is lawful, reasonable and fair.

**National recommendation 3:** To rename ‘pupil referral units’ to ‘schools’, due to the stigma of this type of provision.

## Further research

The DfE monitors levels of exclusion using key measures based on permanent and fixed-period exclusions, collected two terms in arrears (DfE, 2017e). Within the guidance, schools are required to report the main reason for the exclusion from a choice of the following descriptions:

- Bullying
- Damage
- Drug and alcohol-related
- Persistent disruptive behaviour
- Physical assault against an adult
- Physical assault against a pupil
- Racist abuse
- Sexual misconduct
- Theft
- Verbal abuse/threatening behaviour against adult
- Verbal abuse/threatening behaviour against a pupil
- Other

The DfE (2017e) guidance clarifies that the ‘other’ category should be used sparingly. This research has highlighted variability in the reason for school exclusion and raises questions regarding the current accountability measures on schools to explain the reasons why the child was excluded. Some of the caregivers in this research believed they were never informed of the reason why their child was permanently excluded. Others cited reasons such as: wearing makeup, uniform breaches and forgetting equipment. It is likely these would have been categorised as ‘other’ on the school census return, supporting the claim by Martin-Denham and Donaghue (2020b, p.34) that ‘there is a worrying trend concerning the repeated use of ‘other’ when issuing fixed-period and permanent exclusions to children with no SEN designation. It is both a local and national concern that a miscellaneous category is in use, particularly when its use is prolific’. Further research needs to provide the justification for the removal of ‘other’ to require headteachers to fully account for their reason for excluding a child from school.

## 7. References



## 7. References

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## 8. Appendix

## 8. Appendix

**Table 4:** Recent large-scale qualitative research on school exclusion

| Research                                                                                                                               | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Children’s Commissioner’s Office (CCO) (2019) Exclusions: Children excluded from mainstream schools                                    | This research focused on the lived experiences of children with SEN and exclusion from school. It carried out 16 interviews with children and four of their caregivers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Department for Education (DfE) (2019a) Timpson Review of School Exclusions                                                             | The Timpson Review was a commission from the Government to review exclusion practice, to explore how headteachers use exclusion in practice and why some groups are more likely to be excluded. There were 1000 responses to calls for evidence and visits to 100 organisations, including schools and local authorities. The review found variation in exclusion practice and concluded that more needed to be done to ensure every exclusion is lawful, reasonable and fair and that exclusion is always a last resort.                                                                                                                                                                                                                                       |
| House of Commons Education Committee (2018a) Forgotten Children: alternative provision and the scandal over ever-increasing exclusions | This included 100 pieces of evidence in response to their call for the inquiry from academics, researchers, charities and organisations. A session was held to hear from young people and parents with experience of AP, visit to a school and an unregistered training provider.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Mills and Thomson (2018) Investigative research into alternative provision                                                             | This investigative research commissioned by the DfE, explored the landscape of alternative provision to understand how schools support children at risk of exclusion. This included telephone interviews with 276 schools in England and 25 case studies. This research found that schools took active steps to prevent those perceived to be at risk of exclusion through behaviour logging systems alongside input from pastoral staff. The main preventative strategy was found to be mentoring, temporary withdrawal (internal units or part-time alternative provision) or bringing in external support and changing individual timetabling. The research highlighted a lack of hard evidence of schools evaluating the impact of preventative strategies. |
| Institute for Public Policy Research (Gill et al., 2017) Making the Difference                                                         | This report argued that alongside the growing number of official exclusions, there were significant concerns regarding the use of unofficial exclusions by schools. It also highlighted that of those children who were excluded, they were twice as likely to be in care, four times more likely to have grown up in poverty, seven times more likely to have SEN and 10 times more likely to have recognised mental health problems.                                                                                                                                                                                                                                                                                                                          |
| Adoption UK (2017): Schools and Exclusions Report. Banbury: Adoption UK.                                                               | This was based on analysis of 2,084 responses of adoptive caregivers views on their children’s experiences of school and exclusion. This research shared that adopted children are more likely to have fixed and permanent exclusions than their peers. It highlighted the adverse impact on their school performance and their life chances.                                                                                                                                                                                                                                                                                                                                                                                                                   |











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## Policy Brief

# Excluding children for no real reason: What is the extent of the use of the category 'other' in reporting the reasons for fixed and permanent school exclusion in England?

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## Summary

The Department for Education (DfE) guide on exclusion shares twelve categories that head teachers choose from when reporting the reason for **fixed**<sup>1</sup> and **permanent**<sup>2</sup> exclusions from school. It is made explicit that of these twelve, the 'other' category is 'to be used sparingly' (2017a, p. 17; 2019a, p. 96). This policy brief examines the percentage of 'other' as the reason for **fixed period** and **permanent** school exclusion from 153 local authorities (LA) in England in 2017/18 (DfE, 2019b). In some LA areas, the reason 'other' accounts for over 57% of all **fixed period** and 67% of **permanent** exclusions issued. This report also explores the rate of children excluded under the category 'other' and highlights how the North East accounted for six out of the top ten local authorities that assigned the reason 'other' for **fixed period** exclusions in 2017/18.

<sup>1</sup> A fixed period exclusion is defined as 'when a pupil is barred from school for a fixed amount of time (including exclusions during lunchtime)' (DfE, 2017b, p.56)

<sup>2</sup> A permanent exclusion is defined as 'when a pupil is permanently barred from school premises' (DfE, 2017b, p.56)

## Introduction

When a head teacher excludes a child from school, they must without delay, let parents know the type of exclusion and the reason(s) for it (Education Act, 2002; DfE, 2017b). This can be in the form of a letter or email (Education Act, 1996) with a record of the exclusion being made on the school system. Since 2003/4, schools are required to report the reason for school exclusions through school census returns (DfE, 2017a). The specific details for exclusions are not reported, instead schools select a reason from one of twelve categories available (see Table 1).

The current and previous school census guide (2019a; 2020) acknowledge some school management information systems allow for multiple reasons for an exclusion to be recorded, although only the main

reason is collected for the school census. Schools can assign the category 'other' for exclusions when the reason does not conform to the descriptions available. However, the school census guidance states that 'the descriptions should be used as a guide and are not intended to be used as a tick list for exclusion decisions' (DfE, 2017a, p.17). The guidance also states how 'the "other" category should be used sparingly' (ibid, p. 17; 2019a, p. 96). According to the Oxford Dictionary of English (2010), sparingly can be defined as 'moderate; economical' with the Cambridge Dictionary (no date) defining it as 'using very little of something'.

**Table 1.**

Reasons and descriptions for school exclusion in England

| Exclusion reason/category                           | Description                                                                                                                                                 |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical assault against a pupil                    | Fighting, obstruction and jostling, violent behaviour, wounding                                                                                             |
| Physical assault against an adult                   | Obstruction and jostling, violent behaviour, wounding                                                                                                       |
| Verbal abuse/threatening behaviour against a pupil  | Aggressive behaviour, carrying an offensive weapon, homophobic abuse and harassment, swearing, threatened violence, verbal intimidation                     |
| Verbal abuse/threatening behaviour against an adult | Aggressive behaviour, carrying an offensive weapon, homophobic abuse and harassment, swearing, threatened violence, verbal intimidation                     |
| Bullying                                            | Verbal, physical, homophobic bullying, cyber bullying                                                                                                       |
| Racist abuse                                        | Derogatory racist statements, racist bullying, racist graffiti, racist taunting and harassment, swearing that can be attributed to racist characteristics   |
| Sexual misconduct                                   | Lewd behaviour, sexual abuse, sexual assault, sexual bullying, sexual graffiti, sexual harassment                                                           |
| Drug and alcohol related                            | Alcohol abuse, drug dealing, inappropriate use of prescribed drugs, possession of illegal drugs, smoking, substance misuse                                  |
| Damage                                              | Arson, graffiti, vandalism                                                                                                                                  |
| Theft                                               | Selling and dealing in stolen property, stealing from local shops on a school outing, stealing personal property (adult or pupil), stealing school property |
| Persistent disruptive behaviour                     | Challenging behaviour, disobedience, persistent violation of school rules                                                                                   |
| Other                                               |                                                                                                                                                             |

Source: DfE, 2017a; 2019a; 2020



## Findings

### Part A: Percentage of exclusions categorised as 'other' in local authorities in England (2017/18)

The following section presents the extent of the use of 'other' by 153 LAs firstly, in relation to **fixed period** and then **permanent** exclusions in England (DfE, 2019b).

- Nationally, 20.1% of all **fixed period** exclusions in England were categorised as 'other' (DfE, 2019b).
- When looking across local authorities, there were 13 out of 153 (9%) who used 'other' sparingly.
- 'Other' was the most common reason for **fixed period** exclusions in 41 local authorities (27%).

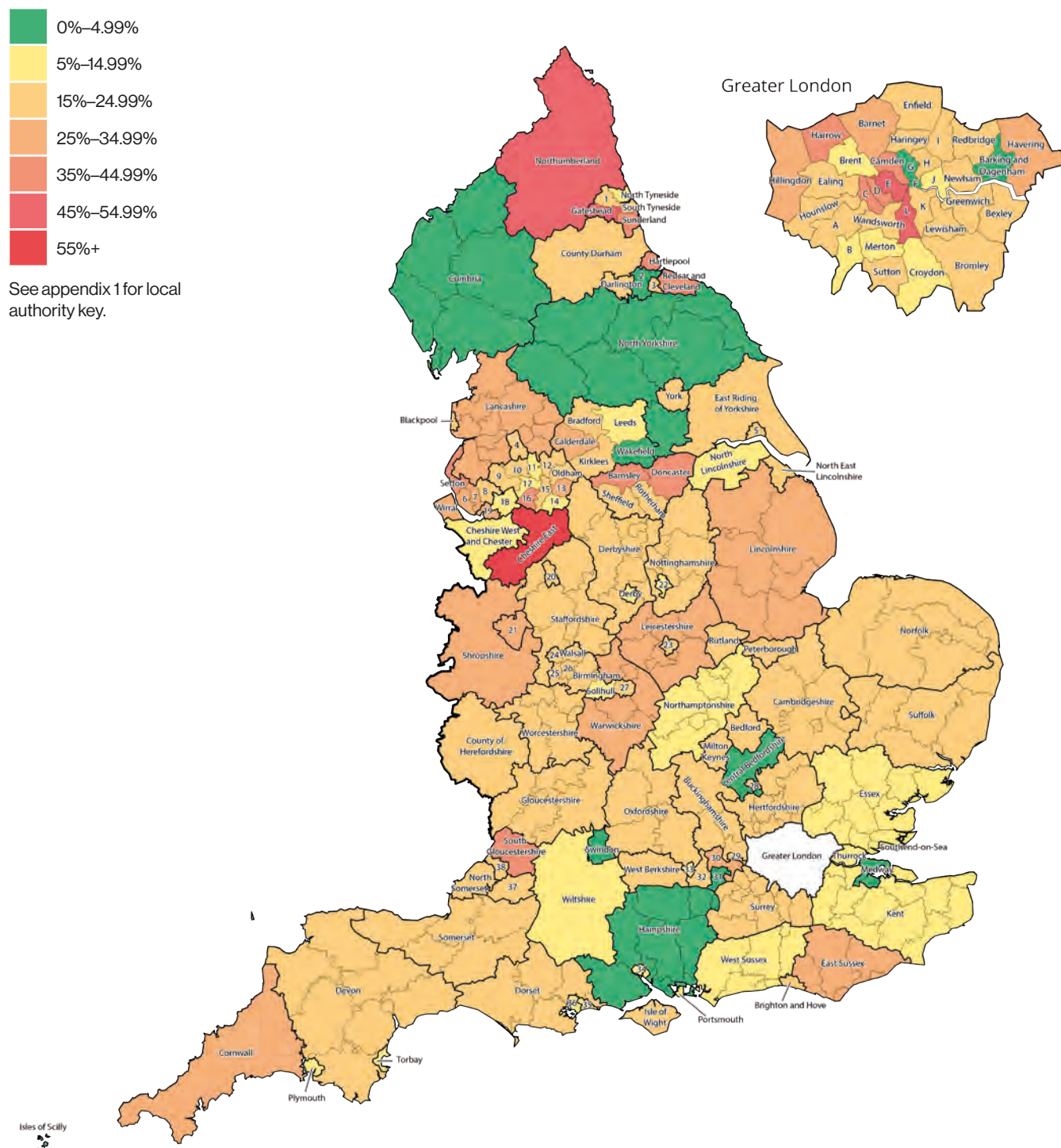


Figure 1. The percentage of **fixed period** exclusions categorised as 'other' in local authorities in England

- 'Other' was the most common reason for **permanent** exclusions in 40 local authorities (26%).
- Of these, there were 20 where 'other' was the most common reason for both **fixed period** and **permanent** exclusions.

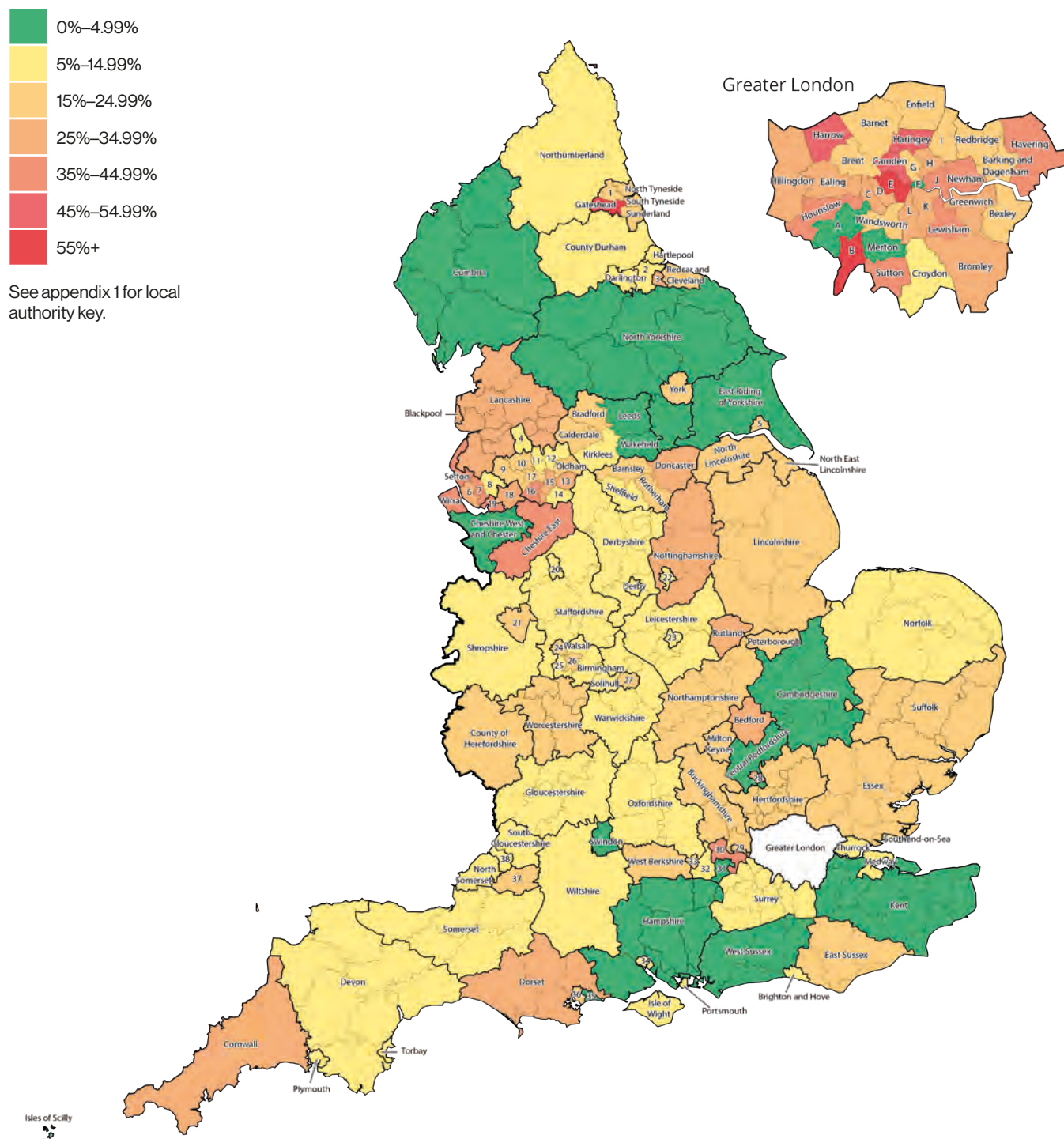


Figure: 2. The percentage of **permanent** exclusions categorised as 'other' in local authorities in England



## Part B: Top ten local authorities with the highest percentage use of the reason 'other' for fixed period and permanent exclusions in England (2017/18)

This section presents the top ten LAs with the highest percentage use of the reason 'other' for **fixed period** and **permanent** exclusion and is based off the same data used in Figures 1 and 2. As shown in Figure 3, Cheshire East, Gateshead and Northumberland have the highest percentage nationally for allocating the reason 'other' for **fixed period** exclusions. Gateshead also appears in the top three for **permanent** exclusions alongside Kingston upon Thames and Westminster.

## Part C: Top ten local authorities with the highest rate of pupils allocated the category 'other' as the reason for fixed period and permanent exclusions in England (2017/18)

So far, this policy brief has considered the percentage use of the exclusion reason 'other' across LAs in England. In recognition of the varying population sizes in each LA, this section presents the number and rate of pupils excluded with this category. Hartlepool, Doncaster and Redcar and Cleveland have the highest rate of pupil **fixed period** exclusions categorised as 'other' (see Table 2). Of the top ten LAs, six are from the North East of England. **Permanent** exclusions account for a much smaller percentage of pupils and there is no one region over-represented (see Table 3).

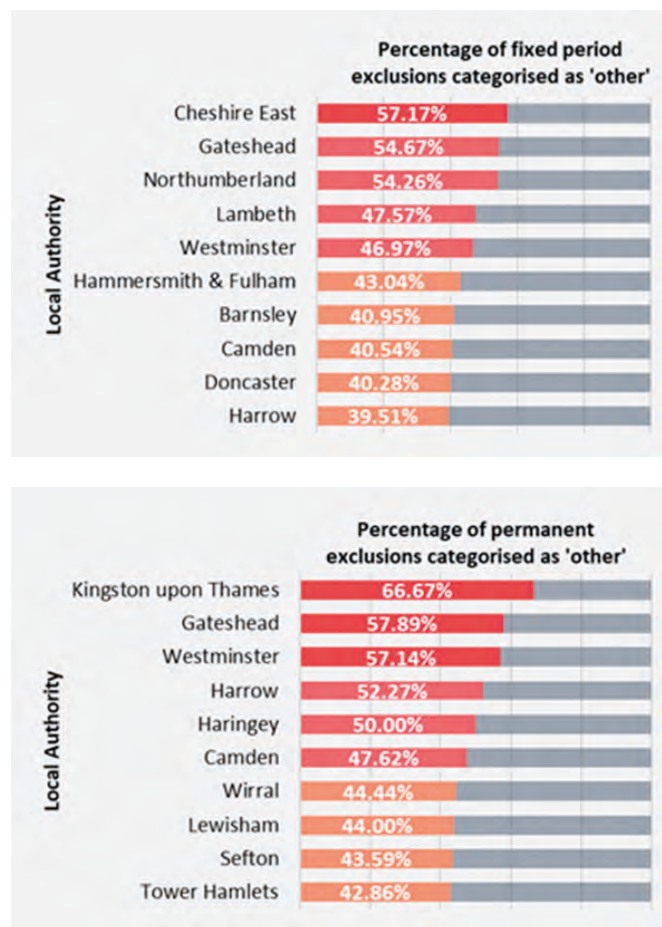


Figure 3. Top ten local authorities with the highest percentage use of the reason 'other' for **fixed period** and **permanent** exclusions

**Table 2.**

Number and rate of pupils who received a **fixed period** exclusion categorised as 'other'

| Local authority       | Total pupil population | Number of pupils excluded ('other') | Rate <sup>3</sup> of pupil exclusion ('other') |
|-----------------------|------------------------|-------------------------------------|------------------------------------------------|
| Hartlepool            | 15,192                 | 1,818                               | 11.97%                                         |
| Doncaster             | 47,364                 | 4,314                               | 9.11%                                          |
| Redcar and Cleveland  | 21,931                 | 1,708                               | 7.79%                                          |
| Barnsley              | 33,709                 | 2,392                               | 7.10%                                          |
| Northumberland        | 45,257                 | 2,344                               | 5.18%                                          |
| Middlesbrough         | 24,197                 | 913                                 | 3.77%                                          |
| Sunderland            | 40,202                 | 1,444                               | 3.59%                                          |
| Cheshire East         | 53,303                 | 1,893                               | 3.55%                                          |
| South Gloucestershire | 39,141                 | 1,152                               | 2.94%                                          |
| Gateshead             | 28,409                 | 813                                 | 2.86%                                          |
| <b>Total</b>          | <b>348,705</b>         | <b>18,791</b>                       |                                                |

Source: DfE, 2018; 2019b

**Table 3.**

Number and rate of pupils who received a **permanent** exclusion categorised as 'other'

| Local authority        | Total pupil population | Number of pupils excluded ('other') | Rate <sup>3</sup> of pupil exclusion ('other') |
|------------------------|------------------------|-------------------------------------|------------------------------------------------|
| Gateshead              | 28,409                 | 57                                  | 0.12%                                          |
| Tameside               | 36,326                 | 97                                  | 0.09%                                          |
| Harrow                 | 36,120                 | 44                                  | 0.06%                                          |
| Trafford               | 41,285                 | 67                                  | 0.06%                                          |
| Blackpool              | 18,771                 | 42                                  | 0.06%                                          |
| Lancashire             | 170,689                | 324                                 | 0.06%                                          |
| Lewisham               | 40,501                 | 50                                  | 0.05%                                          |
| Kensington and Chelsea | 12,959                 | 21                                  | 0.05%                                          |
| Redcar and Cleveland   | 21,931                 | 59                                  | 0.05%                                          |
| Bedford                | 28,252                 | 54                                  | 0.05%                                          |
| Middlesbrough          | 24,197                 | 42                                  | 0.05%                                          |
| <b>Total</b>           | <b>459,440</b>         | <b>857</b>                          |                                                |

Source: DfE, 2018; 2019a

## Conclusion

This policy brief has provided evidence that indicates the exclusion reason 'other' is not being used sparingly across all LA areas in England and in some cases the use is prolific. A possible explanation for this could be the lack of adequate reasons available in guidance that do not encapsulate why children are excluded from school (Centre for Social Justice, 2018; DfE, 2019c). This view is strengthened by the data showing that nationally 'other' exclusions amount to over 20% of **fixed period** exclusions and 18% of **permanent** exclusions in 2017/18. Until the reasons why children are excluded from school are fully understood, there will continue to be a substantial gap in the administration data surrounding why children are excluded from school.

2. The way exclusions are recorded and the descriptions of the reason(s) are different for each nation in the UK (see Table 4). We would recommend that schools are able to record multiple reasons for school exclusion in order of severity (where there is more than one contributing factor). There must be the option to add limited text in place of the category 'other' replicating the policy in Northern Ireland. These changes combined would allow for greater accuracy in the data capture in relation to school exclusions. It is also recommended that the DfE report all the captured data for the purposes of further analysis.

<sup>3</sup>The rate of pupil exclusion ('other') uses the same rate calculation that appears in statistical releases (DfE, 2017a), however it is specific only to exclusions categorised as 'other'.

## Recommendations for policy

1. The reasons head teachers choose the 'other' category when reporting school exclusions needs to be better understood. If specific reasons were known, similarities could be identified to inform new and relevant descriptions of why children are excluded from school. These additional reasons may highlight new patterns of behaviour among groups and reduce or eliminate the need for the 'other' category.

**Table 4.**

Differences in the recording of school exclusions across England, Scotland, Wales and Northern Ireland

| Nation           | Number of categories | Multiple reasons recorded | Multiple reasons reported | Option for free text | Option of 'other' category |
|------------------|----------------------|---------------------------|---------------------------|----------------------|----------------------------|
| England          | 12                   | No                        | No                        | No                   | Yes                        |
| Scotland         | 29                   | Yes                       | Yes                       | No                   | Yes                        |
| Wales            | 12                   | No                        | No                        | No                   | Yes                        |
| Northern Ireland | 11                   | No                        | No                        | Yes                  | No                         |

Source: DfE, 2017a; Scottish Government, 2018; Welsh Government, 2019; DfE in NI, 2015a; 2015b

## Limitations

The main limitation with this research is that by using administrative data, the analysis is based on aggregate figures per LA, not at school level. There may be instances where the majority of schools within an LA area use 'other' sparingly but a minority of schools do not. Additionally, the data concerns state-funded primary, secondary and specialist schools only and not all types of provision such as nurseries and independent schools. It could also be argued that the rate of children excluded may not reflect the true nature of exclusions as children can receive multiple exclusions per year and that rate calculations include sole and dual main registered children which may exaggerate figures. However, as the DfE argue, the calculation 'more accurately reflects the number of pupils who could be excluded, resulting in more accurate exclusion rates' (2017a, p.9).

## Method

This research utilised data on school exclusions from 153 LAs published by the DfE and Office for National Statistics (2019b). Percentages were calculated for each of the twelve reasons for exclusion, with those recorded as 'other' mapped by LA area (see Fig. 1 and 2). The DfE guidance (2017a) suggests 'other' should be used sparingly, however to the authors' knowledge, this term does not hold any numerical value. Therefore a range of 0-4.99% was selected to represent appropriate usage of this category (this is approximately equivalent to 1-in-20 exclusions or fewer). The remaining bands increased in increments of 10% to aid readability (see Fig. 1 and 2). The rate of children excluded due to 'other' was calculated using pupil population (DfE, 2018) and exclusion data for each LA area (DfE, 2019b).

## Further research opportunities

To contribute to more effective policy design, further research is needed to understand the behaviours children are presenting with that lead head teachers to select the 'other' category.

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## Appendices

### Appendix 1

**Table 5.**

Local authority key for Figures 1 and 2

|                                 |                                     |                      |                              |                                        |
|---------------------------------|-------------------------------------|----------------------|------------------------------|----------------------------------------|
| <b>A</b> Richmond upon Thames   | <b>K</b> Southwark                  | <b>9</b> Wigan       | <b>19</b> Halton             | <b>29</b> Slough                       |
| <b>B</b> Kingston upon Thames   | <b>L</b> Lambeth                    | <b>10</b> Bolton     | <b>20</b> Stoke-on-Trent     | <b>30</b> Windsor and Maidenhead       |
| <b>C</b> Hammersmith and Fulham | <b>1</b> Newcastle                  | <b>11</b> Bury       | <b>21</b> Telford and Wrekin | <b>31</b> Bracknell Forest             |
| <b>D</b> Kensington and Chelsea | <b>2</b> Stockton-on-Tees           | <b>12</b> Rochdale   | <b>22</b> Nottingham         | <b>32</b> Wokingham                    |
| <b>E</b> Westminster            | <b>3</b> Middlesbrough              | <b>13</b> Tameside   | <b>23</b> Leicester          | <b>33</b> Reading                      |
| <b>F</b> City of London         | <b>4</b> Blackburn with Darwen      | <b>14</b> Stockport  | <b>24</b> Wolverhampton      | <b>34</b> Southampton                  |
| <b>G</b> Islington              | <b>5</b> City of Kingston upon Hull | <b>15</b> Manchester | <b>25</b> Dudley             | <b>35</b> Bournemouth                  |
| <b>H</b> Hackney                | <b>6</b> Liverpool                  | <b>16</b> Trafford   | <b>26</b> Sandwell           | <b>36</b> Poole                        |
| <b>I</b> Waltham Forest         | <b>7</b> Knowsley                   | <b>17</b> Salford    | <b>27</b> Coventry           | <b>37</b> Bath and North East Somerset |
| <b>J</b> Tower Hamlets          | <b>8</b> St. Helens                 | <b>18</b> Warrington | <b>28</b> Luton              | <b>38</b> City of Bristol              |







## Policy Brief

# Out of sight, out of mind? Managed moves in England

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## Summary

Children move schools or enter alternative provision without an official exclusion through a process known generically as a managed move (Hutchinson and Crenna-Jennings, 2019). Managed moves have been defined in previous Government guidance as a process that enables a child to have a fresh start in a new school; when their current school place is no longer deemed to be viable due to the child's behaviour (DCSF, 2008) and/or a breakdown in relationships with teachers (Muir, 2013; Craig, 2015; Bagley and Hallam, 2016).

This policy brief shares the findings from freedom of information (FOI) requests that were sent to 149 Local Authorities (LAs) in England. The questions asked were:

- Does the LA record data on managed moves?
- How many children have had one or more moves in the last two years?
- How many of the managed moves in the last two years were successful?
- What was the reason recorded for the new school placement failing?

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<sup>1</sup>A permanent exclusion is defined as 'when a pupil is permanently barred from school premises' (DfE, 2017b, p.56)

## Why are managed moves used?

Current research suggests managed moves are the main approach used as an alternative to excluding children from school (Gazeley et al. 2015; Mills and Thomson, 2018; Craggs and Kelly, 2018). They are believed to be an alternative for children who are on the edge of permanent school exclusion and are thought to give children the opportunity to form new relationships, escape previous reputations and experiment with new behaviours in school (Flitcroft and Kelly, 2016). As early as 2004, the DfES raised concerns regarding managed moves, reporting that they did not address any underlying difficulties children may have. This view is supported by research that found managed moves are commonly used where a child displays behavioural difficulties linked to special educational needs (SEN) and/or social, emotional, mental health (SEMH) needs (Chadwick, 2013; Craig, 2015; Hoyle, 2016; Atkinson, 2017).

## Who agrees the managed move?

The managed move process should be a voluntary arrangement between the child, caregivers and the admission authority for the new school (DfES, 2008; DfE, 2017). However, research from the Children's Commissioner Office (2019) and Hutchinson and Crenna-Jennings (2019) found that some families felt pressured into agreeing to a managed move to prevent their child being permanently excluded.

## What are the issues with managed moves?

Since 2008, concerns have been raised over the increasing use of managed moves despite their frequent failure (Gazeley, 2010) and use across England without Government monitoring (Messeter and Soni, 2017; Martin-Denham, 2020); causing some children to be lost in the system (Ofsted, 2010). More recently, Ofsted (2019) called for the Department for Education to collect data on managed moves as the exact number was unknown. They added that nationally they do not know how many children were 'managed moved' to a different school, why they moved, how long for, or with what effectiveness. Hutchinson and Crenna-Jennings (2019) raised concerns that there is no transparency over the cause and prevalence of managed moves. They added that there are varying processes and a lack of knowledge of how supportive caregivers are of the process.

## Method

For this policy brief, we sent Freedom of Information Requests (FOI) to 149 LAs who were educational authorities for their area. Of the 149 authorities, 55 were Unitary Authorities, 36 were Metropolitan Districts, 32 were London boroughs and 26 were County Councils. The request contained questions on the number of single and multiple managed moves, the success rate and the reasons for the managed move being unsuccessful (see Appendix). The requests were sent between January and February 2020.

## Findings

### Part A. Number of Local Authorities that record data on managed moves

The findings section is split into five sections, each relating to one of the questions from the FOI request. All data are available to view on a supplementary table online.

Of the 149 LAs that were sent FOIs on managed moves, 133 (89%) responded in time for publication (35 working days after the initial request). Of these, 71 (53%) held data on managed moves, 58 (44%) did not hold any information and 4 (3%) refused to share their information on economic grounds. Of the LAs that held data, 51 (72%) were able to report the number of managed moves and 20 (28%) reported partial information, for example they only:

- Answered one question
- Reported one year's worth of data
- Reported one phase of education
- Reported some LAs within catchment area

### Part B. Number of children who have had at least one managed move

There were 54 LAs who reported they held data for 2017/18 and 56 LAs for 2018/19. The analysis showed that 4,190 children across England had one managed move in 2017/18, increasing to 4,720 in 2018/19. All LAs acknowledged that as schools are not legally required to record and share managed move information, their data would have significant inaccuracies.

### Part C. Number of children who had multiple managed moves

There were 40 LAs who reported they held data for 2017/18 and 43 LAs for 2018/19. In 2017/18, there were 182 children who had more than one managed move which increased to 185 children in 2018/19. To protect the identity of children, there were three LAs that responded with either <5 or <3 for 2017/18 and five for 2018/19; these were not included in the totals.

### Part D. Number of managed moves that were successful

There is difference in the managed moves protocols of LAs as some deemed a placement successful when the child enrolled onto the receiving school beyond the 12-week period. Whereas others reported using managed moves to give school staff a short break, allowing pupils to return to their original school after a short period of time.

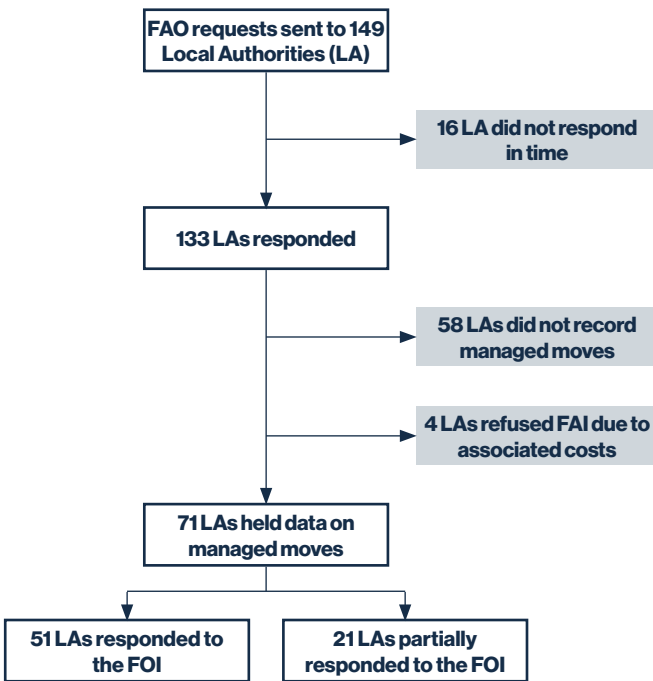


Figure 1. Local Authority response to the FOI request (2017/18)



2017/2018

Based on the data collected using FOIs, the average success rate for managed moves in England in 2017/18 was 42%. The success rate ranged from 3% (City of York) to 100% (Plymouth City). Figure 2 presents the top ten LAs with the most and least successful managed moves in 2017/18.

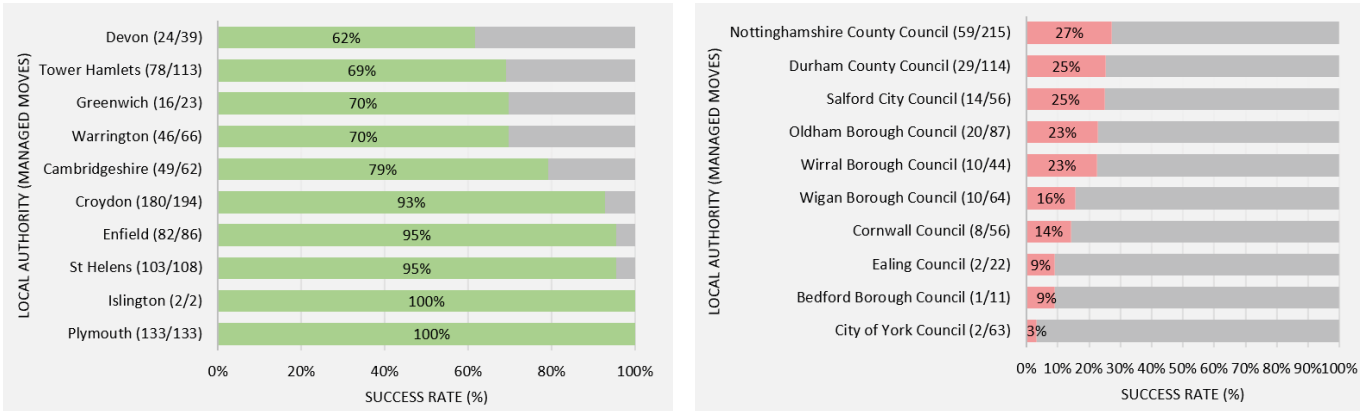


Figure 2. Local Authorities with the most (left) and least (right) successful managed moves (2017/18)

2018/2019

For 2018/19, the average managed move success rate decreased from 42% to 38% and ranged from 0% (Windsor and Maidenhead) to 100% (Plymouth City). Figure 3 presents the top ten LAs with the most and least successful managed moves in 2018/19.

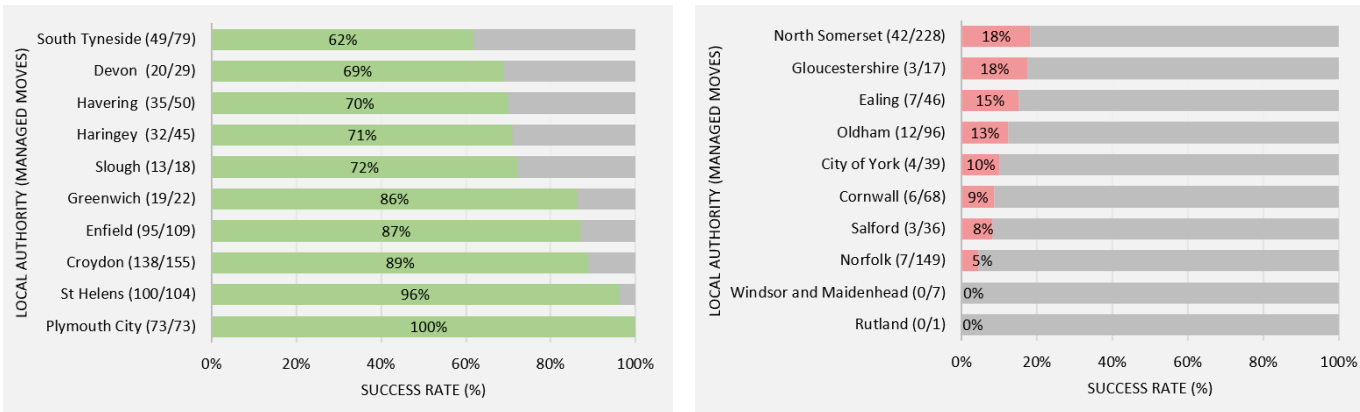


Figure 3. Local Authorities with the most (left) and least (right) successful managed moves (2018/19)

Part E. The reported reason why the managed moves were unsuccessful

Of the 71 LAs, 15 were able to report the reasons for unsuccessful managed moves. The LAs that recorded this data generally used published exclusion reasons (DfE, 2020) and additional reasons such as:

1. poor behaviour
2. student not complying
3. disruptive behaviour (separate from persistent disruptive behaviour)
4. increasing disruptive behaviour (separate from persistent disruptive behaviour)
5. young person was unhappy
6. poor social engagement with peers
7. fireworks
8. school behaviour policy breach
9. returned to home school
10. failure to follow instructions
11. extremely unhappy and impacting on mental wellbeing
12. parental choice to return
13. behaviour escalating
14. truanting
15. defiance
16. refusing to attend the new school
17. moved out of the area
18. one-off serious incidents

There appears to be some crossover with statutory exclusion reasons (DfE, 2020) and the above as the exclusion reason 'persistent disruptive behaviour' appears to be similar to the 'poor behaviour', '(increasing) disruptive behaviour', 'behaviour escalating' and 'defiance'. However, what is quite concerning, is that schools were able to terminate a managed move for a range of reasons that are not properly defined in legislation nor recorded universally.

Concluding remarks

This policy brief set out to better understand the extent and success of managed moves in England. One of the most significant findings from this research is that there is variability across England in how likely a managed move is to fail or succeed. It is important to acknowledge that due to a lack of accountability, this piece of research is unable to share the full extent of managed moves in England due to clear gaps in administrative data capture.

The findings show that less than half of the LAs held any data on managed moves, and approximately a third were able to report the number of managed moves over the last two years. This suggests that there is a lack of data captured by local areas, so the effectiveness and justification for the managed move protocol cannot be evaluated at a local or a national level.

The FOI requests identified that a managed move can be terminated for a range of reasons that include statutory exclusion reasons (DfE, 2020), but also minor reasons such as 'poor behaviour', 'young person was unhappy' and 'defiance'. With limited data on this issue and no clear guidelines on when to terminate a managed move, schools will continue to have the power to potentially end placements for unclear reasons. This study has raised important questions about the nature of the managed move process and further evidences the need for improvements in administrative data.

Recommendations for policy

**Recommendation:** The findings of this research compliment those of Hutchinson and Crenna-Jennings (2019) who suggest managed moves should be recorded and reported on in a similar manner to legal school exclusions. A key policy priority should be to add managed move data to the school census return.



## Limitations

This research is based on FOI requests that were sent to local authorities. Legally, schools (including maintained schools and academies) are not required to record or share data on managed moves with their corresponding authority (Messeter and Soni, 2017; Hutchinson and Crenna-Jennings, 2019; Ofsted, 2019; 2020). This means that reported data and the data within this brief is subject to significant inconsistencies.

The FOI did not request information on the destinations of children following a managed move to keep the cost of the FOI down for each LA. However, some authorities acknowledged they did not record managed moves when a child moved to a school in another locality.

## Further research opportunities

Further research should investigate the true prevalence and success rates of managed moves by collecting data directly from schools. This should also include an investigation into the reasons why the managed move was necessary and the reasons for any failed placements. Research should also attempt to learn from the LAs that reported high managed move success rates to justify the protocol.

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## Appendix

### Freedom of Information Request

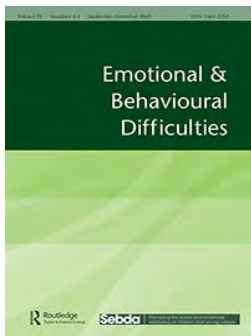
Please can you provide the following data in relation to managed moves in schools over the last two academic years (2018/19 and 2017/18 or equivalent – please state where this is the case):

- number of children who have had a managed move
- number of children who have had more than one managed move
- number of managed moves that were successful (i.e. where children remained in their school beyond the 12-week period)
- the reason why the managed moves were unsuccessful (if recorded)



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## Riding the rollercoaster of school exclusion coupled with drug misuse: the lived experience of caregivers

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ARTICLE



## Riding the rollercoaster of school exclusion coupled with drug misuse: the lived experience of caregivers

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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. 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

### 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 Katsipataki 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 (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, 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 2019). 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, Donaghue., and Benstead 2017; Martin-Denham 2020a, 2020b, 2020c). Horridge (2019) 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, 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 and Emond 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 2019). 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, Donaghue, and Benstead (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 2020a, 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 Donnermeyer (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 (Department for Education and Employment) 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 Frederickson 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, Dekovic, and Prinzie 2013). Strong sibling bonds have been shown to provide protection and emotional support during adversity (Buist, Dekovic, and Prinzie 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 2019 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, Horrocks., and Brooks. 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 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 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, Horrocks., and Brooks. 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 Nicolson 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 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

### *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.

**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<br>PeX (2) Drug related/<br>Persistent disruptive behaviour<br>One unsuccessful MM                                              | No formal diagnosis | Xanax                                                | One younger sister                                           |
| Father Jacob              | No                | Tom 16             | FeX (multiple) Persistent disruptive behaviour/<br>Drug related<br>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/<br>Drug related<br>PeX (1) Verbal abuse/<br>threatening behaviour against an adult                                             | No formal diagnosis | Green, ecstasy                                       | One younger sister, one older brother and two adult siblings |
| Mother Zita, Father Karim | Yes               | Mo 15              | FeX (multiple) Persistent disruptive behaviour/<br>Physical assault against a pupil<br>PeX (1) Verbal abuse/<br>threatening behaviour against a pupil<br>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

### 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 1999). 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) 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. The analysis was inductive in that it used interpretative analysis of the data that was grounded in close examination in the views of the caregivers (Smith and Osborn 2015). 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 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, Jarman., and Osborn 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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### Notes on contributor

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# The benefits of school exclusion: Research with headteachers in England

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May 2021



## Summary

This policy brief is based on the thematic analysis of interviews with 46 headteachers (HTs) regarding their views on whether or not there are benefits to school exclusion. Through thematic analysis, the findings showed a 50/50 divide of HTs who described benefits of the practice of school exclusion and those who acknowledge there was no benefit to the child, family, or school. The benefits shared included: to keep staff and other children safe, to give the child and caregivers time to reflect on the seriousness and consequences of their behaviour and to find external solutions. Those who proposed there were no benefits to school exclusion based their views on the belief they did not solve the behavioural difficulties but rather gave children a few days off school to enjoy themselves.

## Introduction

### **The extent of school exclusions in England**

‘Fixed period’ and ‘permanent’ school exclusions, were introduced by The Education Act (1986, c. 61) allowing the removal of a child from school if they were deemed to be persistently or severely deviating from the school’s behaviour policy, and when allowing them to remain would seriously harm the education or welfare of others (DfE, 2017).

Between 1995-96 and 2011-12 the DfE (2018) reported a downward trend in school exclusions that rose again in 2012-13. Later data from 2018-19 showed a marginal decrease of 11 permanent exclusions when compared to the previous year (DfE, 2020)

with fixed period exclusion rising from 410,000 to 438,300. Furthermore, this most recent data highlighted those children designated as having special educational needs on (SEN) support were five times more likely to be permanently excluded, and 2.5 times for those with an Education, Health and Care Plan (EHCP).

### **Why should we care about school exclusions?**

It is widely accepted that children excluded from school have an increased risk of poor educational outcomes (Social Exclusion Unit, 1998; Office of the Children’s Commissioner 2017, Martin-Denham 2020a; 2020b; 2020c; 2020d; 2021a; 2021b) and a short- and long-term detriment to their mental health and wellbeing and that of their wider family (Martin-Denham, 2020a; 2020b; 2020c; 2020d; 2021a; 2021b). The

DfE (2017, p.6) state ‘disruptive behaviour can be an indication of unmet needs. Where a school has concerns about a pupil’s behaviour, it should try to identify whether there are any causal factors and intervene early in order to reduce the need for a subsequent exclusion’. The SEND code of practice (DfE and Department of Health (DoH), 2015, p.97) also requires ‘a detailed assessment of need should ensure that the full range of an individual’s needs is identified, not simply the primary need’. The **current body of works by Martin-Denham (2020-2021)** suggest that these statutory requirements are not consistently undertaken in schools leading to increasing numbers of school exclusions.

**The benefits of school exclusion**

Limited conclusions have been made as to the effectiveness of school exclusions, as there is scarce evaluation of these practices

in academic research (Obsuth et al., 2017). The DfE (2017) statutory guidance on school exclusions makes no reference to the benefits, though it does state:

‘Where a pupil has received multiple exclusions or is approaching the legal limit of 45 school days of fixed-period exclusion in an academic year, the head teacher **should** consider whether exclusion is providing an effective sanction (p. 11)’.

There is little historical evidence that exclusion improves behaviour in school (Skiba, 2000), and researchers have suggested that such practices fall short due to their reluctance to identify the child’s underlying difficulties (Theriot, Craun and Dupper, 2009; Bowman-Perrott et al., 2013; Martin-Denham, 2020c). Scenarios in which a child is excluded multiple times further illustrate the shortcomings of how exclusions are implemented in their current state.

Participants

There were 35 female HTs (76%) and 11 male HTs (24%). The HTs who took part in the research were all employed in schools in Sunderland (Table 1).

**Table 1. Number of schools interviewed out of all schools in Sunderland**

| Type of School        | Number of schools in Sunderland | Number of schools in the study | % of schools |
|-----------------------|---------------------------------|--------------------------------|--------------|
| Mainstream primary    | 62                              | 25                             | 40%          |
| Mainstream secondary  | 18                              | 9                              | 50%          |
| Nursery school        | 8                               | 4                              | 50%          |
| Special school        | 7                               | 4                              | 57%          |
| Alternative provision | 6                               | 4                              | 67%          |
| Total                 | 101                             | 46                             | 46%          |

# Findings

Following thematic analysis, two themes were generated; **'benefits of school exclusion'** and **'no benefit to school exclusion'**.



Fig 1: Themes and their components generated through thematic analysis.

## Benefits of school exclusion

Half of the HTs (across all age phases) suggested that school exclusions did have benefits.

### The safety of staff and other children

HTs reported that the main benefit of school exclusion was to keep their staff and other children safe. They felt concerned that allowing the child to remain in school endangered other students and staff, and that exclusion was the responsible course of action.

A primary HT claimed that exclusion was 'unfair terminology, because they've come to the end of the road in terms of health and safety.' Other primary HTs

agreed that they excluded due to safety reasons as 'the absolute last resort', and 'the bottom line', with another adding:

**'I feel very strongly about exclusions and I wouldn't exclude if I didn't think there was adequate reasons it would always be around safety. There are some children that we make a lot of allowances for and they have additional provision, but the benefit of exclusion in our context has been for the safety of themselves and the other children.'**

Primary school HTs reported dangerous behaviour such as 'assault', 'biting', 'spitting' and 'horrendous aggression' when describing behaviour that they felt warranted exclusion. Secondary HTs also mentioned similar behaviours, and special schools recounted incidents of 'strangulation' and 'premeditated assault'.

The exclusions implemented by HTs also varied in length, therefore their aim also varied correspondingly. While longer fixed-period or permanent exclusions were implemented as a safety measure, some HTs used exclusions for different purposes. One common purpose was to give other children a 'break' or 'respite.' For example, one secondary HT suggested that exclusions could be used so that the student's classmates were 'not having their learning disrupted.' Another secondary HT remarked:

**'School has to have its law and order; we also need to make sure that our children are looked after and safeguarded as best we can. Sometimes that does involve spending some time away from school for different parties - fixed term exclusion - it just allows an incident to die down.'**

Across the interviews, HTs spoke about exclusion in terms of how the child's behaviour was impacting those around them. Secondary HTs indicated that other children's responses to the excluded child's behaviour ranged from 'stressed' to 'terrified'. A primary HT believed that exclusion could alleviate some of these negative impacts on other children:

**'You're sat next to a child that is struggling for whatever reason and can be emotionally unpredictable, so that is going to put stress on you. So, the benefit of that child being removed is that there is a de-escalation of tension in the room.'**

## **Time for the child to reflect**

Most of the alternative provision (AP) HTs felt that fixed-period exclusion was a means for the child to learn that their behaviours were not acceptable by reflecting on what they had done. 'It's about the learning that that's not acceptable and giving them time to reflect.' There was an acknowledgement that they may not actually think about their actions: 'whether they do or not reflect, I don't know.' Another commented that there are children who find it too hard to control their impulses and behaviours, and the way they react, perceiving that having a school exclusion gives them space to think about their reactions.

A few AP HTs described that excluding a child would act as a deterrent to other children:

**'I would use it, also it's for other children to see. This child has punched this child and that child knows we have dealt with it. Do I overuse it? I don't think so. But it's there and mainstream use it in the same way.'**

**'Other students see what's acceptable**

**and not acceptable. They can see that there are consequences and fairness in the system.'**

A primary HT also described using school exclusion to send a message to other children about the behaviour expectations in the school. They felt that the excluded child knows why this is necessary.

The primary HTs agreed with the AP HTs that a benefit of fixed-period school exclusion was that children would have time to reflect on behaviours and to see there were consequences for their actions. One said that:

**'It would normally be two to three days to get through to the parent and the child and the class: yes, that really upset and hurt you all, and that behaviour cannot happen in school, and to start thinking about that this is not behaviour that is normal that can be condoned.'**

The secondary HTs also indicated a benefit of fixed period school exclusion was that 'it gives them a chance to think about what they have done' and 'a chance to talk about what went wrong and talk about what we're going to do moving forward, to reflect on those negative behaviours.'

Most secondary HTs used exclusion to set an example to other children and deter them from non-compliance. 'It's a way of showing pupils that if you do something wrong or display negative behaviour, this is potentially what could happen' and 'to the school there's a benefit the other pupils see that as something they don't want to happen to them; it's a deterrent.' Others felt it was about setting an example:

**'It's about setting a precedent, setting your expectations. If we don't permanently exclude, that is a bit like: why do we bother having rules and law and order? The purpose of a fixed term**



## **exclusion is to reinforce your expectations.'**

Another secondary HT agreed that some children test boundaries: 'There has to come a point where you say 'these are our boundaries and you're not going past them. I think that's probably the only benefit.'

## **To find external solutions**

HTs across all types of schools used exclusions to allow them time and opportunities to seek external solutions, such as managed moves, and aid from external agencies.

Some HTs felt that exclusion allowed the family to seek solutions at another school that was better equipped to cope with the child's needs. One primary HT felt that persisting for so long with one child before exclusion was actually a missed opportunity:

**'Everybody said, "How did you hang onto him for so long?" Behaviour provision could not meet his needs, and they put him on a part-time timetable. As a mainstream school, we hung on to him to the very end; there's opportunity for that transition to be right for him and that just did not work. He's in year eight now and is still not in full-time education.'**

A secondary HT recalled receiving feedback from a child's new school after their own school's exclusion had led to an alternative placement. They concluded from this feedback that 'sometimes, a fresh start can help.' Another secondary HT explained that moving schools may be essential to the child's welfare, as they required 'specialist support.' The role that

exclusions played in changing the child's school was unclear, with one primary HT suggesting that exclusions were 'crucial' to obtaining a specific placement for a child at their school. Another primary HT shared a similar experience, in which they recounted using a fixed-period exclusion to gain the attention of external services:

**'It was successful in a funny sort of way, as it resulted in him getting a place at behaviour support for about two weeks.'**

Primary HTs predominately used fixed-period exclusions to access external support. They had concerns that allowing a child to remain in school would further damage relationships with children and staff, and felt they needed support with managing the child's behaviours. One primary HT used the time the child was on a fixed-period exclusion to:

**'Put some new strategies in place, consult other people think about what you can do differently and get something else in place and get started again, it's really a last resort more often than not.'**

A secondary HT shared a similar approach: 'when I do use exclusion, some of those exclusions are about gathering evidence around EHCP and providing evidence that we cannot manage the child in a mainstream environment.' Similarly, a specialist HT concurred that: 'It is only beneficial as you were then able to get support from agencies. It's a way to a means. We needed intervention from other people.'



## Opportunity for caregivers to reflect

AP, primary and secondary HTs frequently mentioned that they believed school exclusions (mostly fixed period) could help caregivers realise how serious the child's behaviours had become. They used phrases like 'drawing a line' and 'grabbed the parents' attention' when explaining how they believed exclusions impacted a child's parents. One primary HT elaborated that:

**'I knew that Mum and Dad would be really shocked by the fact that I'd actually gone that far, but that made them sit up and take notice, so in a way, that did work. It turned them against us, but actually, it made them realise that he really did need extra help and it wasn't just us saying that he was being a little bit badly behaved.'**

Another primary HT suggested that it would take a 2-3 day fixed period exclusion to really get through to the parent that their child's behaviour was unacceptable. Secondary HTs remarked that they hoped an exclusion would encourage the parents to 'reflect on their child's behaviour', with another suggesting that, unless the exclusion is 'really big' and 'really inconveniences the child or the family', they are unlikely to be effective.

## No benefit to school exclusion

Fifty percent of the HTs said there was no benefit to excluding children from school. This included all four nursery school HTs, 50% of AP HTs, 48% of primary school HTs and 44% of secondary school HTs. The other 50% of HTs, while holding some reservations around exclusion, were able to

list potential benefits and/or recalled using exclusions in their schools.

54% of female HTs and 36% of male HTs reported no benefits of school exclusions, however the sample size for males was small ( $n = 11$ ). A chi-square crosstabulation was conducted to assess the statistical significance of this relationship, and no significant effect was found ( $X^2(1, 46) = 1.09, p = .297$ ). A larger sample size is required to arrive at a statistically informative inference.

## Children want to be excluded

Some of the HTs that did not perceive exclusion to be beneficial felt that children wanted to be excluded, rather than stay in school. One HT minimised the impact of a temporary exclusion on a child as 'a couple of days off', adding that the impact on the parents would simply be that they would be able to have a 'lie-in.' Another HT suggested that children 'enjoy' being excluded, a view shared by two other HTs:

**'It pains me to exclude some children because I know that that's what they want; they want to go home and have two to 10 days with their parents, depending on the type of parent that sending them home to.'**

**'Some of the students are poorly behaved deliberately in order to be excluded; they want to play on their Xbox, or be with their mum, or their mum wants them to look after a younger sibling.'**

## Exclusion doesn't solve anything

Some HTs expanded on their belief that there were no benefits to school exclusion by highlighting which facet of the child's situation it fails to impact. One HT claimed that it is not influential in 'changing

behaviour’, while another stated that ‘all that really happens is you just put the problem off.’ One HT emphasised that exclusion results in social isolation:

‘If you’re excluded, you will never learn how to behave if you’re part of the group. Other children might be upset with what you’ve done, however, you still need to be part of the group to learn how to behave.’

Another common argument made by HTs concerning the detriments of

school exclusion was that schools merely used them to absolve themselves of responsibility. One HT felt that exclusions were often used for ‘trivial reasons.’ Two HTs felt that exclusions are encouraged by the government, with one stating:

‘I think the government should have another look at this; it’s encouraging schools to permanently exclude so that they were no longer responsible.’

## Discussion

A common sentiment among HTs was that safety of staff and other children should be prioritised above all else, and they felt that the only way to achieve this was to exclude children exhibiting dangerous/problematic behaviours. It is understandable that schools are unable to manage children with challenging, violent and aggressive behaviours. If HTs are suggesting that the main benefit of school exclusion is to protect the safety of others, there needs to be clarification of whether the children have had a timely and detailed assessment of all needs (DfE and DoH, 2015) to identify causal factors to intervene early (DfE, 2017).

Given the evidence (Martin-Denham, 2020a; 2020b; 2020c; 2020d; 2021a; 2021b), the multifaceted needs of children are not consistently assessed, identified or met in schools, and this results in dysregulated behaviours that are not understood. It could be argued that identifying needs would prevent the drive by schools to use exclusion to secure alternative provision for children unable to cope in mainstream contexts.

The view that a benefit of school

exclusion is that allows the child time to reflect on their behaviours is contested. Martin-Denham (2020c) found that when excluded from school, children did not reflect on their behaviour but instead slept, completed schoolwork or played games. While many HTs were reluctant to use exclusion as a preventative measure for even the most extreme cases, some HTs were comfortable using it liberally, to the extent that they would use it to make a point to the child and/or the caregivers. It is of serious concern that some HTs described a benefit of exclusion was that it was used as a deterrent, to show other children the consequences of not adhering to school expectations.

HTs rarely expanded on their belief that school exclusions were not beneficial, however, some common arguments were made. Some teachers held ethical objections to school exclusion, while other negative attitudes towards such practices originated from a belief that they were not effective. HTs often employed exclusion to prevent further harm, rather than to change behaviour, and attempts to accomplish the

latter were often perceived to be futile. HTs described how exclusions did not change the child's problematic behaviour, a notion supported by research (Skiba, 2000), potentially due to the reluctance to investigate underlying causes (Theriot, Craun and Dupper, 2009; Bowman-Perrott et al., 2013; Martin-Denham, 2020-2021).

The fact that half of the HTs believed that school exclusion had no benefit correlates with research findings that, if anything, it compounds dysregulated behaviours (Martin-Denham, 2020-2021). The HTs in this study agreed that exclusion fails to impact positively on future behaviours, and instead just puts the problem on hold until they return to school.

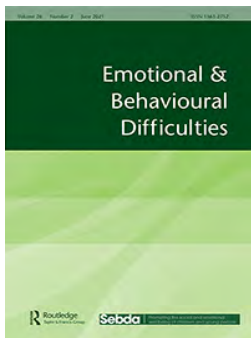
## **National recommendation:**

DfE to update statutory guidance on exclusion to change the terminology from 'should' to 'must', to ensure schools are obligated to address any underlying causes of behaviour, including the use of a multi-agency assessment.

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# Defining, identifying, and recognising underlying causes of social, emotional and mental health difficulties: thematic analysis of interviews with headteachers in England

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## ABSTRACT

In the UK, there is growing concern regarding the increasing prevalence of social, emotional and mental health (SEMH) difficulties experienced by children and young people. Using thematic analysis, this study sought 'to determine how a sample of headteachers (HTs) define, identify and recognise underlying causes of SEMH difficulties'. The analysis found no consensus among the HTs regarding a definition for SEMH, but identified three themes: common characteristics used to define SEMH difficulties; information seeking to identify SEMH difficulties; and how HTs recognise origins and outcomes of SEMH difficulties. The results suggest that headteachers identify behavioural 'problems and difficulties' as a SEN, despite this not being a category within the SEND code of practice. To improve identification and response to SEMH difficulties, it is recommended that the Department for Education revises language in statutory guidance from 'should' and 'could' to 'must', to enforce a legal duty on schools for prompt identification of needs.

## KEYWORDS

Special education; at-risk students; teacher knowledge; educational policy; qualitative research

## Introduction

This article has drawn together unreported data from a two-year study investigating the impact of school exclusion on children's mental health and well-being in the North East of England. The original research examined the barriers and enablers to mainstream schooling through interviews with 174 participants, including 78 education and health professionals, 55 children and 41 caregivers. As part of the original outputs, headteachers' views on how they define, identify and recognise underlying causes of SEMH difficulties were not reported due to time limitations. Previous research indicates that significant gaps exist in professionals' knowledge and understanding of identification of SEMH difficulties in children and young people, compounding risk of exclusion from school (Martin-Denham 2020a). As the SEND code of practice makes explicit, 'the purpose of identification is to work out what action the school needs to take' (Department for Education (DfE) and Department of Health 2015, 97). If headteachers are unable to define what is meant by SEMH difficulties, how can they accurately identify and assess these needs in their learner population. It is important to understand headteachers views on these themes as currently there is a lack of knowledge and understanding of current identification practices in schools (Martin-Denham 2020a).

Children with disabilities are among the most vulnerable in society, with significantly higher mortality rates (The Royal College of Paediatrics and Child Health 2013) and health inequalities (Emerson 2015) than other children, with implications for families and services (Local Government Association 2018). The wealth of evidence shows that mental health difficulties are associated with



reduced quality of life and increased psychological strain (House of Commons 2019; Martin-Denham 2020a). Assessing, identifying, and responding to children's multi-faceted abilities and needs in education, health and social care is fundamental to preventing ill mental health (Martin-Denham 2020a, 2020b, 2020c, 2020d). Horridge (2019) supports the view that when a child's needs are made visible through accurate description and documentation they are more likely to be met. The lack of consensus in defining and operationalising the meaning of 'good mental health', or the validation of a conceptual framework may explain the lack of research attention towards preventative approaches for SEMH for children and young people (Fusar-Poli et al. 2020). Indeed, the National Institute of Clinical Excellence (NICE 2008, 2009) guidance to support social and emotional well-being among primary and secondary age children in schools, reports gaps in research evidence on the effect of preventative approaches. The purpose of this article is to demonstrate the difficulties that educationalists encounter in assessing and identifying SEMH difficulties in children.

## **Definitions of mental health**

### **The World Health Organization (WHO)**

The WHO (2014) defines mental health as:

'A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.

Fusar-Poli et al. (2020, 35) propose the WHO (2014) definition which 'indicates that the absence of mental disorder is not sufficient to experience good mental health' and that good mental health is a state of well-being that allows individuals to cope with normal life.

### **The term 'social, emotional, and mental health' (SEMH)**

Mental health needs were first acknowledged as special educational needs (SEN) in the SEND code of practice for England (Department for Education (DfE) 2015), herein referred to as the 'Code'. This was a deliberate move away from 'behaviour, emotional and social development' in the Department for Education and Skills (2001) Code, to encourage schools to establish the underlying reason for the new broad area of need (SEMH difficulties) (DfE and Department of Health 2015). Norwich and Eaton (2015) believe this was a political move to reduce the number of children categorised as having SEN, as a behavioural difficulty is no longer deemed a SEN. The recent Code (DfE 2015) outlines four broad areas of needs that 'should' be planned for: communication and interaction, cognition and learning, SEMH, and sensory and/or physical needs. SEMH difficulties are described as follows:

'Children and young people may experience a wide range of social and emotional difficulties which manifest in many ways. These may include becoming withdrawn or isolated, as well as displaying challenging, disruptive, or disturbing behaviour. These behaviours may suggest underlying mental health difficulties such as anxiety, depression, self-harming, substance misuse, eating disorders or physical symptoms which are medically unexplained. Other children may have attention deficit disorder, ADHD or attachment disorder' (DfE 2015, section 6.32).

The World Health Organization definition (WHO, 2014) focusses on the outcomes a person with 'good mental health' can achieve using terms such as 'well-being, potential, cope, productively, contribution.' In contrast, the Code's description of SEMH (DfE 2015, 98) includes observable indicators: 'withdrawn, isolated, anxiety, depression, self-harm' and some known risks of SEMH such as 'substance misuse, eating disorders and physical symptoms'. It also includes reference to only three disabilities, omitting many others, which can exhibit comorbidity with ill mental health (Harris et al. 2019; Perera et al. 2020). To achieve the WHO (2014) definition, it is essential to establish government policy that forces stakeholders to assess and identify unmet needs as a protective factor against the adversity of schooling.



Key issues with department for education statutory guidance

A key issue in the Code’s (DfE 2015) statutory guidance is the repeated use of the term ‘should’, which removes schools’ obligation to assess and identify the underlying causes of SEND. The use of non-committal language is found elsewhere in Department for Education guidance is shown in Table 1.

Prevalence of SEMH

The National Health Service (NHS 2020) reported that one in ten children experience mental illness. MIND (2020) added that one in four people would experience mental health problems each year in England. A local study found SEMH difficulties in national assessment years to be 14.03% higher for children in receipt of education, health and care plans (EHCPs) compared to the national average, based on an analysis of 2016 school census data and peaks in SEMH difficulties during these assessment years in 2017 for both primary and secondary education (Martin-Denham, Donoghue, and Saddler 2017). A later study of school census data (2014–2019) showed that SEMH needs increased over five years and were the second most prevalent type of SEN recorded in Sunderland (Martin-Denham and Donaghue 2020a).

Table 1. Use of ‘should and could’ in department for education statutory guidance.

|                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SEND Code of Practice (DfE 2015, 94–95)</b><br><b>Statutory Guidance</b>               | <ul style="list-style-type: none"><li>• A detailed assessment of need ‘<i>should</i>’ ensure the full range of an individual’s needs are identified, not simply the primary need.</li><li>• The support provided ‘<i>should</i>’ be based on a full understanding of their strengths and needs.</li><li>• Schools ‘<i>should</i>’ have a clear approach to identifying SEN.</li><li>• Schools ‘<i>should</i>’ assess each pupils’ current skills.</li><li>• Schools ‘<i>should</i>’ consider evidence that a pupil may have a disability.</li><li>• Class and subject teachers ‘<i>should</i>’ make regular assessments of progress.</li><li>• Assessments of progress ‘<i>should</i>’ identify pupils making less than expected progress.</li><li>• Where progress is less than expected, the teacher working with SENCO ‘<i>should</i>’ assess for SEN.</li></ul> |
| <b>Exclusion from maintained schools (DfE 2017, p.6, 10)</b><br><b>Statutory guidance</b> | <ul style="list-style-type: none"><li>• Where a school has concerns about a pupil’s behaviour, it ‘<i>should</i>’ try to identify causal factors and intervene early to reduce the need for a subsequent exclusion.</li><li>• Schools ‘<i>should</i>’ consider whether a multi-agency assessment that goes beyond the pupil’s educational needs is required.</li><li>• Early intervention to address underlying causes of disruptive behaviour ‘<i>should</i>’ include an assessment of whether appropriate provision is in place to support any SEN or disability.</li><li>• The head teacher ‘<i>should</i>’ also consider the use of a multi-agency assessment for a pupil who demonstrates persistent disruptive behaviour.</li><li>• Assessment ‘<i>could</i>’ go further, for example, by seeking to identify mental health or family problems.</li></ul>     |

Table 2. Intended and actual sample of headteacher (HT) in the original study.

| Participant group         | Intended number of headteachers | Final Number of Headteachers |
|---------------------------|---------------------------------|------------------------------|
| Primary HTs               | 28                              | 28                           |
| Secondary HTs             | 9                               | 10                           |
| Alternative provision HTs | 4                               | 4                            |
| Specialist HTs            | 4                               | 4                            |
| Nursery HTs               | 4                               | 4                            |
| <b>Total</b>              | <b>49</b>                       | <b>50</b>                    |

### *Early identification*

The Code (DfE 2015, 19) states that principles are designed to support ‘the early identification of children and young people’s needs and early intervention to support them.’ The need for prompt identification of SEND has been the outcome of numerous reviews, namely the Bercow Report (Department for Children, Schools and Families (DCSF) 2008); Lamb Inquiry (DCSF 2009); Salt Review, (DCSF 2010); Office for standards in education (2010); and Timpson Review (DfE 2019a). It is accepted that without early identification, children’s difficulties will become increasingly complex, leading to a disruption in pathways to education (Pirrie et al. 2011; Martin-Denham 2020a). For example, research has suggested that internalising symptoms in children as young as two years old can predict emotional symptoms from ages five and upwards (Treyvaud et al. 2012). Horridge (2019) adds that needs that are made visible are more likely to be addressed, reiterating 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’. The reasons children with SEN are not identified promptly are linked with limited training (DfE 2015; Driver Youth Trust 2015; DfE 2018a, 2018b) and a lack of time to explore the reasons for the behaviours (Hastings and Brown 2002; Golder, Jones, and Quinn 2009; Hodgkinson 2009). These compound the challenges encountered by children with complex needs (Gill, Quilter-Pinner, and Swift 2017; Martin-Denham 2020a, 2020b, 2020c, 2020d).

### *Adverse childhood experiences*

The term ‘adverse childhood experiences’ (ACEs) was first introduced by The Centers for Disease Control and Prevention (CDC) Kaiser Permanente ACE study (Felitti et al. 1998). The study investigated childhood abuse, neglect and household challenges. The ACE study’s purpose was to examine the prevalence of ten categories of stressful, traumatic childhood experiences, and whether these had long-term effects (Felitti and Anda 2014). Following their research with 156 graduates, Martin-Denham and Donaghue (2020b) proposed that the original ACE survey does not capture the range of childhood adversities, or the varying level of trauma experienced by the individual. They concluded that current ACE studies underestimate the impact of ACEs on the mental health and well-being of children. Retrospective analysis was conducted in the form of a confidential ACE survey from an obesity clinic, finding that 63.5% of adults had at least one ACE, including experiences such as psychological, sexual and physical abuse, exposure to substance abuse, criminal behaviour, and domestic violence (Felitti et al. 1998; Widom, Horan, and Brzustowicz 2015). A larger study in England revealed that 47% of adults had experienced at least one ACE (Bellis et al. 2014). Exposure to these ACEs has also been found to predict risk factors for leading causes of death in adults (Felitti et al. 1998; Gilbert et al. 2015).

There continues to be no agreement on a standard definition of childhood adversity, possibly due to a lack of knowledge and understanding on how to effectively screen and assess trauma (Anda et al. 2010; Finkelhor et al. 2013; Mersky, Janczewski, and Topitzes 2017). Kelly-Irving et al. (2013, 2) provide a definition of ACEs as ‘Intra-familial events or conditions causing chronic stress responses in the child’s immediate environment. These include notions of maltreatment and deviation from societal norms, where possible to be distinguished from conditions in the socioeconomic and material environment’.

### *Challenging behaviour*

Challenging behaviours such as aggression and non-compliance are associated with reduced academic performance (DiLalla, Marcus, and Wright-Phillips 2004), negative teacher-child relationships and poorer interaction with peers (McMahon and Wells 2006). Nye et al. (2016) suggested that children with identified SEN, where there was an emotional and behavioural component, were

not only at risk of poor outcomes, but were also a challenge for mainstream schools. Schools can be reluctant to accommodate children with disruptive behaviours due to the impact on the teaching and learning of other children (O'Connor et al. 2011). This is reflected by high exclusion rates (The Centre for Social Justice 2011; Martin-Denham and Donaghue 2020c). Fauth, Parsons, and Platt (2014) explain that all children can experience emotional difficulties across schooling, but those with SEN have the additional disadvantage of starting with a higher degree of emotional challenges, which can rapidly escalate. A cumulative risk effect for children identified with SEN is believed to heighten later chances of developing behavioural difficulties (Oldfield, Humphrey, and Hebron 2015).

### ***Social relationships***

The scarce research in this area indicates that children with SEN in mainstream schools have a lower social status than their non-SEN peers (Ochoa and Olivarez 1995; Chatzitheochari, Parsons, and Platt 2016; Nepi et al. 2015; Avramidis et al. 2017; Pinto, Baines, and Bakopoulou 2019), with increased risk of victimisation (Chatzitheochari, Parsons, and Platt 2016). The implications of not having friendships are shown to cause disengagement, loneliness and a negative impact on academic progress (Buhs, Ladd, and Herald 2006; Lubbers et al. 2006; Craggs and Kelly 2018), as well as psychosocial difficulties (Ladd, Herald-Brown, and Reiser 2008; Bagwell and Schmidt 2011). Friendships are fundamental to children achieving a sense of belonging in school (Martin-Denham 2020b). Baumeister and Leary (1995, 497) suggested a definition of the term belonging as 'a need to form and maintain strong, stable interpersonal relationships', concluding 'belongingness is a need rather than a want'. Maslow (1943, 381) explained 'belongingness' as a core psychological need and when children did not belong, and learning needs remained unmet, they would 'hunger for affectionate relationships.' Government guidance (DfE 2016, 8) advises that 'supporting mental health and behaviour in schools' promotes a sense of belonging as a protective factor for building resilience.

### ***Methods***

The purpose of the research was to explore the following research objective 'to determine how a sample of headteachers define, identify and recognise underlying causes of SEMH difficulties.'

Qualitative data is complex (Spiers and Riley 2019), with various procedures for analysing qualitative data existing side by side (Flick 2014). There are standard features of qualitative research, namely that it is studying the outside world with the intention of understanding, describing and explaining social phenomena through the analysis of biographical stories, everyday practices and knowledge and accounts (Flick 2018).

### ***Sample***

For this article, a retrospective sample of 41 headteachers was selected, as these participants were asked the question 'how do you define SEMH difficulties?' Initially, this question was not part of the interview, but was added as it arose as a discussion theme.

Moretti et al. (2011) proposed that it is essential to share the principles and criteria used to select participants, with details of their key characteristics to allow for future transferability of results to other contexts. Furthermore, the data's adequacy depends on robust sampling and saturation (Whittemore, Chase, and Mandle 2001).

The approach to selecting participants in the original study was purposive sampling, as they were met the selection criteria:

- The school had a City of Sunderland postcode
- An overall range of Ofsted ratings from 'inadequate' to 'outstanding'

- An overall range in numbers of high, low and no fixed-period and/or permanent exclusions

### Ethics

Review and approval for the research were gained from the University of Sunderland Ethics Committee in March 2018. The study was conducted under the British Educational Research Association guidelines (BERA 2018), obtaining voluntary informed consent before any data was collected. Silverman (2006) agreed that all social research should be underpinned by informed and free consent, without pressure to agree to take part. Following the Information Commissioners Office (2020) guidance, participants were provided with information sheets and consent forms that included the procedure for processing their data, retention periods for the data, sharing arrangements and privacy information. Participants' right to withdraw, including time frames, was made explicit as per the British Educational Research Association (2018) guidelines. The agreement was sought and gained to record the interviews on a Dictaphone, which were then transcribed verbatim with the omission of personally identifiable information and stored securely in Office 365.

### Recruitment

The headteachers were approached via a letter sent from the research funder, plus a follow-up email sent directly to their schools by the research team (Spiers and Riley 2019). Tables (2–5) show the participant data for those headteachers whose interviews have been used for this article. Table 3 illustrates the number of schools as a percentage of the total number of schools in Sunderland. Table 4 provides the participants' reported gender and Table 5 shows the Ofsted ratings of the schools at the time of the interview.

**Table 3.** Number of schools from which HTs were interviewed.

| Type of school        | Number of schools in Sunderland | Number in sample | % of Schools |
|-----------------------|---------------------------------|------------------|--------------|
| Mainstream Nursery    | 8                               | 2                | 25%          |
| Mainstream Primary    | 62                              | 24               | 39%          |
| Mainstream Secondary  | 16                              | 9                | 56%          |
| Specialist School     | 7                               | 4                | 57%          |
| Alternative Provision | 6                               | 3                | 50%          |
| Total                 | 116                             | 41               | 35%          |

**Table 4.** Reported gender of participants in the retrospective sample.

| Type of school        | Number of females (%) | Number of males (%) |
|-----------------------|-----------------------|---------------------|
| Nursery               | 2 (100%)              | 0 (0%)              |
| Primary               | 18 (75%)              | 6 (25%)             |
| Mainstream Secondary  | 7 (80%)               | 2 (20%)             |
| Specialist School     | 2 (70%)               | 1 (30%)             |
| Alternative Provision | 2 (70%)               | 1 (30%)             |
| Total                 | 31 (%)                | 10 (%)              |

**Table 5.** Ofsted ratings for each type of school.

| Type of School        | Inadequate | Requires improvement | Good | Outstanding | Not yet inspected (new school) |
|-----------------------|------------|----------------------|------|-------------|--------------------------------|
| Nursery               | /          | /                    | /    | 2           | /                              |
| Primary               | /          | 3                    | 20   | 1           | /                              |
| Secondary             | 2          | 2                    | 4    | 1           | /                              |
| Specialist School     | /          | /                    | 2    | 1           | /                              |
| Alternative Provision | /          | 1                    | 1    | /           | 1                              |
| Total                 | 2          | 6                    | 27   | 5           | 1                              |

**Table 6.** Systematic coding of the data.

| Participant code | Central theme                 | Subtheme 1         | Subtheme 1       | Quote                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------|-------------------------------|--------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| HT-Primary 5     | Observing behaviours          | Visible behaviours | Emotional needs  | 'Within the children, I think it is principally really from observations. I think the sad thing is you end up picking up on these things if a child misbehaves or if they are particularly sad and withdrawn. I would suggest that we really know our children well particularly by July, which means they are vulnerable in the first few terms'                                                                                                        |
| HT-Primary 7     | Lack of prompt identification | Visible behaviours | Emotional needs  | 'We don't go looking for that as a category to find; we look at how it manifests itself we will see behaviours and certain behaviours in school and that we work backwards from, so the children that we have got in school with that identified as an area of need coming to school present with a set of behaviours or a set of characteristics.'                                                                                                      |
| HT-Primary 9     | Proactive approaches          | SEN register       | At-risk children | 'We analyse it alongside the SEN register we also look at class provision and those that are doing well academically and any barriers to the learning. In addition, we have regular supervision meetings and record children who are under the umbrella of child protection, child in need, looked after, previously looked after. We use e-comms to update things in school to track anything, to track anything that's social-emotional difficulties.' |

### Procedure

One-to-one, face-to-face interviews were carried out by three researchers between September 2018 and June 2019, with a duration of 30 and 90 minutes. No time limits were imposed, which ensured the participants could give in-depth responses to the open-ended questions (O'Leary 2004).

The use of phenomenological interviews allowed the researcher to secure detailed descriptions of the participants' experiences, feelings, perceptions and understandings of factors leading to school exclusion (Seidman 2012; Vagle 2014). The interviews were structured in their use of pre-determined questions that had to be asked, but were semi-structured in that the interviewer was free to ask secondary questions for clarification or elaboration of responses (Silverman 2017). The interview itself drew upon what Dinkins (2005) described as the 'interpret-view', as they drew on a hermeneutic process whereby the researcher and participants were co-enquirers, reflecting together on the meaning of their experiences through shared dialogue. This approach is advocated by Bell (2014), as it leads to rich data that more structured methods can miss. Before any initial data analysis was undertaken, all of the transcripts were examined to critically assess for any instances of researchers leading the participants to responses (Elo et al. 2014).

### Question design

To ensure the questions were not steering participants to give particular responses, drafts were shared with a critical reference group of academics and external professionals, an approach advocated by Pyett (2003). The purpose was to evaluate the proposed questions to ensure they were understandable, non-leading, non-judgemental and accessible (Elo et al. 2014).

Guthrie et al. (2004) advocate providing a full description of the analysis process to illustrate how the results have been created. Thematic analysis (TA) was selected as a flexible method rather than a methodology, not assigned to a particular theoretical perspective or epistemology (Braun and Clarke 2006; Clarke and Braun 2013).

Braun and Clarke (2006, 6) describe TA as 'a method for identifying, analysing and reporting themes within data.' Thematic analysis is the coding of text according to categories or themes

deemed significant, based on a theory or prior research (Firth 2020). Latent analysis explores beyond what has been said (semantic analysis) and begins to 'identify or examine underlying ideas, assumptions and conceptualizations and ideologies that are theorized as shaping or informing the semantic content of the data' (Braun and Clarke 2006, 84). Owen (1984) suggests that when using TA, it is key to identify repetition (where a participant says the same thing many times), with force and reoccurrence, whereby others say the same or similar views. Braun and Clarke (2006) advocate a six-step process, as follows:

- (1) Immersion in the data through repeated reading of the transcripts
- (2) Systematic coding of the data
- (3) Development of preliminary themes
- (4) Revision of those themes
- (5) Selection of a final set of themes
- (6) Organisation of the final written product around those themes.

### *Step 1. Immersion in the data through repeated reading of the transcripts*

Multiple readings of the transcripts organised by participant group were carried out, making initial notes in consideration of the research question 'how do headteachers define, identify, and recognise underlying causes of social, emotional and mental health difficulties?' An example of early notes is shown below:

Most alternative provision headteachers (HTs) thought it was challenging to define SEMH due to the vast range of behavioural indicators. They used terms such as 'vulnerable, anti-social, disaffection, disengagement, social issues, aggression, extremes, and relationships' within their descriptions of the term SEMH. Early identification was identified as fundamental to support the children with their SEMH difficulties to prevent further school exclusion.

### *Step 2. Systematic coding of the data*

Theoretical TA was used to capture specific data relevant to the objective of the research. Following initial notetaking from the transcripts in step 1, open coding in NVivo 12, a qualitative analysis software programme, was used to simplify the data into smaller observations based on their meaning. Pre-set themes were not used, but new themes and subthemes were developed as the data was analysed. Additionally, previous themes were modified and, in some cases, collapsed. The coding included the central theme, capturing the essence of what was said, and two subthemes for additional aspects (Table 6).

### *Step 3. Development of preliminary themes*

As the coding progressed, themes were organised into broader themes (Table 7), which related directly to the research objective.(Table 8)

### *Step 4. Revision of those themes*

The next step involved asking and responding to critical questions, namely:

- Do the themes make sense?
- Does the data support the themes?
- Are the themes too broad?
- If themes overlap, are they separate themes?
- Are there themes within themes (subthemes)?
- Are there other themes within the data?

(Maguire and Delahunt 2017, 3358).

**Table 7.** Step 3: Example of preliminary themes and subthemes.

| Theme 1                                                                                                                                                                   | Theme 2                                                                                                                                              | Theme 3                                                                                                                                                  | Theme 4                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <b>Unable to cope in school</b>                                                                                                                                           | <b>Lack of prompt identification of SEMH needs</b>                                                                                                   | <b>Finding the root cause of behaviours</b>                                                                                                              | <b>Change in emotions</b>                                                                                |
| <b>Subtheme</b><br>Heightened emotional needs<br>Caregivers raise concerns<br>Challenging, violent or aggressive behaviours<br>Autism is impacting on the emotional state | <b>Subtheme</b><br>SEN register<br>Needs are difficult to identify<br>A spectrum of needs missed<br>Increasing prevalence of mental health needs     | <b>Subtheme</b><br>Using the Early Years Foundation Stage Framework as reference<br>Observing behaviours<br>Caregivers to blame<br>Diagnosis from health | <b>Subtheme</b><br>Child sad or withdrawn<br>Displaying new or unusual behaviours<br>Caregivers concerns |
| <b>Theme 5</b>                                                                                                                                                            | <b>Theme 6</b>                                                                                                                                       | <b>Theme 7</b>                                                                                                                                           | <b>Theme 8</b>                                                                                           |
| <b>Broad Factors</b>                                                                                                                                                      | <b>Observing behaviours</b>                                                                                                                          | <b>External referral processes</b>                                                                                                                       | <b>Diagnosed disabilities</b>                                                                            |
| <b>Subtheme</b><br>Whole-school approaches to SEMH<br>Holistic needs of the child<br>Homelife<br>Exposure to adverse childhood experiences                                | <b>Subtheme</b><br>Teachers using EYFS to assess social and emotional development<br>Frequency of SEMH episodes<br>Difficulties settling into school | <b>Subtheme</b><br>Health professional involvement<br>Information from external agencies                                                                 | <b>Subtheme</b><br>Autism indicative of SEMH needs<br>Need for safe spaces                               |

**Table 8.** Themes and subthemes pre-revision.

| Theme                                                                                                                                                                                                                                     | Theme                                                                                                                                                                      | Theme                                                                                                                            | Theme                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Establishing the root cause of behaviours</b>                                                                                                                                                                                          | <b>Unable to cope in school</b>                                                                                                                                            | <b>Variation in child's emotional state</b>                                                                                      | <b>Unidentified mental health difficulties</b>                                                                                                |
| <b>Subtheme</b><br>Exploring how the behaviour manifests<br>Gathering information from multi-agency professionals and feeder schools<br>Exploring barriers to learning for those on SEN register<br>Gathering information from caregivers | <b>Subtheme</b><br>Unable to cope with day-to-day aspects of schooling<br>Exposure to adverse childhood experiences<br>Isolated, unable to form and/or sustain friendships | <b>Subtheme</b><br>Staff observing changes in child's SEMH<br>Increase in anxiety, challenging violent and aggressive behaviours | <b>Subtheme</b><br>Children's disabilities identified too late<br>Children's SEMH identified too late<br>Too difficult to identify SEMH needs |

The revision process enabled the refinement of the codes and themes to create final themes and subthemes.

- 'Broad factors' and 'observing behaviours' were disbanded and attached to other existing themes that were similarly appropriate.
- 'External referral processes' and 'diagnosed disabilities' were reallocated to 'finding the root cause.'
- 'Inadequate parenting' was collapsed into 'unable to cope in school.'
- 'Using Early Years Foundation Stage (EYFS) milestones' moved into 'finding the root cause of behaviours.'
- 'Finding the root cause of behaviours' amended to 'ascertaining the root cause of behaviours.'
- 'Lack of prompt identification of SEMH needs' amended to 'unidentified mental health difficulties.'

Finally, refinement took place to ensure there were no overlapping subthemes in each of the 'themes'.

**Table 9.** The final set of themes and subthemes.

| Themes                                                             |                                                                          |                                                             |
|--------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------|
| Common characteristics used to define SEMH difficulties            | Information-seeking to identify SEMH issues                              | How HTs recognise origins and outcomes of SEMH difficulties |
| <b>Subtheme</b>                                                    | <b>Subtheme</b>                                                          | <b>Subtheme</b>                                             |
| Unable to cope with the day-to-day aspects of schooling            | Gathering information from multi-agency professionals and feeder schools | Exploring how the behaviour manifests                       |
| Isolated, unable to form and/or sustain friendships                | Gathering information from caregivers                                    | Exploring barriers to learning for those on SEN register    |
| Increase in anxiety, challenging violent and aggressive behaviours | Staff observing changes in child's SEMH                                  | Exposure to adverse childhood experiences                   |
|                                                                    | Children's SEMH difficulties identified too late                         |                                                             |

**Step 5. Selection of a final set of themes**

This stage aims to ‘identify the “essence” of what each theme is about’ (Braun and Clarke 2006, 92). Represents a thematic map based on the research question ‘how do headteachers define, identify, and recognise underlying causes of social, emotional and mental health difficulties?’

**Step 6. Organisation of the final written product around those themes**

Following the coding process, three overarching themes were developed (Table 9).

**Results**

**Common characteristics used to define SEMH difficulties**

**Unable to cope with the day-to-day aspects of schooling**

One primary and one secondary HT agreed that a definition for SEMH included the child’s ability to cope with everyday experiences: ‘When children struggle to cope with everyday things that happen. They struggle to understand that other people have needs and to manage their emotions’ and, ‘It would be linked to a child’s ability to cope with everyday experiences and not being able to manage emotions; not being able to manage social situations, not having a standard response to everyday activities.’

Another felt defining emotional difficulties was about ‘Children who have responses that are outside of the normal spectrum or children who are unable to manage their own emotions.’ One secondary HT felt that SEMH could be defined broadly,

‘It’s almost like on a spectrum where every young person has some SEMH need, but it’s whether they, in their home and school and social environment, with levels of intelligence and self-awareness, can cope with it.’

**Isolated, unable to form and/or sustain friendships**

Many primary HTs referred to children with SEMH encountering challenges in forming and sustaining friendships. ‘A child who is not displaying any kind of issues that would concern you in terms of behaviours but may not be very good at making friends, may be very isolated, that kind of thing’ and, ‘You might have a child who can’t sustain friendships so they might flit from one child to another. They might start off being friendly, nice and happy, but then it turns because they don’t know how to move the relationship to the next level.’ One alternative provision (AP) HT theorised that most of their students fell ‘within the parameters of SEMH and that high levels of prompt social skills support was needed.’ This stance was shared by another AP HT, who felt SEMH was defined by:

‘They can’t talk to each other; they don’t respect each other. They find it difficult to maintain friendship groups; they fall in and out of who likes who. A lot of the social is social media related, so a lot of it is outside. You’re constantly trying to broker these relationships on behalf of the students because they don’t have the skills.’



### *Increase in anxiety, and challenging, violent and aggressive behaviours*

Primary HTs determined that children with SEMH are not managing socially in class.

'Mental health is children who don't manage socially within classes, who demonstrate behaviours that show they are not managing; children who are withdrawn or are acting out for whatever reason, children come into nursery we see needs very early on.'

Challenging, violent and aggressive behaviours of children with SEMH difficulties were shared by a primary HT as: 'Children who have been quite upset over things, who can become quite aggressive without any triggers; bouts of anger that often come from nowhere. It's a change in mood.'

A secondary HT agreed: 'For the children that are really struggling, it's scale ten and they've missed out scale 1,2,3 ... I've seen it more in terms of anger or poor behaviour, or just non-compliance, rather than only distress or upset.' Likewise, an AP HT defined SEMH as: 'They can't regulate their emotions. Something like: a door is smashed, or language, or throwing things, because they haven't got that regulation.' One AP HT explained two extremes when defining SEMH difficulties, from 'Low self-esteem and self-image, lacking in confidence to the other extreme, we are looking for children who unable to sit down, unable to focus, concentrate, who are disruptive and can't form relationships, quite aggressive and unable to be managed in school, at risk of social exclusion.'

### *Information-seeking to identify SEMH difficulties*

#### *Gathering information from multi-agency professionals and feeder schools*

Some secondary HTs referred to being given SEMH information on children from external agencies or feeder schools. 'We look at the children in terms of their emotional needs. If that is a child suffering from anxiety or a child that is suffering from depression, that might have come through to us from outside agencies.' Information on the transition between primary and secondary was relied on by secondary HTs: 'A lot of information we will get through transition from primary school. If there is a clear diagnosis for a child, then we would factor that in as an actual category of SEMH. As a school, if someone presents something, then we will investigate. Whether that is through the SEN department or the educational psychologist.' A different secondary HT described using transition information to identify SEMH difficulties: 'So we go out to the primary school, we often talk to the SENCO in primary schools. On the whole, they would have been categorised.'

#### *Gathering information from caregivers*

A primary HT suggested that caregivers might raise concerns regarding their child's SEMH:

'We also have our parents who come and see us about their child; their behaviour isn't normally what it should be, or they're saying something that is rather alarming, and they panic, and they don't know what to do, and they come into school and talk to us and do we have a conversation about that.'

A secondary HT shared that SEMH difficulties were identified by talking to caregivers and knowledge of the family history. 'It is the history of families that we have had here.' The importance of gathering information from the caregiver was raised by another secondary HT. 'So, what we would do first, is look at the data of that child, we would talk to the family, we would talk to the child.' Similarly, another added, 'I suppose anyone who approaches, or whose parent approaches us for help who have any social emotional mental health need that would trigger a reaction in school.' This line of action was shared by another secondary HT, who said 'We would talk to the family; we would talk to the child. We would gather that together.'

#### *Staff observing changes in a child's SEMH*

All references to this subtheme were from the primary HTs, who reflected that the most prominent way SEMH difficulties were identified was through observations of changes in children's typical

behaviours: 'I think it's principally from observations. You end up picking up on these things if a child misbehaves or if they are particularly sad and withdrawn.' This thinking was supported by the claim that 'teaching staff who have noticed someone may be feeling a bit withdrawn, a little bit quieter than normal, or they may say something that they normally wouldn't say.' A further example was a comment that, 'Something like a social emotional difficulty will come up in the child's behaviour so it could be that the child is stressed, or the child is displaying different behaviours.' Unusual or new behaviours were proposed as common indicators of SEMH difficulties, with another HT sharing, 'We are always alert for children who are behaving out of character not normal, we look for signs from home in terms of how they present themselves in school, children coming in distressed or emotional.' Knowing the children well, and their characteristic behaviours, were identified as key to staff being able to identify SEMH difficulties as soon as they arise:

'We are a family-feeling school. The beauty of it is that we have really strong relationships with the children, so if the children have any concerns and we can notice things straight away, the children will come and talk to us.'

### *Children's SEMH difficulties identified too late*

Most participant groups had concerns regarding a lack of prompt diagnosis and rising prevalence of SEMH difficulties and other disabilities. A specialist school HT observed that: 'Increasingly, we're seeing children with a range [of issues] and the complexities of individual children are rising. Whilst we have children with autism or severe learning difficulties, there are also issues with mental health needs going on, but they aren't diagnosed as such.'

One primary HT revealed that 'We have a high number of looked after children and quite a few who are post-looked after. Those children are coming in with issues because they are late getting into the system, so children have been adopted when they are three or four or older.' Another primary HT reinforced:

'We are seeing an increase definitely. It tends to be when they get to about year five, whether it's when the curriculum changes or expectations change, or whether there are hormonal changes. Whether it's harder to diagnose when they get up the school, I'm not sure. When the children get older, it is becoming more pronounced.'

Likewise, a further primary HT maintained: 'Children that have got autism quite clearly have additional needs. But then there will be a whole load of other children that will be displaying the same or very similar behaviours and you just categorise them.' The view that children were not coping in school due to lack of timely identification was shared by secondary HTs, 'They are not coping in mainstream schools, because of certain underlying causes, which sometimes aren't identified' (secondary HT).

## *How HTs recognise origins and outcomes of SEMH difficulties*

### *Exploring how the behaviour manifests*

Primary headteachers explained 'We don't go looking for SEMH as a category to find, we look at how it manifests itself we will see certain behaviours in school that we work backwards from'. Similarly, another primary HT agreed that they focused on understanding the manifestation of behaviours by trying to:

'Unpick the root causes behind the behaviours, the way a child interacts with others, or it could be something to do with a child's inability to manage their responses, maybe some inhibition going on there. Sometimes it can just be indefinable almost, but you know there is something very, very wrong that's presenting itself as a big barrier to engagement, to compliance, to happiness. Often it is in the manifestation of behaviour that we first begin to see that there is something wrong.'

Secondary headteachers also addressed responses to the manifestation of SEMH difficulties displayed by children. 'It would probably be picked up as a referral from head of house and passed to

our SENCO, or our school counsellor may well be involved depending on what the pupils are showing or displaying.' In the secondary stage of education, it was described as, 'Helpful if the child had a diagnosis, but habitually, when they come to us in Year 7, they don't have that.' Another secondary HT said they relied on visible behaviours:

'The emotional side, I think it's easier to define because that is what we would see on a day-to-day basis. We try and look back at the beginning of their behaviour, what their triggers would be. Not just emotion; it can also be a lack of emotion. It's not just the explosive behaviour, the verbal behaviour the tears, the tantrums, but it can be withdrawal, it can be lack of engagement.'

Both primary and secondary HTs were united on the links between autism and SEMH: 'A lot of our children have social, emotional mental health needs. Obviously, autism comes into that. We have over 20 children in the school who are diagnosed with autism' (primary HT) and: 'We have quite a lot of children who have a diagnosis of autism in school, social emotional links with that. We have children who are displaying signs of concerns with their mental health and well-being and anxiety. That is getting worse' (secondary HT).

One secondary HT described how they consider patterns of behaviour and social interactions to determine SEMH difficulties: 'They go on the code of practice as a result of the investigative work that we would do. Our triggers are normally around behaviour; interactions with peers, interactions with staff.'

### *Exploring barriers to learning for those on the SEN register*

In addressing the origins and outcomes of social, emotional and mental health difficulties, the most common response related to a need to discover and understand the root cause of the child's behaviours. The two nursery HTs drew upon the Early Years Foundation Stage Framework, where personal, social and emotional development are prime areas of learning and development to assess for SEMH difficulties (DfE 2017):

'We use the EYFS framework; we have the PHSE statements which give us a chronological age band which they should be in if they aren't meeting their chronological age levels in PHSE, we have a clear marker data-wise as to where they are at and potential delay.'

Another HT commented: 'What we would do is look to see if children are operating around their age band and if they're not, that's when staff would come forward to me to say they have concerns about a child'. Other primary HTs determine the root cause of behaviours by referring to their SEN registers to identify documented barriers to learning. 'We analyse it alongside the SEN register; we also look at class provision and those that are doing well academically, and any barriers to the learning'. Others recalled referring to other school records for children who were under the child protection umbrella and finding out information from family support workers.

The secondary HTs associated SEMH with children on the SEN register: 'The standard definition of special needs where children might be categorised in terms. I think its SEMH in terms of their special needs. In terms of our recording in school.' It was acknowledged that some children with SEMH needs may not be on the SEN register. 'There might be children that have a need but don't meet the SEND register, or who might have a relatively small need compared to those on the register' and, 'I don't always go on what their SEN needs are, some of it, I will be honest with you, is a gut feeling. I haven't got one definition that I would go with but as a school, we tend to piece parts of the jigsaw together.'

### *Exposure to adverse childhood experiences*

Several primary HTs related SEMH to exposure to adverse childhood experiences, 'ranging from bereavement through to some children who have been fostered and adopted, including children with depression, suicidal tendencies, various family break up issues and the overlap with autism and ADHD.' Contrasting views described different adversities, 'Like domestic violence, ongoing violent

abuse, a parent in prison, abuse or neglect.’ One primary HT proposed that SEMH presents in a range of ways and felt some of it is ‘Normal human experience such as the death of somebody, a divorce, nothing overly complicated but they need something to help them get through it.’ An alternative perspective described children who live in chaos, causing them to be ‘Badly behaved and lashing out, running away, hurting other children, or it could just be that they are withdrawn and won’t talk to others.’ A belief that parents were spoiling children was key in their definition of SEMH for one primary HT:

‘A child who didn’t get his own way and had a toddler tantrum and you would normally say he’s been spoiled. There is an element of a lack of parenting capacity. I know that he has been up ‘til all hours watching Netflix, so there is that element of what he has seen.’

## Discussion

The purpose of the research was to explore the following research objective: ‘to determine how a sample of headteachers define, identify and recognise underlying causes of SEMH difficulties.’ The analysis found no consensus among the headteachers of a definition of SEMH, though the three themes identified common characteristics used to define SEMH difficulties; information seeking to identify SEMH difficulties; and how HTs recognise origins and outcomes of SEMH difficulties.

As per the DfE (2015) description, some headteachers depicted SEMH in terms of the manifestation and features of behaviours observed in school that were beyond the child’s ability to self-manage or change. It was clear from the interviews that the current description of SEMH (DfE 2015) is ambiguous, omitting any thresholds or criteria for schools to determine whether a child has SEMH difficulties, or unidentified or unmet SEND needs. None of the headteachers referred to the ‘state of well-being’, a phrase used in the WHO (2014) definition. When asked to define SEMH, most headteachers referenced observing certain behaviours, leading to raising concerns through school systems and processes. There was a sense that schools are attempting to identify the triggers from patterns of and new and unusual behaviours. However, a barrier to this is a lack of formal diagnosis from health professionals. This study supports previous research, which has found that a lack of prompt diagnosis is a causal factor in the rising prevalence of SEMH difficulties (Martin-Denham 2020a, 2020d).

The definitions provided by the headteachers all share one commonality: that children with SEMH difficulties are under immense psychological strain, supporting findings of the House of Commons (2019) and (Martin-Denham 2020a, 2020c, 2020d). A common term that arose in defining SEMH was a child’s ‘inability to cope’ with everyday experiences, as they were unable to regulate their emotions. Some headteachers included social difficulties as part of their definitions of SEMH, including an inability to form friendships. The issue of sustaining friendships was a particular factor in SEMH difficulties among children in alternative provision following time in mainstream education.

There was some consistency across the age ranges of how the headteachers identified SEMH, with evidence of the existence of mental health needs from nursery to year 11. However, only the primary headteachers talked about how they would use observation techniques to identify underlying SEN. There continues to be immense challenges for schools in terms of resource to support early identification and intervention of children’s needs despite numerous national reviews advocating these principles (DCSF 2008; DCSF 2009; DCSF 2010; Ofsted 2010; DfE 2019). The study suggests that, without early recognition and identification of needs, children are more likely develop challenging, violent and aggressive behaviours, increasing the risk of school exclusion, a finding echoed by Martin-Denham (Martin-Denham 2020a, 2020d).

The findings suggest that headteachers identify behavioural ‘problems and difficulties’ as an SEN, despite the removal of ‘behaviour’ as an SEN category in the DfE (2015) current statutory guidance. Headteachers need better guidance to provide timely identification and assessment of both SEN and

SEMH, as this is the only way to ensure that needs are accurately described, documented and responded to (Horridge 2019). Feeder schools and external agencies were cited as a useful source of information, particularly in the move between primary and secondary education. The analysis has shown that immediate formalised assessment processes are needed to identify SEMH difficulties as advocated in the DfE (2015) Code. The nursery headteachers seemed secure in their processes of identification due to the availability of the EYFS framework and its focus on personal, social and emotional development to assess for SEMH needs.

Headteachers felt that if they broke down SEMH difficulties into the behaviours they associated with these difficulties, they could 'work backwards' to determine the origins of behaviours. Some headteachers felt that exposure to ACEs was a core contributing factor to subsequent SEMH difficulties. They recognised the detrimental impact of adversity on children's mental health, but did not recognise schooling as a potential source of adversity (Martin-Denham 2020a). Headteachers also considered that children with SEN may also present with SEMH difficulties, although some suggested that this association was based on their own instincts rather than thorough investigating any causal association. This notion that addressing the origins of SEMH difficulties necessitates a consideration of comorbidity is further illustrated in headteachers' responses regarding links between SEMH and autism, as some headteachers explained that they had many students with such a diagnosis.

This study recommends a change to the wording in the Department for Education policies on SEND (DfE 2015) and on exclusion from maintained schools (DfE 2017). Specifically, the words 'should' and 'could' need to be revised to 'must'. This would place an explicit duty on schools to identify and assess both SEND and underlying SEMH difficulties, compared with the current position, which does not impose a statutory duty to determine causes of a child's emotional needs. The evidence from this study shows that there is variability on how headteachers from nursery to secondary education identify the underlying causes of SEMH difficulties. Only the Nursery headteachers that have clear criteria to assess within the Early Years Framework. This has resulted in varying approaches adopted across primary and secondary schools. Until these policy changes are made and enforced, there is a risk that the multi-faceted needs of children will not be identified or met. This, increases the risk of education disaffection (Martin-Denham 2020a), with potential for health inequalities (Emerson 2015), increased mortality rates (RCPCH 2013) and reduced academic performance (DiLalla, Marcus., and Wright-Phillips 2004; Nye et al. 2016).

## Limitations

The interpretation of the data and findings of the research were arrived at subjectively by the researcher, and this is a limitation of the study. As Golsworthy and Coyle (2001) explain, no two analysts would interpret data in the same way, which raises questions of validity and reliability. This study was relatively small scale, and the findings could be further refined through a larger scale study.

## Note

This journal article forms the background to a policy brief.

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## SCHOOL EXCLUSIONS

# School exclusion, substance misuse and use of weapons: an interpretative phenomenological analysis of interviews with children

SARAH LOUISE MARTIN-DENHAM

The study presents data drawn from semi-structured interviews with five young people permanently excluded from schools in North East England. The research aimed to investigate the risk factors that led to the children using illegal drugs, and to determine the drivers and implications for drug misuse and the carrying of knives into school. The research also hoped to elicit, from the young people, the solutions that could have prevented their exclusion from school. The interviews were analysed using interpretative phenomenological analysis to understand how a homogenous sample made sense of their lived experiences. The findings highlight the importance of prompt identification and support for children with learning and mental health needs, as the evidence suggests they lead to perceived negative behaviours by teachers. The research provides further evidence that behaviour sanctions in mainstream schools such as detention and isolation booths do not always improve behaviour, and can instead make it worse. Original to this research is the finding that children are consuming drugs before school to cope with their inability to access learning and teaching, to aid their concentration and to medicate themselves to reduce the likelihood of being sanctioned by teachers.

**Key words:** school exclusion, special educational needs, drug misuse, knives, qualitative research.

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## Introduction

Dong and Krohn (2020) raised concerns that few studies that have examined the impact of school exclusion on subsequent negative behaviours including crime and drug use.

Considering this, this research utilises 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 (Martin-Denham, 2020a, 2020b, 2020c). This article focuses on five of the interviews with young people from the original study who were excluded from school, consumed street drugs and/or were caught in possession of a knife in school.

## School exclusions

School exclusion in England refers to a 'disciplinary sanction that prevents pupils from attending school for either a fixed-period or permanently' (Gazeley, 2010, p. 451). The Education Act (1986) first introduced the terms 'fixed-period' and 'permanent' exclusions which enabled the removing a child from school when they were deemed to be persistently or severely deviating from the school's behaviour policy (DfE, 2017a). Various Acts, rights and regulations make explicit that a decision to exclude a child must be lawful, rational, proportionate and fair (Education Act, 2002; European Court of Human Rights, 2010; Education Act, 2011).

The number of permanent exclusions was on a downward trend since 1995–1996 but has been rising since 2012–2013 (DfE, 2018). The most recent 2018/19 data from DfE (2020) is similar to the previous year, in that the rate of permanent exclusions has remained the same but that the rate of fixed-period exclusions has risen from 410,800 to 438,300. Increasing school exclusions have received national attention, with the report into alternative provision (House of Commons Education Committee, 2018) prompting the Timpson Review (DfE, 2019).

Findings by Martin-Denham *et al.* (2017) brought to attention the prevalence of both fixed-period and permanent exclusions being more evident in years 5, 6, 9 and 10 in the lead up to national assessments, coupled with increased social, emotional and mental health difficulties in these school years. This view was, in part, highlighted by Education Datalab (2018) who illustrated spikes in pupil moves in year 10, in the year prior to GCSE examinations, reflecting concerns regarding national assessments and the impact of these on schools retaining low-attaining children (House of Commons Education Committee, 2018).

### ***The relationship between school exclusion and drug misuse***

The correlation between school exclusion and the onset of drug misuse and anti-social behaviour has been widely recognised in England (DfEE, 1997; Home Office, 2004; Martin-Denham, 2020b) and the UK (Stationery Office, 1998; Lloyd, 1998; Miller and Plant, 1999). It is understood that many factors can influence a child's consumption of tobacco, alcohol or drugs including 'early life experiences, family relationships and circumstances, and parental attitudes and behaviour' (Advisory Council on the Misuse of Drugs, 2006, p. 5). McCrystal *et al.* (2007) added that not only was there an increased risk of drug misuse, but also marginalisation from society as adults. NHS Digital (2019) ran an online multiple-choice survey of 13,554 children asking a core set of questions relating to smoking, drinking and drug use. They found children predominantly obtained drugs from friends, outside of school with the main purpose of getting high.

The National Crime Agency (2020) uses the term 'county lines' to describe the coercion and exploitation of children from gangs to sell drugs. They add that there are increased levels of weapon-related crimes and increased levels of violence. Whilst there is limited research on the impact of drug misuse on the wider family, some studies have reported that there is a detrimental impact of drug addiction, not only on the child but on the family unit as it causes devastation and has been linked to poorer parental mental health (Martin-Denham, 2020a, 2020b, 2020c).

### **School exclusion and use of weapons**

DfE (2017b) advise that carrying a weapon is classified as threatening behaviour against an adult or against a pupil. There is growing national concern of the use of serious violence in England and Wales (Smith, 2019) including rising numbers of young people carrying knives (Office for National Statistics, 2019a). The Home



Office (2019) reported that in England and Wales over 17,500 boys aged 14 carry a knife or weapon and a third of those who are armed have also had others use weapons against them. The consequence of this is sentencing statistics reporting around 4500 knife or offensive weapon offences committed by 10- to 17-year olds that resulted in caution or sentencing between April 2018 and March 2019 (Ministry of Justice, 2019). They added that although this is 31% less than the year ending March 2009, the numbers remain higher than five years ago.

The House of Commons (2018, p. 13) shares the view that 'it would be reasonable for schools to take a zero-tolerance approach to drugs or weapons' but not for minor infractions including uniform violations. The Timpson Review (DfE, 2019) asked headteachers to use their judgement when knives or other weapons were brought into school, requesting they consider the 'full circumstances and facts in reaching their decisions' (p. 103). Ofsted (2019) raised concerns regarding the appropriateness of the criminalisation of young people who carried knives and whether it was a criminal offence if the child perceived that they were at risk of harm.

## Barriers to mainstream schooling

A growing body of evidence exists in England (Social Exclusion Unit, 1998; Daniels *et al.*, 2003; Martin-Denham, 2020a) which suggests that young people excluded from school are at increased risk of poor educational outcomes. The international debate on how best to support children with diverse abilities to remain in mainstream education is ongoing (Blatchford and Webster, 2018; Martin-Denham, 2020a, 2020b, 2020c). Researchers and practitioners agree there are many factors in school that affect children's ability to learn, such as the availability of support staff and the number of children in the class. Ofsted (2010) and Martin-Denham (2020b) highlighted the additional barrier of a lack of prompt access to relevant expertise within education, as a diagnosis from health services was often a prerequisite. This view is shared by DfE (2017c) and Johnson *et al.* (2017) who suggested that barriers to providing effective support was due to resource issues and the availability of teaching assistants and external professionals.

A further barrier to mainstream schooling is school exclusions, which by its very nature means time learning is lost, as children are not in school accessing teaching, which may result in lower achievement levels (Smith, 2009; Dong and Krohn, 2020; Martin-Denham, 2020a). The longer children are excluded, or if

they are excluded multiple times, the greater the difficulty of catching up with lost learning and a decreased likelihood of reintegration into mainstream education (Duncan and McCrystal, 2002; Martin-Denham, 2020c).

## Teacher-student relationships

Several studies have explored the relationship between positive teacher-student relationships and good academic-related outcomes (Nind *et al.*, 2012; Furrer *et al.*, 2014; Jalali and Morgan, 2018; Martin-Denham, 2020c). Emotionally supportive teachers in classrooms give the children increased autonomy in improving their outcomes, (Ruzek *et al.*, 2016) acting as a protective factor when they are encountering difficulties within school (Meehan *et al.*, 2003; Martin-Denham and Watts, 2019; Martin-Denham, 2020b). However, many studies note that children feel negatively perceived by teachers, and they feel that this was often due to their past behaviours in school (O'Connor *et al.*, 2011; Nind *et al.*, 2012; Sheffield and Morgan, 2017; Cosma and Soni, 2019; Martin-Denham, 2020a, 2020b, 2020c) resulting in entrenched behaviours from children and reactions from staff (Lopes *et al.*, 2012).

## Belonging

'Belonging' is a complex term which psychologists have, over the years, found hard to define (Cartmell and Bond, 2015). Following a review of literature, an accepted definition was provided by Baumeister and Leary (1995, p. 496) which stated, 'a need to form and maintain strong, stable interpersonal relationships, belongingness is a need rather than a want'. They explained that belongingness is fundamental to wellbeing and healthy development. This is not a new idea, as Maslow (1943), in his hierarchy of needs, described how the need to belong had to be satisfied before other needs could be fulfilled. Furthermore, Baumeister and Leary (1995) agreed that children have a basic psychological need to feel a sense of belonging to a social group. Other studies have suggested that a positive sense of belonging has associations with good mental health, being hopeful about the future (Kidger *et al.*, 2012; Marraccini and Brier, 2017), and importantly, it has a powerful effect on children's emotional, motivational and academic functioning (Craggs and Kelly, 2018). To achieve a sense of belonging, children need to feel cared about and accepted into a community (Cutrona, 1982; Antrop-Gonzalez, 2006; Smedley, 2011; Martin-Denham, 2020c).

## The study design

As typical in interpretive research, qualitative data collection methods were used to capture participant views (Silverman, 2000; Willis, 2007; Nind *et al.*, 2012). The data from the interviews with the children were suitable for interpretative phenomenological analysis (IPA) as they included rich detail with novel stories and language (Smith *et al.*, 2009; Riley *et al.*, 2017, 2018; Spiers *et al.*, 2017, 2018; Spiers and Riley, 2019). The children interpreted their experiences and told their stories in a way that made sense to them in their own words (King *et al.*, 2019). A two-stage process or double hermeneutic was used, where the participant makes sense of their world, and the researcher, in an active role, attempts to authentically make sense of their experiences (Colaizzi, 1978; Giorgi, 1985; Smith and Eatough, 2007; van Manen, 2014) by examining their complex attitudes and emotions (Harding, 2019). The researcher was therefore able to gain an in-depth understanding of the five young people's lived experiences of school exclusions and/or drug misuse and the carrying of weapons (Smith and Osborn, 2008; Smith *et al.*, 2009; Flick, 2018) to provide further insight into topics where currently, little is understood (Tompkins and Eatough, 2012).

## Sample

A small purposive sample was chosen to adhere to the approach of IPA (Collins and Nicholson, 2002; Smith, 2004). They were recruited through schools that provided placements for children who had been permanently excluded from school (Martin-Denham, 2020a, 2020b, 2020c). The convenience sampling ensured the children would have experienced the phenomenon being explored, meeting the following criteria to take part (Smith and Eatough, 2007; Flick, 2018).

- a The child had received fixed-period and/or permanent school exclusions
- b The child had consumed street drugs and/or carried weapons into school

Participants all identified as male and were aged between 14–16 years. They were taught in an alternative provision or a pupil referral unit following multiple school exclusions. Further information on the children can be found in Table 1 and in Figure 1.

## Data collection methods

As recommended by Smith and Osborn (2003), face-to-face and two-to-one semi-structured interviews were adopted as the children chose a safe adult to



Table 1. Sample characteristics

| Name   | Gender | Age | Exclusion      | Isolated in booths at school | Carried weapons   | Drug use                                              | SEND                                                  | Police involved       |
|--------|--------|-----|----------------|------------------------------|-------------------|-------------------------------------------------------|-------------------------------------------------------|-----------------------|
| Noah   | Male   | 14  | PeX – 2        | Yes                          | None              | None but availability discussed                       | SEN support                                           | No                    |
|        |        |     | FeX – Multiple |                              |                   |                                                       | SEMHD awaiting ADHD diagnosis                         |                       |
|        |        |     | MM – 0         |                              |                   |                                                       |                                                       |                       |
| Luca   | Male   | 15  | PeX – 2        | Yes                          | Knife             | Green                                                 | Born <24 weeks gestation                              | Yes (criminal record) |
|        |        |     | FeX – Multiple |                              |                   |                                                       | SEMHD (suspected depression and sensory difficulties) |                       |
|        |        |     | MM – 1 failed  |                              |                   |                                                       |                                                       |                       |
| Zak    | Male   | 16  | PeX – 1        | No                           | Knife             | None                                                  | SEMHD                                                 | Yes                   |
|        |        |     | FeX – 0        |                              |                   |                                                       |                                                       |                       |
|        |        |     | MM – 0         |                              |                   |                                                       |                                                       |                       |
| Ben    | Male   | 15  | PeX – 2        | Yes                          | None              | Green, ecstasy, MDMA, whizz, alcohol, smoking tobacco | (Awaiting ADHD diagnosis)                             | No                    |
|        |        |     | FeX – Multiple |                              |                   |                                                       |                                                       |                       |
|        |        |     | MM – 0         |                              |                   |                                                       |                                                       |                       |
| Carlos | Male   | 16  | PeX – 0        | Yes                          | Knife (suspected) | Green, pills, coke, whizz, alcohol, smoking tobacco   | SEMHD                                                 | No                    |
|        |        |     | FeX – Multiple |                              |                   |                                                       |                                                       |                       |
|        |        |     | MM – 1         |                              |                   |                                                       |                                                       |                       |

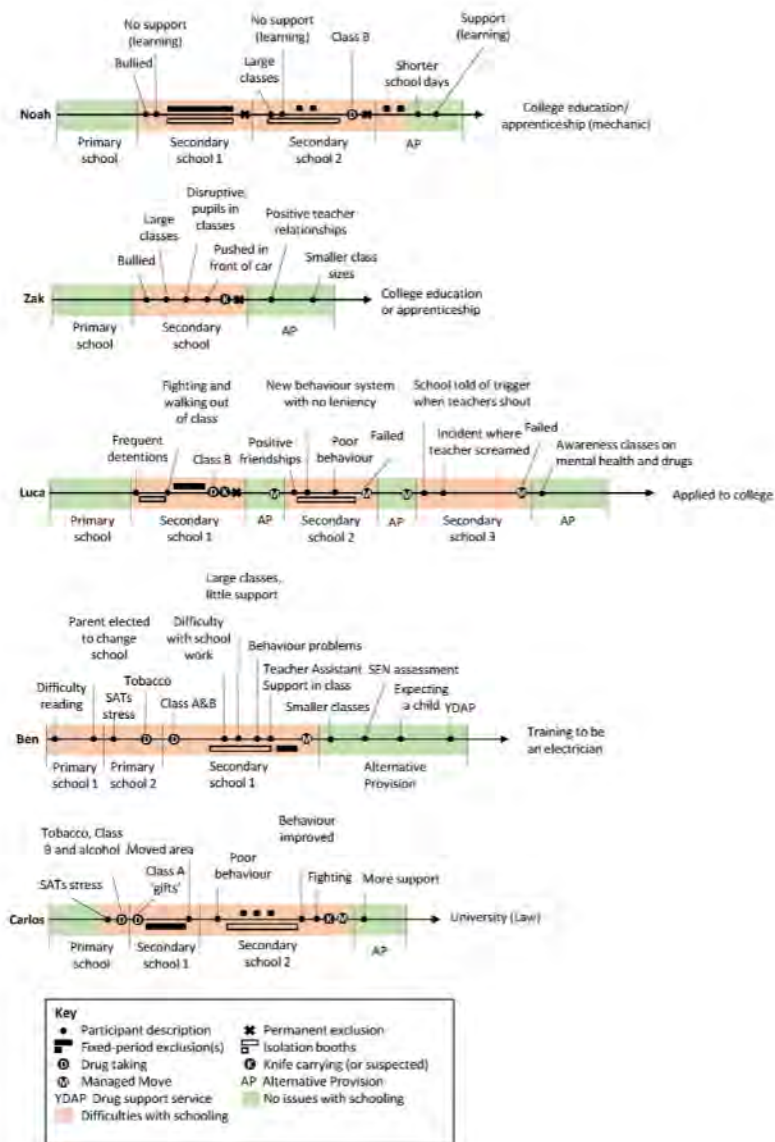


**Figure 1.** Theogeographs of participants' journey through education [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com)]

accompany them. The interviews ranged from 20–40 minutes in duration and took place between September 2018 and June 2019. To support the natural flow of conversation, open-ended questions were used so the children could express their feelings while allowing the exploration of salient points relating to the research aims (O’Leary, 2004). Two of the participants became emotional (tearful) when recounting their experiences of school exclusion and were supported by their trusted adult and the researcher. All children wanted to share their stories and, despite being upset, said they wanted to continue the interviews. This approach is encouraged by the phenomenological method, with the researcher taking a neutral, non-directive stance, focusing on the meaning participants’ make from their experiences (Seidman, 2012) while recognising the participants as the primary expert (Alexander and Clare, 2004). In using this approach, detailed descriptions of the children’s experiences, feelings, perceptions and understanding of the phenomenon were gained (Vagle, 2014). A Dictaphone was used to record all interviews which were then transcribed verbatim with the omission of personally identifiable information.

## The conduct of the study

This research gained ethical approval from the University of Sunderland Ethics Committee and was conducted under the British Educational Research Association guidelines (BERA, 2018). A letter outlining the research project was sent to the children’s caregivers, and this was followed up with a phone call and meeting to gain consent to interview the children (Martin-Denham, 2020a, 2020b, 2020c). Informed consent was obtained voluntarily, from gatekeepers, caregivers and their children before any research was undertaken. In accordance with the Information Commissioner’s Office (2019), the children were provided with information sheets (in the form of a comic strip) and consent form which included the procedure for processing their data, retention periods for the data and who it will be shared with, known as privacy information. Their right to withdraw, including time frames, were made explicit as suggested in the BERA (2018) guidelines.

## Limitations of the study

A limitation of the research is that the findings were an interpretation of participants’ views (Smith *et al.*, 1999) meaning the analytical account produced is the joint reflection of both participant and researcher (Smith *et al.*, 1997; Osborn and Smith, 1998). Clearly, no two analysts would interpret the data the same

way, which can raise questions of validity and reliability (Golsworthy and Coyle, 2001).

## Process of analysis

The participants' names and other identifying information were changed to protect anonymity. In accordance with the principles of IPA, Smith and Osborn (2003) the data were analysed in four broad stages:

- Detailed listening to and 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 participants' experiences in their own words.

During the exploratory themes phase, each transcript was read multiple times to ensure the interpretation was part of the original account rather than the researcher's interpretation (Smith and Osborn, 2003). The themes were then carefully labelled once the overall name was determined. The researcher then revisited the themed transcripts to check accuracy, identify any misconceptions and compare and combine key superordinate themes across the five transcripts.

## Results

The study aimed to investigate the risk factors that lead to a young person misusing drugs and to determine the drivers and implications for drug misuse and the carrying of weapons. The research also hoped to elicit, from the young people, the solutions that could have prevented their exclusion from school. Based on the results of the research, conclusions can be drawn under three broad subordinate themes:

- Drivers, supply and implications of drug use.
- Drivers and implications of carrying a knife.
- Solutions to reducing fixed-period and permanent exclusion.

To present the children's journey through education, a series of graphical timelines or theographs (NHS England and the Health and Social Care Information



Centre, 2013) were made and included key information about the five children in the study (see Figure 1).

## Drivers, supply and implications of drug use drivers for drug misuse

Most of the children said that a driver for taking drugs was to help them cope with and get through the school day without being disciplined. Noah explained that some children smoke 'green' (cannabis) before school to help them concentrate in lessons: 'People smoke it before they go in, they get stoned. Because it makes them concentrate more. You can always tell when you're stoned like because if you are always like moving about and then you'll be sat there doing nothing', Luca agreed that he smoked green to make school easier: 'I've done it before school, I would just be able to sit in my lesson'. Ben seemingly took drugs before school to avoid being told off, though it also prevented him from learning, 'because then if you get wrong off the teachers you would just laugh at them. You can't help but laugh. I just can't help but laugh even if nothing was funny, I would just laugh at myself and put my head down on the table'. In contrast to these views, Carlos maintained he smoked drugs simply because he wanted to, he enjoyed the feeling. These comments indicate that smoking cannabis can be used as a coping mechanism when children know they are unable to meet the behaviour expectations set out by their school. It is a form of self-medication to allow them, in most cases to conform to school's requirement to sit still, listen and complete their work.

Carlos explained that he started taking drugs when he saw older children partaking:

'Younger people would get involved because the older people were taking it. The younger people would start hanging around with them and then they would take it. That happened to me, I was in Year 7 and I was messing up. So, I was "cool", so I started hanging around with Year 10s and 11s. That was how I got into it and that is how most people get into it'.

Ben and Luca talked about how they enjoyed taking drugs. Luca, who consumed green, described how some children would take it because they were showing off, but personally he felt it was because he enjoyed it: 'Either because they're showing off or because when you smoke green it's so good. And you like it, but really it's just like you just do it'. Like Luca, Carlos described it as experimenting, also to be seen by others in a particular way: 'Sometimes it is just experimenting.

You want to try it and see what it feels like. Sometimes it is to look cool and big'. Ben who took a range of class C to class A drugs also enjoyed taking drugs but described it as just 'a hobby' but made it clear he did not take them anymore.

## Supply of drugs

All of the children said they could easily get hold of drugs from a range of sources including other children, and dealers who were older teenagers or adults. Ben described how getting access to drugs was easy, initially he got a dealer's number from his friends and then mostly got it free: 'It was easy, because people say, "how did you get the money for it?" But the way they do it is they buy it in bulk. They would save up and buy 40 pills for £250. They would sell them till they made the money back and then the ones that were left we would take them. That is what I used to do'. Luca paid for drugs from dealers after school: 'Just dealers. On a night they would go home get changed and go out with their friends. Then they'd meet them. They would just keep some for the next morning. Like a fiver or a tenner'. Noah also agreed that buying drugs was easy and Carlos got his supply from: 'Older teenagers, or people in their twenties, or sometimes off other children'.

## Implications of taking drugs

Although none of the children used the term 'addiction' they did say 'needing' in reference to their desire to take drugs. Ben, who was the most prolific drug taker in the group, had been 'clean' for a few weeks, as he recognised the detrimental affect drug taking can have on life: 'The drugs that most children are taking now they can kill you, if you get a dodgy batch'. The only other deterrent seemed to be police involvement and families finding out. Luca took a knife into school to make a drug-taking device but got caught. He seemed more worried about the school and police finding out about the drugs than being found with the knife: 'I didn't want them to know we were smoking drugs. They were going to get the police involved, so I said that I was scared someone was going to jump me. But that just made it even worse'.

## Solutions to drug misuse

Of the children who consumed more than one type of street drug, they agreed that from taking cannabis (class B) it escalated into higher class drug misuse (class A). Carlos explained: 'In year 6 I started weed and drinking and smoking. Then

in Year 7 it turned to pills and other things. Coke, whizz. That carried on mostly'. Ben followed a similar pattern: 'I started smoking in Year 5 (tobacco). The green was Year 6. From Year 7–8 I started doing all the pills (MDMA)'. In the analysis of the interviews, the main barrier to taking drugs was finding the funds to buy them as Ben described: 'I only did it a few times before school. Now and again if I had some on me. Depends how much I could afford. I would have a bucket or a joint on the way to school'. Both Ben and Luca described how they had stopped consuming drugs largely due to the fact they wanted to stop. They had parental support and drug education from their pupil referral unit. Luca explained:

'One of the good things about this school, and what other schools don't do, is that they do awareness about alcohol and drugs and mental health. Other schools are just pushing so much on academic subjects that they don't teach you things that you need to know. In my year there has been 6 people permanently excluded. They all got excluded when they started taking drugs. Their behaviour changed. If we were educated on that in Year 7 when it gets to Year 9 and people start experimenting maybe, we wouldn't have started'.

Ben managed to become clean by slowly cutting down the frequency of drug taking until he stopped: 'I cut down to now and then. I was having one just every week. If I can do it once a week, then why not two weeks. Then I just stopped'.

## Drivers and implications of carrying a knife

Some of the children in the research were also accused of or admitted taking a knife into school. Carlos was clear that he was wrongly accused, saying he wasn't searched: 'I had a fight and then the person I had a fight with made up a story that I had a knife. All his mates backed him up. They didn't search me ... Just to get me kicked out'. Luca and Zak talked openly about taking the knife into school, for Zak it was for self-defence following years of intolerable bullying:

'I got sick of the bullying. It went on for like 3 or 4 years. So, when I nearly got hit by the car I decided enough. I'm not gonna die just because someone thinks I should. And one child pushed me into the middle of the road, I almost got hit by a car. So, I decided I had had enough. So, I took a knife into school'.

Zak explained that he made no attempt to use the knife, and despite a known history of being bullied he was immediately permanently excluded: 'They tried stuff,



but it didn't work at all. The person that did the most bullying, they moved him to a different school. But within a few weeks he was right back at school. Even if I had been moved to different classes, I would have been fine'.

In Lucas' case, he took a knife to school to make a bong to smoke drugs before school. He explained that he had no intention to use the knife other than to make the smoking device: 'I took a knife into school, when I say that it makes me sound like a proper psychopath. But I'd taken it in because I'd used it to make a bucket, a bong, before school'. Like Zak, he was immediately permanently excluded for the possession of a knife.

## Solutions to reduce fixed-period and permanent exclusions

All the children felt that having understanding teachers was fundamental to allowing them to remain in education. They all reflected on how the approaches and strategies in alternative provision enabled them to engage with learning. Carlos reflected on the attributes of his current teachers: 'Canny ... most of them. Most of them are proper sound. They get, that you aren't going to be good all the time. That you aren't going to be perfect, but they help you with that'. Similarly, Ben described how they talked to him and were not too busy to give him the time he needed. Likewise, Zak described his teachers as: 'Kind, helpful but strict if they have to be'. Noah also shared that they got more help and understanding in alternative provision: 'The teachers they understand more compared to mainstream. What they do is just kick you out of mainstream instead of speaking to you, instead of getting to know what's wrong. They listen more than any other place that I've been cos I've been to two schools. They just didn't listen. They just excluded'. Ben felt that in his new provision, he could talk to his teachers as they weren't too busy with the other children: 'It would be an hour and a half later before I got seen. So, I would just sit there and do no work. Then I would get wrong for doing no work and saying I was stuck'.

The main challenge to remaining in mainstream schooling was the inability of the children to meet expected standards of behaviour, and cope with the ensuing consequences. Many of the children gained more behaviour points as a result of inflexible systems in schools which resulted in them being placed in isolation booths, detention and ultimately fixed-period or permanent school exclusion. Ben



found being sent to isolation booths unbearable, reacting with refusal which led to numerous detentions:

‘It was a tiny little box with a chair in with a little wooden desk and wood down the middle. I wouldn’t go in it. I went in a few times but not for something daft I would rather get kicked out; I would say no. I would sit down, and they would get the headteacher. They would say they are taking me, and I would say I’m not going. So, they would have to phone my mum to send me home’.

Likewise, Carlos had negative memories of isolation: ‘We always used to say that it was called “The Bridge” because it made you want to jump off a bridge’. A main issue with isolation booths was the lack of support with learning when placed there, as Luca described: ‘The teachers would change every lesson. The isolation tutor would be in on a morning and different teachers in during the day. They’d barely have a conversation with you though. If you ask them about work, they might help you’. Noah also felt that a lack of support meant he would be seen to be misbehaving and sent to isolation as a punishment. He felt they were deliberately targeting him so he would miss his favourite lesson Physical Education: ‘Because I like PE, they would put me in isolation for the first two lessons which were P.E’.

Luca talked about the ineffective sanction of detention: ‘I had hundreds of detentions at that school and still kept getting them. You just sit there and write the school rules out. I think detention is the worst. If you’ve got your lessons and no break time’. The children talked about the causes of their behaviours in school. Some cited stress in year 6 due to impending SATS tests, large class sizes preventing them from accessing the learning support they needed and the impacts of bullying contributing to low levels of concentration in lessons. Noah felt shorter school days could have helped them remain in mainstream school: ‘Well, I do think that we could start later. And finish earlier. Because they give you a break, where in mainstream they just force you to do work all day. And if you don’t do the work then they put you in isolation. And it’s horrible like’. Luca agreed that formal learning on a morning and activity-based learning on an afternoon were an approach that help him engage in schooling, ‘I liked it better in Year 10 because I preferred the activities in the afternoon’. For Zak smaller class sizes were of utmost importance for him to learn: ‘Smaller classes so you aren’t feeling crowded, the teachers get round to helping you instead of just helping someone else’. In support, Ben reflected on his current alternative provision placement and said what was helping him was: ‘There aren’t a million people in the class’.

Only Ben acknowledged it was his behaviours that caused the teachers the problems, though it seems likely these were caused by his inability to independently complete his schoolwork in some lessons:

'I could manage the Maths. I couldn't do Geography, couldn't do religion. Good at History. I'd go for a wander and then I would come back. For shouting, torturing people, hitting pens off their head. Hitting them with rulers, just for a laugh. But if they did it to me, they wouldn't get wrong. But I would get sent out of class. Then if I came back and did it again, I would be sent to isolation. Then I wouldn't go to isolation so I would get kicked out'.

## Discussion

This study has provided an insight into the lived experiences of five children who received school exclusions, coupled with drug misuse and in some cases carrying knives. The research aimed to investigate the risk factors that led to a young person misusing drugs and to determine the drivers and implications for drug misuse and the carrying of weapons. The research also hoped to elicit from the young people, the solutions that could have prevented their exclusion from school. The analysis of the interviews has provided an appreciation of the relationship between difficulties accessing learning, relationships with teachers and drug and knife misuse.

The learning from this research is there are multi-dimensional factors that compound children's ability to access, enjoy and remain in mainstream schooling. The findings echo those of other research suggesting children need to build and maintain strong relationships through understanding and compassion from their class teachers about their strengths and difficulties with learning underpinned by timely assessment and identification of underlying learning and mental health needs (Martin-Denham, 2020a, 2020b, 2020c). Furthermore, the study supports research on the importance of being listened to and heard by teachers as fundamental to feeling a sense of belonging, children need to feel cared for and accepted into the school community (Cutrona, 1982; Smedley, 2011; Antrop-Gonzalez, 2006; Martin-Denham, 2020c). It is evident that success in mainstream education requires teachers to be a protective factor, a prompt provider of learning and pastoral support (Meehan *et al.*, 2003; Martin-Denham and Watts, 2019; Martin-Denham, 2020a, 2020b, 2020c).

Most children recalled an unproblematic primary school education, with difficulties emerging during their secondary education. These findings reinforce those of Martin-Denham (2020c) who suggested timely transition planning for those at risk of school exclusion during primary school through a formalised and collaborative process with the child and their caregivers was essential. There is no doubt that for these children, the behaviour systems and processes of behaviour points, detention and isolation booths in secondary school were detrimental to accessing and participating in meaningful education. There needs to be a move away from apportioning blame for substance misuse instead considering school related factors such as inflexible, overzealous and ineffective behaviour sanctions such as detentions, isolation booths and school exclusions that compound a child's inability to cope. For these children the cause of their drug misuse was, in part due to an unsuitable and inaccessible curriculum coupled with unidentified special educational needs and disabilities. The addition of other risk factors for school exclusion such as large class sizes, inflexible behaviour sanctions meant the reasons for the children's behaviours may not have been identified, assessed, understood or responded to in an effective manner. Once difficulties in school are coupled with drug misuse and knife carrying, the inevitable school exclusions begin and the child enters a spiral of risk. Figure 1 illustrates the journeys taken by these children, the turning point being a permanent exclusion from secondary mainstream school and securing a place in alternative provision where smaller class sizes, opportunities for talk and support for learning needs resulted in engagement in learning and future aspirations being identified.

Most disturbingly, the majority children shared they were consuming drugs to self-medicate, to cope with school, to help them concentrate, keep out of trouble with teachers and to get through the school day. The children stated school related factors as a key reason to take drugs, unlike the Advisory Council on the Misuse of Drug (2006) report which instead stated familial and parenting as deterministic factors. The findings also provide new insight when compared to the NHS (2019) survey which does not ask or report 'coping in school factors' as reasons for drug misuse. Also, The NHS (2019) findings suggested street drugs were predominantly acquired from friends, contrasting this research where adolescents and dealers were identified as the main suppliers of drugs. Until the cycle of supply is dealt with, children are going to be targeted by dealers at a young age to generate income for those who deal in drugs. The evidence shows that young children are influenced by older children and that children can quickly progress from class B to A drugs use when they see their friends and siblings using. The theographs in Figure 1 illustrate drug misuse correlates with a lack of in school support for learning. As



the participants' difficulties at school increase, so does their drug misuse or simply their experimentation and enjoyment. During analysis, it became clear that there is a necessity for preventative engagement with children and young people within the primary phase of education to prevent the escalation and embedding of drug misuse in secondary school. Currently, it seems that drug education peaks in year 8 and 9 rather than in the primary phase of education (NHS, 2019). It would seem sensible for drug education to be targeted to the upper primary phase of education continuing in secondary school by youth workers due to the problematic relationship children can have with some teachers. Community support and opportunities for children to engage in alternative activities outside of school could go some way to preventing the draw towards drug misuse. The drive to use street and illegal drugs needs to be replaced with something else, a better and safer way to self-regulate so the desire and drive to take drugs is diminished. All school staff need high quality training to identify signs that a child is using drugs so that prompt support can be put in place, this study indicates teachers may not be aware of the warning signs.

In this study the reasons the children gave for possession of a knife in school was varied. The schools all took a zero-tolerance approach to the carrying of weapons as suggested by the House of Commons (2018). It appears that judgement to permanently exclude is based on the full circumstances as recommended by the Timpson Review (DfE, 2019). However, it was not the case for the child who had a history of bullying as they were excluded, seemingly without regard for mitigating factors. This study supports the need for headteachers to explore why the children are in possession of weapons as it is likely there will be a range of reasons.

## Concluding remarks

The research provides critical messages for policy makers and all organisations and professionals involved in the care and education of children and young people. There needs to be prompt identification and assessment of the multi-faceted and holistic needs of children, so that they can access learning and remain in education. Training for education professionals is essential so they can identify, understand and effectively respond to the behaviours children can present with, including indicators of victimisation, so they can intervene and create inclusive and accessible learning environments.

The Government needs to consider the role of education, health, care, youth work and the voluntary sector in drug misuse prevention. One certainty that arises from

this research is that any intervention from services and school-based programmes need to begin in the primary phase of education and be embedded across compulsory education years. Future research should be led nationally incorporating at the heart, children and caregivers' views to inform the prevention programmes, including who should lead the training. The reality from the participants is that the supply of drugs is easy, and therefore drugs will continue to reach children in schools. We need to learn from children and their communities on how to prevent or limit children being drawn into situations involving drug use in the first place. Further research from the NHS smoking, drinking and drug use among young people in England should incorporate school related drivers as an option for consumption of controlled substances. The re-design would allow for the capturing of broader risk factors that lead to drug misuse.

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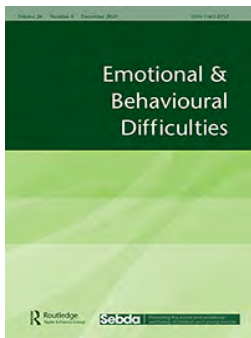
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# Alternatives to school exclusion: interviews with headteachers in England

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## ABSTRACT

In England, there is a lack of qualitative data exploring the approaches used across age phases and types of schools seeking to provide alternatives to school exclusion. The study used thematic analysis and semi-structured 1:1 interviews with 46 headteachers to determine the strategies employed in their contexts. Three themes were identified: exclusionary systems, processes, and practices; limbo (schools in the mid-ground between inclusive and exclusive practices); and inclusionary systems, processes, and practices. The research highlights the vast range of alternative approaches to school exclusion used in different types of schools. It is evident that the lack of definition of 'inclusion' in Department for Education statutory guidance, coupled with schools being able to isolate and segregate children with special educational needs and disabilities for 'limited periods', allows for the adoption of exclusionary practices. The results have important messages for the Department of Education in understanding the range of inclusionary and exclusionary approaches used in schools. Furthermore, the study highlights the importance of 'inclusion' being consistently defined and explained across departmental statutory guidance to support the adoption of inclusive approaches in schools.

## KEYWORDS

Thematic analysis;  
headteachers; school  
exclusion; mental health;  
inclusion; policy

## Introduction

This article draws together unreported data from a two-year research commission investigating the impact of school exclusion on children's mental health and well-being in the North East of England by Martin-Denham (2020a, 2020b, 2020c). The original project examined the barriers and enablers to mainstream schooling from 174 participants including: 55 children; 41 caregivers; and 78 education and health professionals. The study generated a deluge of qualitative data, too much to be analysed and reported in the initial publications. This article presents the unreported data on forty-six headteachers' views from various age phases and types of schools (see Table 1) who discussed alternative approaches to school exclusion. The research objective was to determine, through reflexive thematic analysis, the range of approaches used in schools as an alternative to school exclusion.

## School exclusion

The Education Act (1986, part 3, s23) introduced 'fixed period' and 'permanent' school exclusions, legitimising the removal of a child from school if 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 2017). The Department for Education (DfE) (2020) states a permanent exclusion refers to a 'pupil who is excluded and who will not come back to that school'.

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**Table 1.** Number of schools interviewed out of all schools in Sunderland.

| Type of school        | Number of schools in Sunderland | Number of schools in the study | % of schools |
|-----------------------|---------------------------------|--------------------------------|--------------|
| Mainstream primary    | 62                              | 27                             | 44%          |
| Mainstream secondary  | 18                              | 10                             | 56%          |
| Special school        | 7                               | 4                              | 57%          |
| Alternative provision | 6                               | 5                              | 83%          |
| Total                 | 93                              | 46                             | 49%          |

The DfE (2018) reported school exclusions were on a downward trend since 1995–1996, rising again in 2012–2013. However, recent data from 2018/19 revealed only a marginal decrease of 11 permanent exclusions, whilst fixed period exclusion rose from 410,000 to 438,300 (DfE 2020). This dataset also highlights that children on special educational needs (SEN) support are five times more likely to be permanently excluded, reducing to 2.5 times when an Education, Health and Care Plan (EHCP) is in place. Additionally, the wealth of evidence in the UK shows that those excluded from school have an increased risk of poor educational outcomes (Social Exclusion Unit 1998; Office of the Children’s Commissioner 2017; Martin-Denham 2020a, 2020b, 2020c, 2020d).

### *Isolation and segregation*

The Department for Children, Schools and Families (DCSF) (2008) introduced ‘internal exclusion’ or ‘remove rooms’ as an in-school process for removing a child from a classroom, but not the school site. The guidance intended children would receive a supervised education, for a short period, to reflect on their behaviour. Barker, Watts, and Dodman (2010) believed this school-based exclusion, known as isolation, was a response to ‘political pressure aimed at reducing school exclusions, raise standards, and remove children from classrooms during the school day. The guidance intended children would receive an enhanced supervised education, for a short period, to reflect on their behaviour. Yet both the House of Commons (2018), and Martin-Denham (2020a) provided evidence that some children had been placed in isolation booths for most of the school year, and in the latter case many years of secondary education, without any teaching or support. Ofsted (2018) recently confirmed that children can be placed in ‘isolation’ for limited periods, where the practice is stipulated in behaviour policies, and is lawful, reasonable and proportionate. However, as the DfE (2016) does not define what is meant by a ‘limited period’ schools have been given carte blanche to determine duration themselves (Martin-Denham 2020a).

Research evidence suggests isolating children can increase deleterious health outcomes such as substance misuse, self-medication, anxiety and loneliness (Hall-Lande et al. 2007; Osgood et al. 2013; Martin-Denham 2020a, 2020d) and compound dysregulated behaviours (Martin-Denham 2020a). The use of isolation directly conflicts with DfE (2016) advice to schools of their role is to ensure children’s health and welfare. Giving schools the option to isolate children has had the detrimental effect of schools becoming less inclusive (Gazeley 2010; West and Bailey 2013; Gorard 2014; Martin-Denham 2020a, 2020d). Furthermore, the evidence from the most extensive study on school exclusion suggests placing children in isolation booths does not actually improve behaviour, but makes it worse (Martin-Denham 2020a).

### *Part-time timetables*

The Education Act (1996: s19) states that ‘each local authority shall make arrangements for the provision of suitable education at school or otherwise than at school for those children of compulsory school age who, by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them.’ The DfE (2020, 19) is explicit that ‘all pupils of compulsory school age are entitled to a full-time education’. They add that any part-time attendance must not be a long-term solution and must be recorded as an authorised

absence. However, the Children's Commissioner (2017, 38) reported that some schools were unlawfully placing children on part-time timetables due to a 'profound and troubling lack of awareness of the law.' Indeed, a survey conducted by the Contact a Family (2012) on illegal exclusions among children with SEN, reported 404 caregivers shared their child with a disability, SEN or additional needs were excluded illegally from school.

## Inclusion

The United Nations Educational, Scientific and Cultural Organization (UNESCO) provided one of the seminal pieces of international legislation promoting inclusive education. The Salamanca Agreement (UNESCO 1994, 3) published on behalf of 92 international governments, outlines the policy shifts required to enable schools to 'serve all children, particularly those with special educational needs' (p.3). The agreement clarifies that to develop inclusive schools; there needs to be:

articulation of a clear and forceful policy on inclusion together with adequate financial provision – an effective public information and positive attitudes – an extensive programme of orientation and staff training – and the provision of necessary support services (21).

The statutory guidance for special educational needs and disabilities (SEND) fails to define inclusion (DfE and Department of Health (DoH) 2015, 93) referencing 'schools have wider duties to prevent discrimination, to promote equality of opportunity and to foster good relations.' Similarly, the statutory framework for the early year's foundation stage (DfE 2017b) does not refer to 'inclusion' let alone provide a definition. The National curriculum framework for key stages 1–4 (DfE 2014) omits a definition of inclusion. Still, it guides what teachers 'should' do to set suitable challenges, respond to pupil's needs, and overcome barriers.

Varying definitions of 'inclusion' have been discussed over the decades moving from 'inclusion' to 'integration' by the 1990s (Norwich 2012). Farrell (2000, 154) was more explicit, describing inclusion as 'taking a full and active part in school-life, be a valued member of the school community and be seen as an integral member'. A differing perspective was provided by Lauchlan and Greig (2015). They shared that inclusion was taken to mean children are socially and educationally included, in an environment where they feel welcomed and can thrive and progress. Clark et al. (1999, 173) proposed there should be a move away from trying to determine if schools are or are not inclusive. Instead, there should be a focus on 'understanding the processes of inclusion and exclusion which *operate* in all schools' (p.173). Later, Florian (1998) agreed that inclusive education referred to a philosophy of education, promoting all children's education in mainstream school. Terzi (2008) shared that inclusion is a problematic concept used in different ways to refer to inclusive schools, inclusive societies, or policy to keep more children in mainstream school. Warnock (2005) rejected the idea that inclusion is all about educating children 'under the same roof'. Instead, she argued, it is more important to ensure all children are engaged in a common educational experience and are learning and developing to the best of their ability, regardless of where that might be. The current position in the Children and Families Act (2014, 35(2–3)) is 'those concerned with making special educational provision for the child must secure that the child engages in the activities of the school together with children who do not have special educational needs, subject to subsection (3)'.

Subsection (2) applies only so far as is reasonably practicable and is compatible with:

(a) The child receiving the special educational provision called for by his or her special educational needs

(b) The provision of efficient education for the children with whom he or she will be educated, and

(C) The efficient use of resources.

A literature study by Koster et al. (2009, 128) found 'social integration' and related concepts of 'social inclusion' and 'social participation' did not differ across the 62 studies they examined. The definitions tended to highlight areas such as 'friendship, acceptance, interaction, relationships,

social status and bullying’ while some also mentioned ‘performing a task together, initiation, interactive partnerships, pupils’ self-perception of acceptance, perceived loneliness and perceived social competence (p.128)’. The European Agency for Development in Special Needs Education (2005) conducted various examinations of inclusion practices in schools reported found a few key strategies were vital to inclusive teaching: cooperative teaching; cooperative learning; collaborative problem solving; heterogeneous grouping; and effective teaching. In the context of this study, it is imperative to emphasise the complex relationships between inclusion, exclusion, and social inclusion. While social inclusion may not always refer specifically to the inclusion of those with SEND, there is support for the notion that exclusive and anti-inclusive school practices are likely to be detrimental to all forms of social inclusion, as they have the potential to ‘highlight differences and segregate students in ways that further promote divisions and reinforce negative stereotypes’ (Juvonen et al. 2019, 250).

The Convention on the Rights of Persons with Disabilities (2006) was an international convention signed by the UK, and states the rights of students with disabilities with regards to inclusion, should mandate that ‘individualised support measures are provided in environments that maximise academic and social development, consistent with the goal of full inclusion.’ Approaches to inclusion from a school leadership perspective found inclusive schools shared similar strategies regarding implementing inclusive practices ‘to support capacity building and professional learning focused on addressing individual student and staff need,’ (Abawi et al. 2018, 14). Alur and Timmons (2009, 15) insisted if inclusion is to be achieved, the classroom teacher must plan for learners’ diverse needs. The study emphasises that student needs cannot be met if the staff needs regarding inclusion, such as training, aren’t also met. Horridge (2019, 415) noted the importance of health professionals communicating with multi-disciplinary teams to ensure ‘each and every need of all children and young people is identified, accurately described using clearly understandable terms, documented and communicated to all who need to know.’ Furthermore, Van Reusen, Shoho, and Barker (2000) shared if teachers did not undertake training regarding the inclusion of children with SEND, they were more likely to have negative attitudes towards inclusion; whilst increased training created more positive attitudes towards inclusion (Zwane and Malale 2018). However, significant gaps in course content in Initial Teacher Training (ITT) programmes aimed at preparing teachers to support children with SEND, were reported by the Carter Review (DfE 2015). The Driver Youth Trust (2015) agreed there were issues with access to high-quality training for teachers. They recommended an expert group be created to agree ‘core content’ which would sufficiently prepare trainee teachers to support children with SEND. The DfE (2019) released the ‘ITT core content framework’, which emphasised the importance of high-quality teaching for children with SEND, including mental health needs.

## Materials and methods

Since the introduction of thematic analysis (TA) as an approach to analysing qualitative data, it has been widely used across subject disciplines (Lainson, Braun, and Clarke 2019). Braun and Clarke (2006, 6) describe TA as ‘a method for identifying, analysing, and reporting patterns (themes) within data’. Clarke and Braun (2018) reiterated TA is a term encapsulating a wide range of approaches, and, as such is a method rather than a methodology. In journal articles there continues to be a limited understanding of what thematic analysis is, the approach taken, and the explanation of how researchers have created themes (Attride-Stirling 2001; Braun and Clarke 2020). Despite this, TA is a well-used method due to the ‘flexible, straightforward and accessible’ nature of the approach (McLeod 2011, 146) and its effectiveness for analysing interview data (Hunt 2014).

Boyatis (1998) and Willig (2014) discussed whether Thematic Analysis (TA) is a distinct method, or rather an analytic procedure. Braun and Clarke (2020) clarified TA is a method, a distinct way of analysing qualitative data that shares commonalities with other approaches endeavouring to identify patterns in data such as: interpretative phenomenological analysis (IPA); qualitative content



analysis; and grounded theory. The TA approach has different versions known as variations, such as 'coding reliability,' 'codebook' and 'reflexive' (Braun, Clarke, and Hayfield 2019). For this article, reflexive TA was the chosen approach, as it aligned with the researcher's assumption that analysis should be a reflexive interpretative process, with open and organic coding (Braun and Clarke 2020). As Charmaz (2006) suggests, in reflexive TA, a code is used to develop initial themes capturing multiple observations as interpreted by the researcher. This approach allows for the exploration of a specific question yet to be analysed and reported.

Wilson (1993, 342) describes thematic analysis as 'a strategy in phenomenological research that involves recognising common themes in contextual data.' As described by Morese and Field in 1995, themes can be abstract and difficult to identify, but significant concepts link parts of interviews together. Braun and Clarke (2006, 10) described a theme as 'something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set'. Themes in reflexive TA are patterns of shared meaning, united by a central concept or idea (Braun. and Clarke 2013; Braun, Clarke, Rance 2014). This means themes might draw together data that, on the surface, appear rather disparate. Interviews were selected from the original data corpus (Martin-Denham 2020a) to create a data set, of headteachers who discussed alternative approaches to school exclusion. Several qualitative researchers (DeSantis and Ugarriza 2000; Emmell 2015; Braun and Clarke 2016) hold a shared perspective that there is no agreed definition of a 'theme', or complete standardisation of procedures to identify them. They instead suggest the researcher crafts themes based on their interpretation during the data analysis. Ely et al. (1997, 205–206) proposed that themes reside in the researcher's head from thinking about, and understanding the data to create links. The 'themes' arising from the TA are not summaries of responses on a topic or issue, or necessarily the most prevalent themes. Instead, they should be patterns tying the observations together (Clarke and Braun 2018). The notion of a central organising concept or 'essence' was outlined in Braun. and Clarke (2013) and Braun, Clarke, and Rance (2014) to describe how themes should be thought of as key characters in the story the data tells. DeSantis and Ugarriza (2000) asserted themes are active creations of the researcher, not something that passively emerges; defining a theme as 'an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole' (362). Laison et al. (2019) went on to say knowledge is co-produced between the participant and the researcher through reflexive TA.

### *Recruitment and sample of participants*

Purposive sampling was used for the original study to ensure the participants had experience and knowledge of school exclusion (Martin-Denham 2020a, 2020b, 2020c). To recruit the participants the research team contacted the schools by telephone and email inviting them to take part. As part of the process, the researcher created a tracker containing information to ensure inclusion of: a range of types of provision; Ofsted ratings; and gender of participants. Information was also sought from the funder to ensure the schools included, represented those with high, low and no school exclusions in the previous three years. The participants were provided with information sheets and consent forms prior to the interview including: information on data processing; retention periods; and other privacy information (Information Commissioner's Office 2019). The sample for this article was selected retrospectively to enable the research question to be answered. As detailed in Table 1 and Table 2, the headteachers were employed in various schools, and both male and female participants were represented.



**Table 2.** Reported gender of participants.

| Type of school        | Number of females | % of females | Number of males | % of males |
|-----------------------|-------------------|--------------|-----------------|------------|
| Mainstream primary    | 21                | 78%          | 6               | 22%        |
| Mainstream secondary  | 8                 | 80%          | 2               | 20%        |
| Specialist school     | 2                 | 50%          | 2               | 50%        |
| Alternative provision | 3                 | 60%          | 2               | 40%        |
| Total                 | 34                | 74%          | 12              | 26%        |

### **Ethical conduct**

The original study secured ethical approval from the University of Sunderland Ethics Committee (Martin-Denham 2020a, 2020b, 2020c, 2020d). The participants all provided voluntary, informed consent both in written form and verbally prior to the interview commencing (Berg 2001; King, Horrocks, and Brooks 2019). The BERA (2018) guidelines were adhered to ensuring all participants knew their rights before, during, and post the research.

### **Procedure**

The semi-structured 1:1 interviews took place between September 2018 and June 2019, ranging from 30 to 90 minutes. The interviewer did not impose any time limits to allow the participant to provide in-depth responses to the open-ended questions (O’Leary 2004).

A Dictaphone was used to record the interviews which were then transcribed verbatim, anonymised and stored securely in Office 365.

### **Analysis approach**

Braun and Clarke (2006, 35) used six phases of analysis to guide the analytical process, as described in Table 3.

The themes and patterns within the dataset were identified using inductive analysis through reading and re-reading the data. The data-driven approach allowed for the coding of the data without any pre-existing coding framework or the researcher’s analytic preconceptions (Braun and Clarke 2006). Latent thematic analysis was used to examine for significance, broader meanings, and interpretations in the interviews, and the data was organised to illustrate this (Patton 1990).

**Table 3.** Phases of thematic analysis.

| Phase                                  | Description of the process                                                                                                                                                                                                     |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.Familiarising yourself with the data | Transcribing data, reading and re-reading the data, noting initial thoughts and ideas.                                                                                                                                         |
| 2.Generating initial codes             | Coding interesting features of data in a systematic fashion across the entire data set, collating relevant to each code.                                                                                                       |
| 3.Searching for themes                 | Collating codes into potential themes, gathering all data relevant to each potential theme.                                                                                                                                    |
| 4.Reviewing themes                     | Checking the themes work in relation to the coded extracts and the entire data set. Generating a thematic map of the analysis.                                                                                                 |
| 5.Defining and naming themes           | Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells. Generating clear definitions and names for each theme.                                                                        |
| 6.Producing the report                 | The final opportunity for analysis. Selection of vivid, compelling extract examples. The final analysis of selected extracts. Returning to the research question and literature to produce a scholarly report of the analysis. |

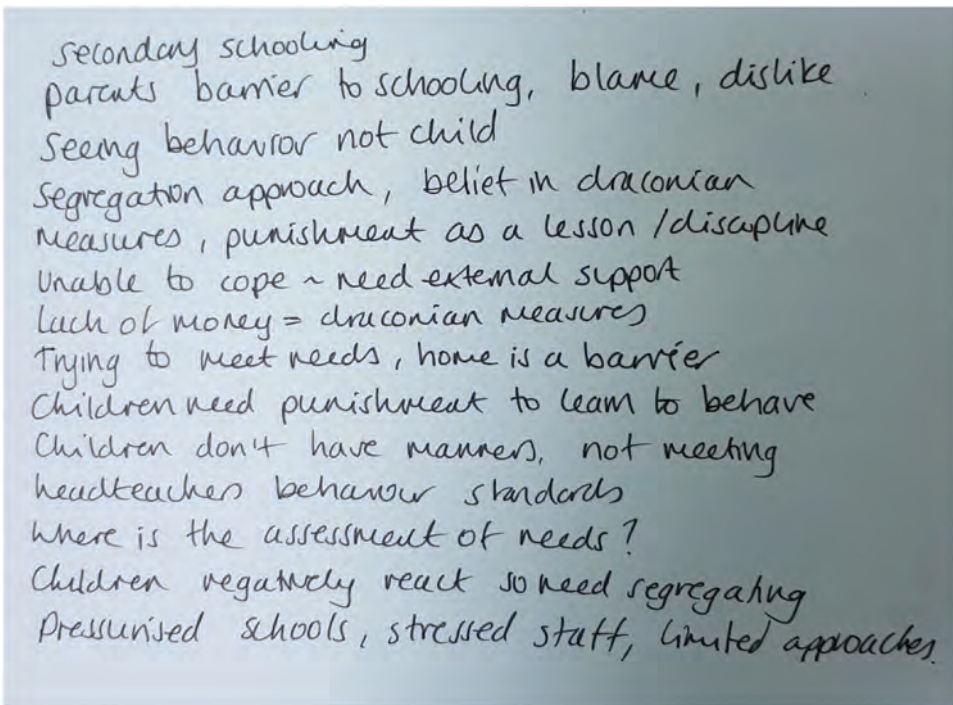


Figure 1. Initial notes.

### **Phase 1: familiarising with the data**

The audio files were repeatedly listened to, followed by re-reading transcripts, noting initial interpretations of the essence and meaning of the headteacher's views, as shown in Figure 1. At this stage, it became clear headteachers had differing alternative approaches to school exclusion, varying from internal segregation to inclusive, individualised provision and practice.

### **Phase 2: generating initial codes**

The researcher used initial notes (Figure 1) to create a generic image of general approaches used as an alternative to school exclusion in schools (Figure 2). This stage of the process was carried out alongside phase 3 to organise the data systematically and meaningfully. Next, initial codes and potential themes were identified.

### **Phase 3: generating initial themes**

The transcripts were transferred into Microsoft Excel for ease of coding. Each segment of the headteacher's relevant responses was captured as data extracts. As the inductive analysis was used, line-by-line coding allowed for codes pertinent to the research question. The original plan was to use NVivo 12, but problems with remote working and access to the software made this not possible. Excel was used to organise the coded data systematically and allowed the data set to be allocated codes (see Table 4). Main themes and codes were created, developed, combined, and modified while interpreting the data for significance.

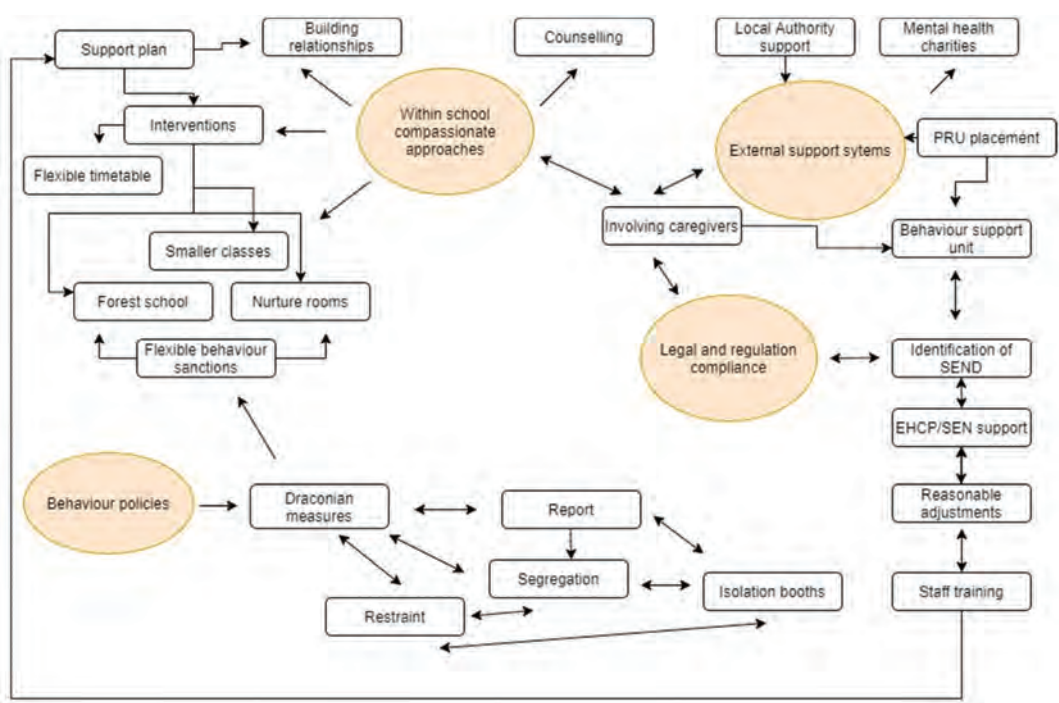


Figure 2. Alternative approaches to school exclusion.

Table 4. Coding the dataset.

| Participant | Gender | Provision type | Main theme                    | Subtheme 1                       | Subtheme 2                       |
|-------------|--------|----------------|-------------------------------|----------------------------------|----------------------------------|
| ALT1        | M      | AP             | Positive approaches           | Assessing and identifying needs  | Caregiver(s) as partners         |
| ALT2        | F      | AP             | Inclusive systems             | Planning for individual needs    | Debriefing to prevent escalation |
| ALT3        | F      | AP             | Inclusive approach            | Nurture groups to regulate child | Sensory room                     |
| PRIM1       | F      | PRIM           | Legal obligations             | Behaviour policies followed      | Bespoke support                  |
| PRIM2       | F      | PRIM           | Exclusionary practice         | Move child to external schooling | Flexible curriculum              |
| SEC5        | M      | SEC            | Exclusionary practice         | Isolation booth                  | Segregation                      |
| SP1         | F      | SP             | Inclusive mental health ethos | External agency involvement      | Caregiver(s) as partners         |

Phase 4: reviewing themes

This stage was the review of the preliminary themes in phase 3. This involved cutting and pasting parts of transcripts into Microsoft Word. The dataset was colour-coded so the age phase and type of provision could be easily identified. The themes and subthemes were checked against data extracts and examined as a collective dataset to check: they made sense; for overlaps; themes within themes; and to collapse similar codes together. The end of phase 4 thematic map of themes (exclusionary, limbo and inclusionary) is shown in Figure 3.

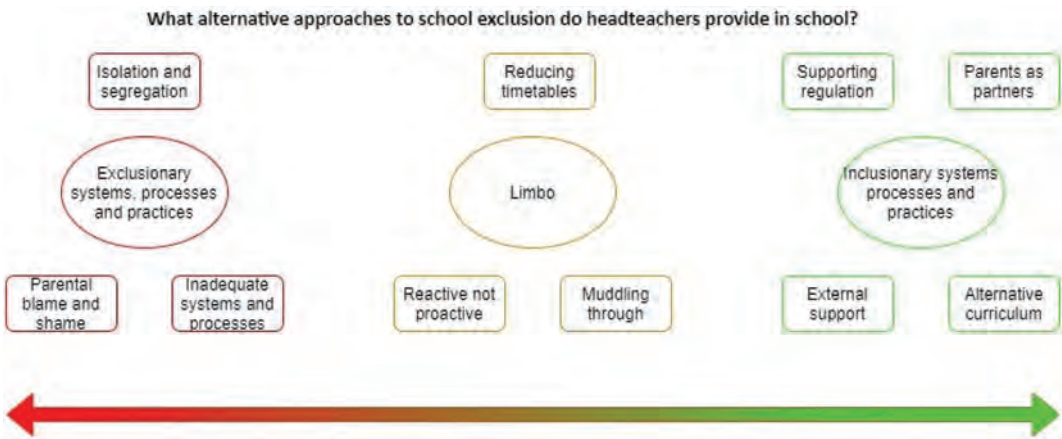


Figure 3. The developed thematic map, showing three main themes.

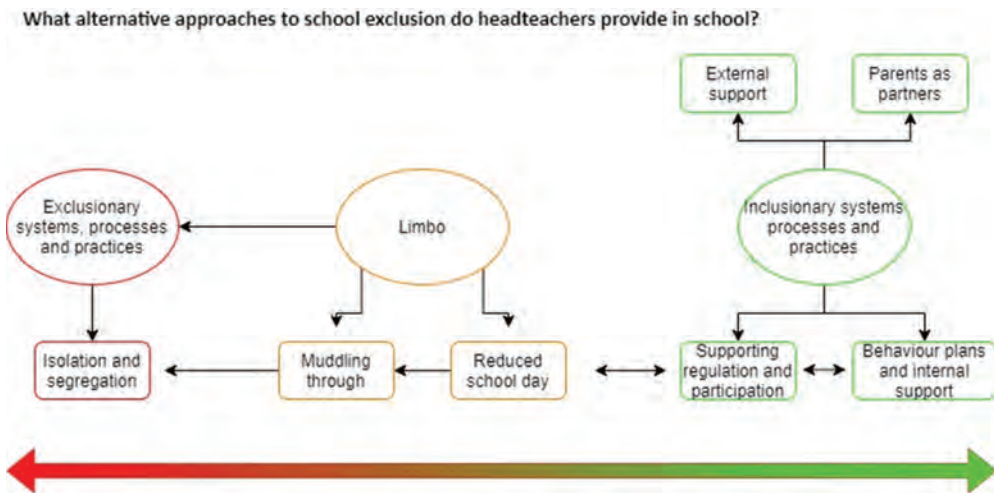


Figure 4. The final themes.

### Phase 5. defining and naming themes

The final stage was to 'identify the essence of what each theme is about' (Braun and Clarke 2006, 92). This part of the process examined what the themes were saying, and how the subthemes supported the central theme. The ongoing analysis created slight changes to the naming of the themes, as shown in Figure 4. The author removed parental blame and shame as it did not relate to the research question. The 'reactive and proactive' subtheme was deleted, as it was no longer needed due to its essence being captured by the other two themes within 'limbo.'

### Findings

All headteachers were able to discuss the alternative approaches to school exclusion they provided in their schools. Through TA, three themes were identified: exclusionary systems, processes, and practices; limbo; and inclusionary systems, processes, and practices. The theme 'limbo' was

determined to capture some schools in the mid-ground between inclusive and exclusionary practices. The horizontal arrow and the themes are colour coded to indicate the perceived level of inclusion for children.

### *Exclusionary systems, processes and practices*

#### *Isolation and segregation*

Exclusionary approaches were more prevalent in secondary schools through systems, processes and practices of isolation and segregation. The most common alternative to school exclusion in secondary education was the use of isolation booths. Most HTs identified this approach was the most suitable method to punish children who did not conform to behavioural expectations set out by the school. There were indications that the children are not taught, but instead complete work set with supervision:

We have an inclusion unit, if children are not behaving to the standards we expect, a few hours or a day or a week depending on the seriousness of what has gone on, could be a bullying issue or an assault on another pupil or just general misbehaviour. A lot of student's hate being in there so they will do anything to not be in there, it's a quiet environment you sit in there on your own in silence.

Other headteachers conveyed different sanctions, including being placed on report, or processes for detentions:

We've obviously got the basic consequences system where you go through report cards. Then we hit serious incidents. We will do isolation with the heads of years first, if it is not extremely violent. But then we've got internal exclusion, which is over the other side of the school. We are trying to cut down on our fixed term exclusions because I think that's what they want; they want a day off school.

and

We have a detention system for punctuality, a detention system from the teacher, a subject detention, to leadership detention. At any point we could put them in isolation; isolation is a small boothed room which is not very nice, where they are working quietly with school behavioural managers, some of whom are leaders. They might be in there for the rest of the lesson, the morning, or the day.

Several headteachers felt isolation was needed do allow the child to regulate their behaviour, and to give respite for other children and teaching staff: 'If it kicks off and they're disrupting the learning of others and mental health problems for all concerned, we have to remove them from that until things calm down' and, 'we have the isolation room, where they have that consistent link with the cover supervisor. That, again, is not a permanent approach; they do then reintegrate into lessons. That is a way of everybody getting a break; the young person as well as members of staff.' Contrary to the original research (Martin-Denham 2020a), the headteachers suggested t segregating and isolating children was not used as a permanent approach. Yet some children in this previous research reported being in isolation booths for several years, compounding their negative behaviours.

Despite the acknowledgement of some HTs that isolation was a non-ideal solution, other HTs did not always speak about exclusionary practices in a negative fashion, and often attempted to rationalise the decision to place students in isolation. One headteacher remarked that children were fortunate to have isolation booths as an alternative to school exclusion:

We have internal exclusion, it has eight booths in it, it's where they are removed, they will receive all the work that the class would have received, but they do it in isolation. There is support in that room, and that member of staff also do some reflective practice about why they are here, say they have had an argument with the teacher or sworn at the teacher, years ago you would have put somebody out for that.

A primary HT who had no school exclusions policy explained how she had a child in the school with

very challenging behaviour. To keep the child in a mainstream school, he was segregated from other children:

We work to manage him outside of the classroom. Any other school I believe he would have been excluded we want to keep them without excluding. This may be by going to a unit for part of the time. I am vehemently against exclusion; you have to look behind the behaviours to see what's happening with the child and work it out. I don't want exclusions in my school.

Another alternative approach reported by a primary HT was that children could elect to work outside the classroom when they were unable to cope in class if they felt unable to, 'they can ask a teaching assistant to take them out, and they have got a space outside the classroom where they can work.'

Some primary schools were reliant on Team Teach for using a behaviour management strategy. Mostly they referred to it in terms of restraint:

If it was an emotional outburst where they might really hurt other children or themselves we might Team Teach in that situation, to make sure that that child and other children are safeguarded. We bring the child along here, and myself and the deputy head would sit and talk to them. It's not about blaming them; it's about understanding the reason why this behaviour has happened.

and

If a child has gone very quickly and we haven't been able to intervene in time, then we have a lot of members of staff who are team teach trained, so we would use the Team Teach de-escalation. But if that doesn't work and the child won't remove themselves we would then in a very managed way we would remove them and calm them down.

Team Teach was also used in a secondary school, but due to funding cuts, they no longer offer the approach, acknowledging there could be better approaches to use: 'I think the cost of Team Teach training, it's any reasonable force, given school budgets now, is prohibitive. I think that some people that have had the training may be more likely to use it when alternatives might be better. So, we are trying to do a lot of work on defusing situations, which works in a classroom setting but not so much in the playground and at social times.'

## **Inclusionary systems, processes and practices**

Most HTs discussed how alternative approaches to school exclusion were needed due to children's challenging behaviours.

### ***Supporting regulation and participation***

The alternative provision HTs frequently shared their approaches to supporting children's anxiety to prevent school exclusion by providing bespoke spaces: 'We've also got a reflection system. They go out of the room, fill in a sheet and then have a conversation about why they couldn't cope' and:

We've got calm rooms upstairs, three in total. One is a sensory room which we use with students who just need time out to calm down. Then we have a music room, as a bit of therapy during break and lunchtime, they love that. Then we've got spaces at the end of corridors with settees and things.

Sensory rooms were most used in primary schools, with HTs stating the importance of children having space to, 'calm down' and that, when they can see the child becoming dysregulated or to diffuse a situation, 'it stops things building up.' They remarked sensory spaces being used dependent on the needs of the child, 'we encourage them to leave and go somewhere to calm down, often the sensory room' and, 'We encourage them to leave and go somewhere to calm down, often the sensory room; it would be very much about what works for an individual child. You've got to let children calm down before you can talk to them about what's going on.' Another primary HT felt, 'the sensory room is used for a range of children, though at times the children can be reluctant to access



the facility, 'we have one in the pupil referral unit (PRU) at the moment, and it takes two of us to move him, and he is in year one.' One primary HT discussed a sensory room and a nurture group being used as a space where children could have time away from a busy classroom to talk about friendships and relationships: 'Talk about all those different issues as well. We suggest sensory breaks, we have children with sensory trays as well so if they finish their work it is a kind of incentive to get the work done so they can have their sensory tray, so they have things like foam glitter sticks.' The forest school approach was also evident in primary school provision for children unable to cope during the school day's social times, 'it's never as a punishment for the children, and it's always framed as helping for the younger ones.' Specialist provision schools also adopted sensory spaces, 'we use various strategies, sensory integration, and we try and have behaviour plans where we know what that child might need, should they become dysregulated. It's finding where the triggers are.'

In specialist provision, safe spaces were provided to allow children to regulate and reduce their anxiety:

'We have two rooms, not isolation rooms but a reflection room which students can choose to go to for various reasons if they are very anxious and need a nice calm, safe space they can ask to go there with a member of staff.' Finding the cause of the anxiety was an approach shared by another HT before the child becomes dysregulated: 'We do have a breakout room, but I am very rigorous about the way that is used, sometimes teachers misuse it. I tell them it shouldn't be used when a child is kicking off; it's for way before that' (specialist HT).

A secondary HT maintained the importance of an inclusion base: 'In the inclusion base, we have staff trained in different areas. We have a mindfulness area; they get a time out card; they sit there for five minutes until they have self-regulated to go back to class. That works for some and doesn't work for others.'

The importance of smaller numbers of children in schools was raised by several primary HTs, 'going with a couple of other children into a smaller space and a member of staff that can help them play.' For children with challenging, violent and aggressive behaviours a primary HT shared they: 'Cannot cope on the yard can't cope on their playing games with other children because their anger just gets the better of them. We take them into the courtyard area with four or five children and play in a much smaller area.' The necessity for reasonable adjustments to be made for children with disabilities was also raised:

Reasonable adjustments are made in the classroom; some children like to have fidget toys built into the plan, we use resources like egg timers bubble cushions you name it we use it, so reasonable adjustments are made in the classroom for the child. We then use the classroom assistants for support, we have the go-to person and worry boxes (primary HT).

A secondary HT highlighted employing staff to observe for behaviours that may escalate: 'We would have a member of staff in the class with them, so if they see any triggers they can take them out, we also offer escorting children to and from lessons or during breaks and lunchtimes. We also offer staff support as well; tell them to try different strategies.'

### ***Behaviour plans and internal support***

The primary and specialist headteachers had a clear focus on creating a plan to detail potential trigger points for the child, leading to them becoming dysregulated. Primary HTs felt behaviour plans were essential as an approach to preventing school exclusion: 'It's very much trying to identify what the reason is for the threat of exclusion. Having very clear behaviour targets, not just a bit of paper but a working document for the behaviour policy for that child' and, 'we have got a behaviour plan in place so it is clearly identifying, with the different areas, what the issues are and what the triggers might be and what action is put in place.' A further primary HT asserted the importance of the plan being negotiated with the child and family: 'So in our school; they will get quite a detailed support plan. It's an individual support plan that is agreed between teachers with parent views and

child views so that everybody contributes.’ Another primary HT found the behaviour plan useful, as it: ‘Avoids the trigger points, has rewards within it. It’s the skill of the class teacher to notice when these things are going to happen, which is often to the detriment of the other children in the class.’ This view was further supported by another HT in the same age phase stating the importance of: ‘Looking at the individual, the triggers and what can be put in place; I call that a “positive handling” plan. Sitting with a child and working out what rewards would work to motivate them; something that’s different.’

Within alternative provision contexts, individual approaches for each child were clearly stated, ensuring they all had behavioural targets in place that were continuously monitored and amended to suit them.

### *Parents as partners*

Very few headteachers shared working with parents as an approach to preventing school exclusion. No headteachers from secondary education mentioned collaboration with parents in any sense. Other headteachers talked about the importance of working with parents to decide what preventative action could be taken, ‘we speak to parents often to have conversations about what we can do’ (specialist HT) and, ‘we involve the parents as much as possible, look your child is struggling with this’ (primary HT). Weekly calls were used as an approach to work with parents to build relationships and to provide support to the child, and wider family: ‘Tutors are expected to make weekly calls to our parents, carers of their tutees. Part of that is building that relationship, providing support where needed’ (alternative provision HT).

Multiple primary HTs reported involving parents from the onset of concerns to get them on board with working together to support the child: ‘Sometimes it is difficult because children might see different parents at different times, and they have different parenting styles. Sometimes getting both on board has been difficult’ and ‘partnership with the parent- I think we do that well. Putting the time in nursery and, you know, I am on the yard at night and morning so they can tell me things quickly.’

We usually involve the families straight away; I don’t think any child has ever done anything where we think woah that definitely deserves an exclusion, it’s more the behaviour that’s disruptive, angry and potentially dangerous that builds up. We involve people right from the start, identify it early and work with the parents all the way through so it’s never a shock if it gets to that point.

### *External support*

A secondary HT described external support they had previously used to support children in building relationships:

‘There used to be some good stuff like “Wear kids” for disaffected kids. They were good. They would come into the school and take them out to like McDonald’s for their dinner, talk to them and then bring them back. We had a great relationship with them. They were good, but they went with budget cuts.’

The primary schools sought free external support, ranging from family learning to programmes to build self-esteem: ‘Family learning courses are absolutely fantastic, and we perhaps target the parents of some of the children who are at risk of exclusion to cover work in school. It’s been life-changing, and we are very lucky that that hasn’t cost us anything.’

In specialist provision, a HT recalled drawing on external providers such as Autism Directions, ‘they can sometimes see the needs of the child in a way that you might have missed.’ Other external support came from health services, ‘we involve CAMHS or CYPS, depending on what’s appropriate for the needs of that child’ and, ‘We access behaviour support, and we look at if we should bring early help in, or CAMHS, so it’s the external services. It’s addressing the root cause of the behaviour.’



'We have got placements on offer in construction, on a farm and in-house here, which is the best thing about moving into here. We have sport, maintenance and nursery placements; it's good because a lot of our students aren't ready to leave here to do things off-site' (Specialist headteacher).

## Limbo

### Muddling through

A few of the Alternative provision HTs felt that, following a 12-week placement in a pupil referral unit (PRU), some schools were reluctant for the child to return to mainstream education: 'I don't think the school wants to change to meet these children's needs because it isn't a priority, that's how the system is.' This view aligns with the view of a secondary HT who stated 'they go for 12 weeks to the PRU, and it doesn't work, sometimes they come back worse. It's a waste of money and not doing it anymore.'

Some of the primary HTs believed mainstream school was not the right place for the child at risk of exclusion due to the complexity of their needs, but delays with Education, Health and Care Plans caused issues: 'One child has significant mental health needs and an inability to cope with social situations, changes to routine and interactions with other children. This child exerts so much that they can collapse and go to sleep' and, 'a couple of children are autistic children. They have got chew toys as well because otherwise, they would just chew everything else. We do what we can.'

Other HTs disclosed similar concerns:

We have had children who have needed that one-to-one support and we've had children who have been so emotionally unstable that they've not been able to stay in school. You have to look at the health and safety risks, to that particular child and their peers. There are times when a child has had to be removed out of the classroom because sometimes frustration can manifest itself in throwing chairs or whatever. At that point, safety supercedes everything (primary HT).

and

We have applied for a PRU place, and we put that on the back burner. Though I think he's going to need it. A lot of things have happened to this young man, and he is at extreme risk of all sorts of things. I've got special things in play at lunchtime, we've got special arrangements in the classroom, so the behaviour policy sort of applies to him, but we appreciate that he can't manage a whole morning of lessons (primary HT).

Other primary HTs' comments also indicated they delayed seeking support for the child or involving caregivers in a timely manner: 'We monitor the behaviour, and we have a consequences system. There will be children who have consequence logs, C1 or C2 but once they start going to C4, then we do tend to talk with parents and talk to the child and look at what the issue is' and, 'I would see parents and come up with a support plan and put that under a view for 3 months and if it's really bad maybe every month.'

There were also reports of some behaviour systems being used to manage children's behaviours, rather than understand them:

The behaviour system roughly will work as the children being given a certain number of chances within the class, then the teachers will give them consequences under the behaviour model. We have got an evidence base on CPOMS, which allows teachers to notice patterns evolving in children's behaviour. If the pattern starts to evolve then the pastoral lead will take it upon herself to start working with that child and involve the parents (Secondary HT).

### Reduced school day

The data suggests there are children who are unable to access a full school day of learning, who instead have a part-time timetable. This part-time offer was often for children in limbo, awaiting an EHCP needs assessment or those who had significant mental health needs. Some of the primary

schools had reduced timetables in place for those children for whom full-day attendance was felt to be unrealistic, as they needed more 1:1 support, 'I have to look at creative ways of staffing, and flexible timetables and one-to-one seem to be working really well.'

We have currently one child who is on a reduced timetable, they are on the SEN register we are currently applying for an Education Health Care Plan. The reduced timetable is staggered to meet his needs. We talk about the provision of things that he particularly enjoys in the day. It works really well, so when he's thriving, it's not an issue but looking at the flashpoints that are causing those issues, match the timetable around it.

And

We look at a reduced timetable if it's more manageable. We look at periods of time where we could have someone to one with that child.

Another primary school had a shortened school day and were able to be flexible in timings: 'We have done, with parental consent, a reduced day. Start at 10 am and go home at 2 pm. Sometimes it's lunchtime that's a problem, so can we have something different happening there.' For a specialist school, they had alternative timetables including out of school hours: 'We have alternative timetables so they could come in on the morning and night times, which means they are out of the social loop and can get to 4 hours of solid learning.'

Of the schools who have reduced school day for children, it did not come across as a temporary solution as made explicit in the (DfE 2020) attendance guidance.

## Concluding remarks

In this study, 46 headteachers took part in semi-structured interviews to discuss alternative approaches to school exclusion. The study set out to determine, through reflexive thematic analysis, the range of approaches used in schools as an alternative to school exclusion. The results were created by constant comparison and revisiting the data extracts used to verify the thematic coding and support the following conclusions.

The findings of this study suggest alternative approaches to school exclusion can be categorised into three distinct categories: exclusionary systems, processes and practices; limbo; and inclusionary systems, processes and practices. The conclusions highlight the importance of statutory school guidance that clearly defines 'inclusion' and legislation that mandates schools to identify, assess and effectively respond to children's special educational needs and disabilities.

### Exclusionary systems

The impact of isolation booths on children's mental and physical health is well-documented (Hall-Lande et al. 2007; Osgood et al. 2013; Martin-Denham 2020a) and has resulted in schools becoming less inclusive (Gazeley 2010; West and Bailey 2013; Gorard 2014; Martin-Denham 2020a). This research has revealed only one headteacher in the study suggested assessing and identifying underlying special educational needs and disabilities as an alternative to school exclusion. This finding deepens our understanding that some children are unable to cope in school; strengthening the view proposed by Horridge (2019) that needs not made visible cannot be met in schools. Secondary HTs in this study accepted exclusionary practices as a necessity, and in some cases, felt it was useful or helpful in preventing negative behaviours though this contradicts previous findings by Martin-Denham (2020) that segregating and isolating children compounds their dysregulation. While there was no suggestion from the HTs that isolation was used as a permanent solution, they rarely gave an explicit value regarding the maximum length of time a child could be held in internal exclusion.

### Limbo

The theme of 'limbo' was used to describe schools that are neither exclusionary nor inclusionary but are holding children in their care (Abawi, Carter, and Carter 2018). The views of alternative provision HTs were mainstream schools do not want children with behavioural challenges on their school roll. It was also apparent that some primary HTs felt mainstream schooling was not the right

placement for some children, but until an EHCP was secured, they were doing what they could to support them. However well meaning the schools were in holding the children in their care, research by Martin-Denham, 2020 suggests when children are not coping in school the detriment to the mental health of both the child, their siblings and caregivers increases (Martin-Denham 2020a, b, c, d). There are clearly children who require early intervention, but school processes can mean that only when a child is frequently receiving sanctions do the caregivers become informed about behavioural concerns. These schools are in limbo, whereby their systems and processes do not allow for timely assessment and identification of the diverse needs of individual children in their care.

#### Inclusionary systems

In contrast to the secondary schools, the primary and specialist schools frequently adopted what they viewed to be inclusive approaches focussed on regulation of behaviour to enable participation in school life. When children displayed anxiety, challenging behaviours or to prevent escalation of behaviour, the schools would provide a range of approaches to support the child in becoming regulated. The spaces included sensory rooms, music rooms, nurture groups, forest school and reflection rooms. They all felt the provision of these bespoke spaces, coupled with reasonable adjustment and in-class regulation resources such as fiddle toys, allowed the children to cope in mainstream school. The transition for children in mainstream primary school, who survive due to access to therapeutic spaces, will need an equitable provision in secondary education. The use of behaviour plans and targets were frequently used to identify individual difficulties and behaviour triggers that present as a risk for school exclusion. The alternative provision headteachers, and some of the primary headteachers, prioritised working alongside caregivers as soon as difficulties became apparent. Being available to caregivers is fundamental to preventing school exclusion at the school site or remotely. Finally, through external support, the headteachers were able to begin to understand how to better respond to individual behaviours as they present in children.

#### Statutory guidance

The statutory guidance for special educational needs and disabilities (SEND) fails to define inclusion (DfE and DfE and DoH 2015, 93) referencing 'schools have wider duties to prevent discrimination, to promote equality of opportunity and to foster good relations.' Similarly, the statutory framework for the early year's foundation stage (DfE 2017b) fails to refer to 'inclusion' let alone provide a definition. In addition, the National curriculum framework for key stages 1–4 (DfE 2014) omits a definition of inclusion only guiding teachers that they 'should' set suitable challenges, respond to pupil's needs, and overcome barriers. These omissions in statutory guidance could explain why the evidence in this study suggests some schools are exclusionary in their systems, processes and practices as there is no mandated statutory duty to be inclusive.

The behaviour and discipline guidance DfE (2016) needs to define what is meant by 'limited period' to prevent schools being able to determine the duration children can be placed in segregated and isolated environments. In secondary schools, in particular, there is a focus on placing children on report, detention, and then isolation; and with every step, the risk of school exclusion increases. Highlighting differences and segregating children can only further promote divisions in the school community (Juvonene et al. 2019). Instead, there needs to be a focus on individualised support, academic and social development as set out in the Convention on the Rights of Persons with Disabilities (2005) and identification and assessment of underlying special educational needs and disabilities. To achieve this, it is imperative investment is made for high quality training for in-service teachers and support staff, to enable them to continue to, or to begin to, provide inclusive schools for children.

## Limitations

As with all qualitative research there are limitations. It is accepted conclusions drawn from qualitative research may not be generalisable (Kvale 1994; Barbour 2001). The study is limited as it is a sample of headteachers from one local area. However, the research does share the views of headteachers from

different types of schools and genders. Many of the headteachers commented they were pleased to have been given the opportunity to share their experiences of supporting children on the edge of or who had experienced school exclusion.

## Note

This journal article forms the background to a policy brief.

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## AUTISM &amp; CAREGIVERS

# Marginalisation, autism and school exclusion: caregivers' perspectives

SARAH MARTIN-DENHAM 

The article presents findings from interviews with five caregivers of children with autism excluded from schools in England. Objectives: to determine the barriers and enablers to mainstream schooling for children with autism and to explore the emotional effect of the journey to school exclusion on the child and caregivers. Background: research has highlighted that some mainstream schools do not listen to caregivers concerns about their child's development, behaviours and mental health. Methods: interpretative phenomenological analysis was employed to understand how participants made sense of their lived experiences, revealing four superordinate themes: inadequate special educational needs and disability (SEND) support, psychological impact, health-imposed barriers to diagnoses, and effective support. Findings: Theographs present the caregivers' journeys, illustrating that the onus fell on the caregivers to advocate for effective support from schools. A lack of prompt diagnose and effective school support is detrimental to the emotional and physical health of both children and caregivers. Training is needed to ensure thresholds for education, health and care needs assessments are understood, alongside evidence-based approaches to support children with SEND. There is a policy need to address barriers to prompt health assessments across services and the impact of decreased funding on schools.

**Key words:** autism, school exclusion, interpretative phenomenological analysis, theographs, qualitative research.

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## Introduction

This article draws on data gathered during a two-year study investigating the impact of schooling and school exclusion on the mental health and well-being of children (Martin-Denham, 2020a, 2020b, 2020c). The original study involved 174 participants, including 55 children, 41 of their caregivers and 78 professionals from schools and health services. This research focuses on five interviews with caregivers of children with autism who had either fixed period or permanent school exclusions. It has two objectives: (1) to determine the barriers and enablers to mainstream schooling for children with autism and (2) to explore the effect of the journey to school exclusion on the child and caregivers.

Historically, the UK strategy for securing parental involvement (Department for Education and Skills (DfEE), 1997a) had three areas of focus: better information, involving parents in their child's education, and parent-governors having a voice in the running of schools. The DfEE green paper 'excellence for all children' (1997b) acknowledged the need to support caregivers across education, health, care and voluntary sectors. This momentum continued within the principles of the Department for Education and Skills (DfES) special educational needs (SEN) code of practice (2001), which states 'parents have a vital role to play in supporting their child's education' (p. 12). The Children and Families Act (CAFA) 2014 intensified the statutory requirement to involve parents in decisions that directly affect children with SEND. In 2015, the Department for Education (DfE) and Department of Health [DoH] statutory guidance, 'SEND code of practice' (herein referred to as 'the code'), emphasised: support for parents in early identification (of SEND), high-quality provision, decision-making, choice and control, and collaboration between agencies. Despite this, the House of Commons Education Committee (2019, p. 3) reported failures in implementing the CAFA (2014), leading to 'unlawful practice, bureaucratic nightmares, buck-passing, lack of accountability, strained resources and adversarial experiences.'

## Early identification

The Bercow Report (Department of Children Schools and Families (DCSF), 2008), the Lamb Inquiry (DCSF, 2009), the Salt Review (DCSF, 2010), the Office for Standards in Education (Ofsted) SEND Review (2010) and the Timpson Review (DfE, 2019) highlighted the critical role early identification plays in improving outcomes for children. Pirrie *et al.* (2011), Horridge (2019)

and Martin-Denham (2020a, 2020b, 2020c, 2020d) agree that early identification reduces the likelihood of disrupted pathways in school, as needs made visible are more likely to be addressed. Research consistently shows that caregivers accurately predict the presence of developmental issues and disabilities in their children (Glascoe, 1999; Tervo and Asis, 2009; Woolfenden *et al.*, 2014; Ireland and Horridge, 2017; Martin-Denham, 2020a, 2020d), though they view diagnosis as the only gateway to support (Driver Youth Trust, 2015). The Timpson Review (DfE, 2019, p. 39) clarified that, where a child's behaviour raises concerns, there is an expectation that schools have clear processes for assessment of 'causal factors such as undiagnosed learning difficulties, difficulties with communication and mental health issues'. The Independent Provider of Special Education Advice (IPSEA) (2020) note, if a local authority is requested to carry out an Education, Health and Care (EHC) needs assessment, they must consider whether:

- The child or young person has or may have SEN; and
- Special educational provision may be required (EHC Plan).

CAFA (2014) established a legal obligation to assess needs where the above criteria are met.

Financial pressures on schools contribute to their inability and willingness to identify difficulties and provide support (House of Commons, 2018). The Future in Mind report (Department of Health and NHS England, 2015, p. 57) recommended a multi-disciplinary approach, coordinating 'assessment and planning around the individual child, facilitated by information sharing'. The House of Commons Education Committee (2019) reiterated the importance of multi-disciplinary support for children with disabilities.

Rising demand for mental health support services adds further barriers to accessing SEND diagnoses (Chief Medical Officer, 2012; Martin-Denham, 2020a), as does a lack of information on pathways to services (Boyd *et al.*, 2011; Anderson *et al.*, 2017; Iskra *et al.*, 2018), resulting in caregivers seeking out information independently (Williams and Rheingold, 2015). Hutchinson and Crenna-Jennings (2019) reported that in the previous five years 55,800 children referred to Child and Adolescent Mental Health Service (CAMHS) were not deemed eligible for support, and long waiting times for appointments are the critical barrier to engagement with mental health support services (Golding, 2010; Anderson *et al.*, 2017; Iskra *et al.*, 2018; Martin-Denham, 2020b).

## School exclusion

The Education Act, 1986 first introduced the terms ‘fixed-period’ and ‘permanent’ exclusions, paving the way for schools to remove a child when they were deemed to be persistently or severely deviating from the school’s behaviour policy (DfE, 2017). A permanent exclusion refers to ‘a pupil who is excluded and who will not come back to that school’, while fixed period exclusion refers to a pupil who is excluded from a school for a set period (DfE, 2020). A pupil may be excluded for one or more fixed periods up to a maximum of 45 school days in a single academic year. A decision to exclude a child must be lawful, rational, proportionate and fair (Education Act, 2002, 2011; European Court of Human Rights, 2010).

A wealth of evidence in the UK shows that those excluded from school have increased risk of poor educational outcomes (Social Exclusion Unit, 1998; Daniels *et al.*, 2003; Office of the Children’s Commissioner, 2017; Martin-Denham, 2020a, 2020b, 2020c, 2020d). The Autism Education Trust (2020) highlights that children on the autism spectrum have increased vulnerability to exclusion from school due to a lack of awareness of autism, leading to situations where the child becomes overwhelmed by unstructured aspects of their school life.

## The prevalence of school exclusion

Permanent exclusions declined from 1995–1996 then rose again in 2012–2013 (DfE, 2018). The number of permanent exclusions decreased by only 11 in 2018/2019, with fixed-period exclusions rising from 410,800 to 438,300 (DfE, 2020). Hatton (2018) suggested that rates of fixed-period exclusions are at least three times higher for children with autism compared to those without SEN. Ambitious about Autism (2020) note that exclusions of children with autism have increased significantly in the last few years, reporting that 56% of children with autism are excluded unlawfully. Furthermore, the national data do not include unofficial exclusions such as managed moves, inclusion units, nurture rooms and isolation rooms (Power and Taylor, 2020). Atkinson (2012), Gill *et al.* (2017) and Martin-Denham (2020c) presented examples of caregivers being coerced to agree to a managed move as an alternative to a permanent school exclusion, which would remain on their school records.

Increasing school exclusions continue to generate national concern. Findings from the Timpson Review (DfE, 2019) highlight a lack of specialist settings for pupils with autism and social, emotional or mental health (SEMH) needs, meaning they remain in unsuitable schools lacking in specialist knowledge.

## Methods

Interpretative phenomenological analysis (IPA) was used to determine the barriers and enablers to mainstream schooling for children with autism, and to explore the effect of the journey to school exclusion on the child and caregivers. IPA is founded on the premise that humans can interpret and understand their world through biographical stories (King *et al.*, 2019), enabling them to make sense of their major life experiences. The method enables in-depth analysis due to the rich detail within individual stories (Smith *et al.*, 2009), giving rise to valuable insights into participants' experiences, perceptions and behaviours (Cuthbertson *et al.*, 2020). IPA is also useful when examining 'complex and emotionally laden' topics (Smith and Osborn, 2015, p. 1). Each case is analysed individually to gain as much as understanding as possible before progressing to the next (Cassidy *et al.*, 2011). In the latter stage of cross-case analysis, the emphasis on the individual's experiences is retained alongside examination of how their thoughts and beliefs align with more general themes (Smith and Eatough, 2008).

One limitation of IPA is that analysts may interpret data differently, raising questions around validity and reliability, particularly if a small sample size is used (Charlick *et al.*, 2016). Generalisability is therefore not possible here, due to the small sample and the localised nature of the study. However, claiming generalisability was not an objective; this research aims to share the lived experiences of the five caregivers of children with autism who had been excluded from school.

Theographs provide a visual representation of the data. Their value lies in their ability to identify gaps and patterns of events (Georghiou, 2020).

## Sample selection and recruitment

The original study used purposive sampling to ensure that the participants were a homogenous sample with first-hand experience of the process of school exclusion.

**Table 1.** Caregiver (with pseudonyms to preserve anonymity) and child profiles

| Participant      | Marital status    | Employment status      | Age of child (years) | Gender of child | Diagnoses                        | School exclusions                                 | SEN status                                 |
|------------------|-------------------|------------------------|----------------------|-----------------|----------------------------------|---------------------------------------------------|--------------------------------------------|
| Father (Justice) | Married to mother | Employed               | 6                    | Female          | Autism and Physical Disabilities | Multiple il-legal FeX                             | Awaiting referral for EHC needs assessment |
| Mother (Sadie)   | Single parent     | Employed               | 8                    | Male            | Autism                           | Multiple FeX <sup>a,b</sup><br>1 PeX <sup>b</sup> | SEN support (since infant school)          |
| Mother (Olwen)   | Married to father | Employed               | 10                   | Male            | Autism, ADHD, ODD                | Multiple FeX <sup>a,b</sup><br>1 PeX <sup>c</sup> |                                            |
| Mother (Viv)     | Married to father | Employed               | 16                   | Male            | Autism and ADHD                  | Multiple FeX <sup>a,c</sup><br>1 failed MM        | EHCP (Agreed age 16)                       |
| Mother (Lucy)    | Single parent     | Resigned to homeschool | 17                   | Male            | Autism and Fragile X Syndrome    | 1 PeX <sup>c</sup>                                | EHCP (Agreed age 7)                        |

*Note:* ADHD, attention deficit hyperactivity disorder; EHCP, education, health and care plan; FeX, fixed period exclusion; MM, managed move; ODD, oppositional defiance disorder; PeX, permanent exclusion.

<sup>a</sup>Persistent disruptive behaviour.

<sup>b</sup>Physical assault against an adult.

<sup>c</sup>Physical assault on a pupil.

Of the 41 caregivers who took part in the original study, five met the criteria for this article (see Table 1 for details of caregivers and children).

1. They had a child with a diagnosis of autism.
2. That child had received fixed period and/or permanent exclusions.

## Procedure

Semi-structured interviews took place between September 2018 and June 2019. These were digitally recorded, transcribed verbatim, anonymised and stored securely. To allow in-depth responses to open-ended questions, no time limits were imposed on the interviews. The researcher took a neutral, non-directive stance, allowing the caregiver to share their stories as the primary expert (Alexander and Clare, 2004; Smith *et al.*, 2009).

## Data analysis

In accordance with IPA, the five transcripts were analysed using the six-step process advocated by Smith and Osborn (2003), and Smith *et al.* (2009).

1. Listening to, reading and re-reading the interviews.
2. Initial noting of semantic content and language.
3. Developing emergent themes.
4. Searching for connections across emergent themes.
5. Moving to the next case.
6. Looking for patterns across cases.

Table 2 shows stages 1–3 of the IPA process, recording what mattered to each participant in terms of relationships, processes, places, events, values and principles.

The next stage involved drawing together the emergent themes (abstraction) from the transcript to identify patterns to create a potential superordinate theme (Table 3).

The next stage involved repeating the process with the next interview transcript. To be faithful to the idiographic commitment, ideas from the first case were bracketed, and the focus restarted on the following subject (Smith *et al.*, 2009). To identify patterns and connections across the cases, a table of superordinate themes was created (Table 4). All superordinate themes were present in over half of the sample.

**Table 2.** Steps 1–3 of IPA (interview with Justice)

| <i>Emergent themes</i>                                                                                                        | <i>Quote from the interview transcript</i>                                                                                                                                                              | <i>Exploratory comments</i>                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Interview question</b>                                                                                                     |                                                                                                                                                                                                         |                                                                                                                                                                                          |
| Was it easy getting health assessments carried out?                                                                           |                                                                                                                                                                                                         |                                                                                                                                                                                          |
| Mourning for what could have been                                                                                             | We had to pressure them, if she had been diagnosed earlier then she would have got that support.                                                                                                        | Onus on the caregiver to push for the child to have their SEND needs assessed                                                                                                            |
| Hope for the future                                                                                                           | We still haven't been able to get into a special school. Hopefully, though in September she will start one                                                                                              | Use of 'if' suggests Justice was reflecting on what could have been if his daughter was diagnosed sooner                                                                                 |
| Loss of future                                                                                                                | She was supposed to start this September (special school), but she couldn't because the application had been delayed and there wasn't enough space                                                      | Processes matter to them, application for an EHC needs assessment was delayed and he believes this resulted in there not being a place available for his daughter in a specialist school |
| The current EHC needs assessment system can lead to securing appropriate provision that meets the needs of children with SEND |                                                                                                                                                                                                         |                                                                                                                                                                                          |
| Lack of accountability                                                                                                        | It is the council's responsibility to provide special education.                                                                                                                                        | Feels council failed in their duties                                                                                                                                                     |
| Schools holding children until special provision can be secured                                                               | Last year she was in reception and this year she is in reception; they haven't moved her up. I guess it is not their fault because they are saying that if she moves up to year one, she will struggle. | Emphatises with the school                                                                                                                                                               |
| The National Curriculum is not suitable for all children                                                                      | Her speech hasn't developed, she just has simple words, so things have been on hold for a year                                                                                                          |                                                                                                                                                                                          |

## Development of theographs

When the arising themes, related themes and superordinate themes had been developed, theographs were also created. These were made by noting and recording key events and milestones, as reported by the caregivers. Theographs were created as follows, using Sadie's interview as an example:

1. Reading and re-reading the original data, and listening to the audio files.

**Table 3.** Searching for connections across emergent themes (Justice)

| <i>Emergent themes from steps 1–3</i>                                         | <i>Related themes</i>                                     | <i>Potential super-ordinate them (step 4)</i>            | <i>Keywords</i>                                                |
|-------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|
| Mourning and grief for what could have been                                   | Importance of early assessment and identification of SEND | Health-imposed barriers to diagnosis                     | Pressure, cuts, shortages, diagnosis, hopefully, earlier, late |
| Importance of early identification of SEND                                    | More funding needed for health to support early diagnosis |                                                          |                                                                |
| Funding cuts can cause delays to identification and assessment of SEND        | Lack of qualified and skilled staff                       | Inadequate SEN support                                   | 1-1, support, regressing, part-time schooling                  |
| Caregivers feel teaching assistants are not best placed to meet child's needs |                                                           |                                                          |                                                                |
| School has a lack of funds to meet the needs of children with SEND            | Illegal exclusions                                        | Schools may have a lack of understanding of legal duties | Lunchtime, home, part-time, pressurising, remove               |
| Lack of special educational provision                                         | Pressure on caregivers to remove the child from school    | Inadequate SEN support                                   |                                                                |
| School unable to accommodate the needs of children with SEND                  | Child unable to access with the National Curriculum       | Unachievable curriculum expectations                     | Not developing, toys, count, interaction                       |
| School unable to meet child's learning needs                                  |                                                           |                                                          |                                                                |
| Ineffective school placement processes                                        | The child needs specialist educational provision          | Inadequate SEN support                                   | Friends, pressurising, Ofsted, hope                            |
| The school does not want the child                                            |                                                           |                                                          |                                                                |
| Any specialist school will do                                                 |                                                           | Psychological impact on child and caregivers             |                                                                |
| Hope                                                                          |                                                           |                                                          |                                                                |

(Continues)



Table 3. (Continued)

| <i>Emergent themes from steps 1–3</i>             | <i>Related themes</i>                       | <i>Potential super-ordinate them (step 4)</i> | <i>Keywords</i>                       |
|---------------------------------------------------|---------------------------------------------|-----------------------------------------------|---------------------------------------|
| Broken relationship with school is hard to repair | Importance of collaboration with caregivers | Psychological impact on caregiver             | Honest, research, trying, interaction |
| Distrust of school                                |                                             |                                               |                                       |
| Caregivers upskilling to meet their child’s needs |                                             |                                               |                                       |

**Table 4.** Identifying recurrent themes

| <i>Superordinate theme</i>           | <i>Justice</i> | <i>Sadie</i> | <i>Olwen</i> | <i>Viv</i> | <i>Lucy</i> | <i>Present in over half the sample</i> |
|--------------------------------------|----------------|--------------|--------------|------------|-------------|----------------------------------------|
| Inadequate SEN support               | Yes            | Yes          | Yes          | Yes        | Yes         | Yes                                    |
| Psychological impact                 | Yes            | Yes          | Yes          | Yes        | Yes         | Yes                                    |
| Effective support                    | Yes            | Yes          | Yes          | Yes        | Yes         | Yes                                    |
| Health imposed barriers to diagnosis | Yes            | Yes          | Yes          | Yes        | No          | Yes                                    |

Table 5. Example of theograph table

| Year group | Setting  | Event                                                                    | Quotes                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------|----------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1          | School 1 | <b>Child begins to have difficulties</b>                                 | His needs changed as he went through school. Initially, it was not being able to sit still at carpet time and not being able to put his hand in the air. He would just shout out which was exactly what was happening when he joined the junior school                                                                                                                                                       |
| 2          | School 1 | <b>Autism diagnosis</b>                                                  | The route to his diagnosis was kind of convoluted. We had some private observations done by a neuropsychologist. They said he's very high functioning but, on the autism spectrum. It was always borderline, always quirky. With him moving to the junior school, if there were a diagnosis, they would be obligated to take account of that which in theory is great if the school can be bothered to do it |
| 2          | School 1 | <b>Referred to CAMHS</b>                                                 | We started trying to refer him to CAMHS. We were told he had to go through CYPS. Then CYPS rejected him. CAMHS wouldn't have been relevant for him. It wouldn't have been specific enough for him. CYPS might have been able to do something, but they rejected the case anyway                                                                                                                              |
| 2          | School 1 | <b>CAMHS refer to CYPS</b>                                               |                                                                                                                                                                                                                                                                                                                                                                                                              |
| 2          | School 1 | <b>CYPS reject CAMHS referral</b>                                        |                                                                                                                                                                                                                                                                                                                                                                                                              |
| 2          | School 1 | <b>Junior school rejected caregiver requests for transition meetings</b> | I had been offering to go in since before the school holidays to talk to them about his needs and what he would require in terms of settling in properly. It was all declined. As a parent there is only so much you can offer and then the school don't take it up                                                                                                                                          |

(Continues)

**Table 5. (Continued)**

| <i>Year group</i> | <i>Setting</i> | <i>Event</i>                                                        | <i>Quotes</i>                                                                                                                                                                           |
|-------------------|----------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3                 | School 2       | <b>His class is changed the day before he starts his new school</b> | The day before he started in September, the school phoned me and told me they were changing his class. It was just a complete lack of comprehension of how that would affect him        |
| 3                 | School 2       | <b>No SEN support in place</b>                                      | They didn't find out from the infant school how they managed him. So, he was dumped into a classroom with 30 odd and left to get on with it. It went down-hill drastically very quickly |

*Note:* CAMHS, child and adolescent mental health services; CYPS, children and young people's service.

2. Creating a spreadsheet with setting, event and quotes, as shown in Table 5.
3. Colour coding the events and experiences: red for negative and green for positive on excel to create a theograph.

## Theographs for each of the caregivers' interviews (Figures 1–5) and respective keys (Tables 6–10).

### Findings

The following superordinate themes arose: Inadequate SEND support, psychological impact, and health-imposed barriers to diagnoses and effective support.

### *Inadequate SEND support in school*

All caregivers commented that most mainstream schools offered inadequate SEND support. Sadie recounted that there was no support for her son with autism, despite a medical report informing the school that, without strategies to support him, he would experience significant behavioural difficulties:

They didn't put any support in place; they didn't put any time-out breaks in place, no sensory support in place. So, he was dumped into a classroom with 30-odd, it went downhill drastically. There were lots of things that we talked about the day before they excluded him, putting in place for him, an individual visual timetable which he didn't have.

Similarly, Lucy explained that her child's EHCP and educational psychologist report stated the need for a safe space and time outside. She perceived that the

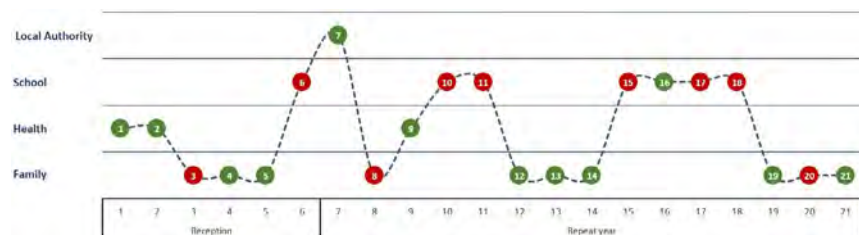


**Figure 1.** Theograph presentation of the interview with Justice [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

**Table 6.** Figure 1 data key

| Key | Event                                                                                                    | Key | Event                                                                                       |
|-----|----------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------------|
| 1   | Support from multiple health consultants for physical disabilities                                       | 12  | Caregiver offers to home school their child, mother works with LA to find a suitable school |
| 2   | GP refers child to SaLT                                                                                  | 13  | Child added to waiting list for a school specialising in autism                             |
| 3   | Caregivers share developmental concerns with school                                                      | 14  | Caregivers request funding support for 1:1 tuition                                          |
| 4   | Mother carries out independent research into how to support daughter                                     | 15  | School rejects request – insufficient funds                                                 |
| 5   | Mother volunteers at special school to learn how to support her child's needs                            | 16  | School provides support from a teaching assistant                                           |
| 6   | School take decision to retain child in reception for a second year                                      | 17  | School suggests ½ day attendance, parents decline                                           |
| 7   | LA educational psychologist assessment, recommends transfer to a specialist unit                         | 18  | School imposes illegal fixed-period exclusions (insisting on part-time attendance)          |
| 8   | Caregivers decline specialist placement, feel the school does not want child                             | 19  | Mother buys more educational toys to support development at home                            |
| 9   | Paediatrician diagnoses ASD, recommends that child remain in mainstream school with support              | 20  | Caregivers share concern with school that child is regressing                               |
| 10  | School recommends alternative placement, caregivers refuse as the school is not for children with autism | 21  | Caregivers request dual placement for child                                                 |
| 11  | School pressures caregivers to take place, citing concerns over upcoming Ofsted inspection               |     |                                                                                             |

Note: GP, general practitioner; LA, local authority; SaLT, speech and language therapist; TA, teaching assistant.

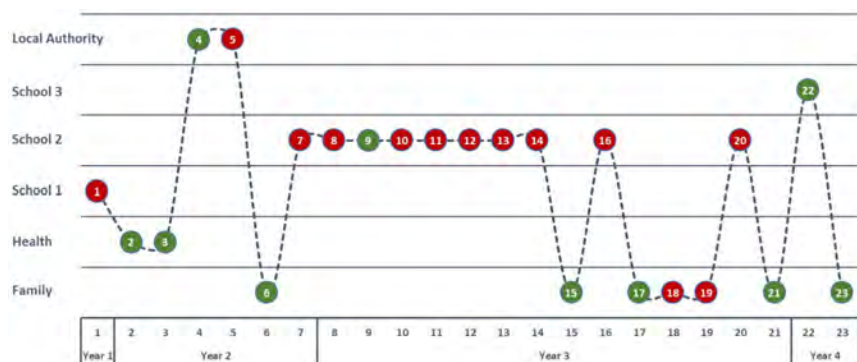


**Figure 2.** Theograph presentation of the interview with Sadie [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

**Table 7.** Figure 2 data key

| Key | Event                                                      | Key | Event                                              |
|-----|------------------------------------------------------------|-----|----------------------------------------------------|
| 1   | School report behaviour concerns to mother                 | 13  | Child moved to back of class                       |
| 2   | Child diagnosed with ASD                                   | 14  | Multiple fixed-period exclusions                   |
| 3   | Referred to CAMHS                                          | 15  | Mother requested that school seek external support |
| 4   | CAMHS refer to CYPS                                        | 16  | School declines request                            |
| 5   | CYPS reject referral                                       | 17  | Mother contacts Autism Outreach                    |
| 6   | Mother requests transition meeting with school 2 (juniors) | 18  | Mother feels school does not want child            |
| 7   | Junior school rejects request for transition meetings      | 19  | Child assaults another pupil                       |
| 8   | School changes child's class the day before term starts    | 20  | Permanent school exclusion                         |
| 9   | Child starts school 2                                      | 21  | Mother homeschooling, considers tribunal case      |
| 10  | No SEN school support in place                             | 22  | Child starts school 3                              |
| 11  | First fixed-period exclusion                               | 23  | Child participating and learning                   |
| 12  | School tells parent child is difficult to manage           |     |                                                    |

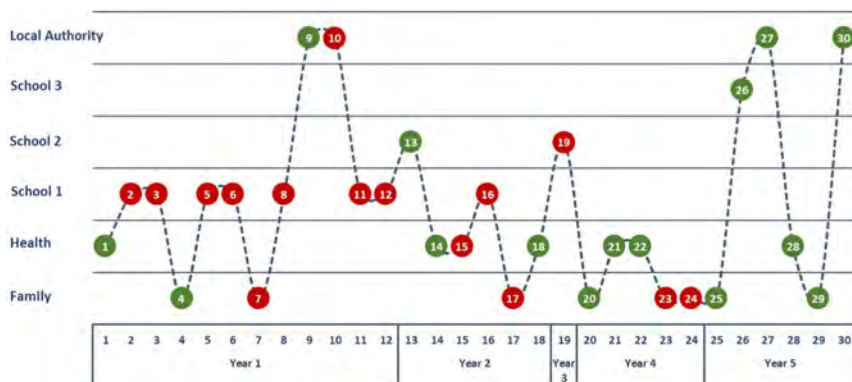


**Figure 3.** Theograph presentation of the interview with Olwen [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

**Table 8.** Figure 3 data key

| Key | Event                                                                           | Key | Event                                                                            |
|-----|---------------------------------------------------------------------------------|-----|----------------------------------------------------------------------------------|
| 1   | Accessed CAMHS who referred to CYPs who referred back to CAMHS                  | 16  | Multiple fixed-period exclusions                                                 |
| 2   | Teacher reports being hit by child                                              | 17  | Caregivers continue to raise concerns over schools ability to meet child's needs |
| 3   | Multiple fixed-period exclusions                                                | 18  | Child diagnosed with ASD, ADHD and ODD                                           |
| 4   | Caregivers request that school refer EHC needs assessment                       | 19  | Multiple fixed-period exclusions                                                 |
| 5   | School refuses EHC needs assessment referral                                    | 20  | Caregiver returns to GP multiple times due to school exclusions                  |
| 6   | School unable to meet needs, segregates child at breaktime, caregivers complain | 21  | GP referral to CAMHS                                                             |
| 7   | Mother becomes anxious that school will ring about child's behaviour            | 22  | CAMHS refer to CYPs                                                              |
| 8   | School attributes behaviour to home life and parenting                          | 23  | Caregivers feel school does not want child                                       |
| 9   | Early help carry out a home visit                                               | 24  | Child becomes unable to attend school. Caregiver withdraws child from school     |

(Continues)



Table 8. (Continued)

| Key | Event                                                           | Key | Event                                                                    |
|-----|-----------------------------------------------------------------|-----|--------------------------------------------------------------------------|
| 10  | Early help unable to support                                    | 25  | Child starts at school 3                                                 |
| 11  | School describes child as “naughty”, won’t allow sensory breaks | 26  | Mother seeks external agency report which secures LA involvement         |
| 12  | Mother told to start parenting course by school                 | 27  | LA provide a PRU place                                                   |
| 13  | Child starts school 2                                           | 28  | CYPS give mental health support to child, external agency support parent |
| 14  | CAMHS access resumed                                            | 29  | Child formally withdrawn from mainstream schooling to attend a PRU       |
| 15  | CAMHS discharge – no issues                                     | 30  | EHC plan secured                                                         |

Note: PRU, pupil referral unit.

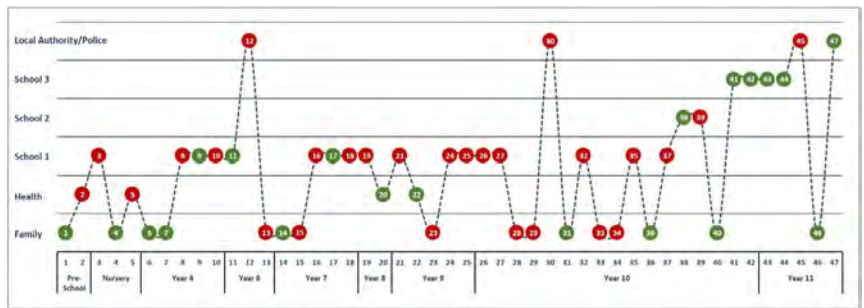


**Figure 4.** Theograph presentation of the interview with Viv [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

school did not appreciate the importance of supporting self-regulation: ‘For the last six months they didn’t have this in school; they were put in a classroom which has less space. They never explored letting him outside.’

Olwen recalled that her son, who was diagnosed with autism, ADHD and ODD following multiple fixed period exclusions, was ‘not allowed to move and not given movement breaks. Those days he found particularly difficult. I knew I’d get that phone call that day to go and get him.’ Olwen raised concerns to the school regarding the lack of sensory breaks: ‘If you’re going to lock him up in a room,

**Table 9.** Figure 4 data key

| Key | Event                                                                     | Key | Event                                                                         |
|-----|---------------------------------------------------------------------------|-----|-------------------------------------------------------------------------------|
| 1   | Parent requests SaLT referral                                             | 25  | Child placed on school report                                                 |
| 2   | SaLT report no concerns                                                   | 26  | Multiple fixed-period exclusions                                              |
| 3   | School reports disruptive behaviour to caregivers                         | 27  | Child physically assaulted by another child, resulting in a dislocated finger |
| 4   | Parent requests consultant referral                                       | 28  | Mother reports incident to school, dismissed as an accident                   |
| 5   | Consultant discharges with no concerns                                    | 29  | Caregivers contact police about disability discrimination                     |
| 6   | Mother arranges referral to consultant, child diagnosed with autism       | 30  | Police interviews result in no further action against the child               |
| 7   | Caregivers request school refers EHC needs assessment                     | 31  | Mother requested a managed move/EHCP assessment to school                     |
| 8   | School refuse to support EHC needs assessment referral                    | 32  | School declines managed move and referral for EHC needs assessment            |
| 9   | Educational psychologist assessment arranged by school                    | 33  | Mother prescribed beta blockers for anxiety                                   |
| 10  | Educational psychologist assesses and identifies no learning difficulties | 34  | Child assaults another pupil                                                  |
| 11  | SENCO requests EHC needs assessment                                       | 35  | Permanent school exclusion                                                    |
| 12  | LA decline EHC needs assessment                                           | 36  | Caregiver's re-request school referral for EHC needs assessment               |
| 13  | Child discloses suicidal feelings to caregivers                           | 37  | School refuses EHC needs assessment referral                                  |

(Continues)

Table 9. (Continued)

| Key | Event                                                              | Key | Event                                                                        |
|-----|--------------------------------------------------------------------|-----|------------------------------------------------------------------------------|
| 14  | Caregivers tell child about their autism diagnosis                 | 38  | Child moves school                                                           |
| 15  | Child assaults a pupil in school                                   | 39  | Child bullied for being different                                            |
| 16  | First fixed-period exclusion                                       | 40  | Mother requested managed move, managed move agreed to PRU                    |
| 17  | School refers to CAMHS                                             | 41  | Child moves school                                                           |
| 18  | Multiple fixed-period exclusions                                   | 42  | Bespoke curriculum implemented; vocational college training agreed           |
| 19  | Multiple fixed-period exclusions                                   | 43  | Child passing exams                                                          |
| 20  | CAMHS suspect ADHD and refer to CYPS                               | 44  | School 3 submits EHC needs assessment                                        |
| 21  | Multiple fixed-period exclusions                                   | 45  | EHC needs assessment rejected by L/A                                         |
| 22  | CYPS diagnose ADHD, child medicated for ADHD                       | 46  | EHC needs assessment refusal appealed, school 3 provides supporting evidence |
| 23  | Caregivers report bullying to school                               | 47  | EHC needs assessment decision overturned, EHCP granted                       |
| 24  | School removes break times but reinstates after parental complaint |     |                                                                              |



**Figure 5.** Theograph presentation of the interview with Lucy [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

well, he'll just be like a crazed animal.' Viv, whose son also received multiple fixed period exclusions prior to diagnosis of autism and ADHD, disclosed that her son's school removed break time in case he became 'wound up'.

I went absolutely mad. I know that it's hard for them sometimes. They haven't got the resources. There needs to be something in place. These children can't be ignored and put in a room. There must be thousands of these children.

Justice's daughter was diagnosed with physical difficulties in pre-school and autism in reception. He believed that having only a teaching assistant for support was detrimental to her social skills and academic development. 'They have teaching assistant support. That's it. No extra support in helping her to develop, she needs constant interaction to help her and she's not developing because of that.' He also had a recommendation from a paediatrician that she remain in mainstream schooling with support. Despite this, the school repeatedly suggested reducing her full-time schooling to part-time. 'At one time, they were trying to push for her to only to attend for half a day, because of a lack of lunchtime facilities to support her to eat'.

### ***Inadequate staff training for schools***

All caregivers shared the view that many barriers to mainstream schooling occurred due to a lack of staff training on how to support children with SEND. Sadie felt that teachers needed a better understanding of the impact of transitions on children with autism:

**Table 10.** Figure 5 data key

| Key | Event                                                                              | Key | Event                                                                                             |
|-----|------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------------------|
| 1   | Diagnosis fragile X syndrome                                                       | 12  | Six different social workers in a year – recommending residential care against caregiver's wishes |
| 2   | Diagnosed autism spectrum disorder                                                 | 13  | Child starts school 2                                                                             |
| 3   | EHC plan secured                                                                   | 14  | Permanent school exclusion (following 16–18 holds (restraints) in 12 weeks)                       |
| 4   | Moved to specialist provision                                                      | 15  | Mother resigns employment to homeschool, child is regulated and seems happy                       |
| 5   | School building entrance system changed the day before he starts a new school year | 16  | Child starts school 3 (tutored approach 1:1)                                                      |
| 6   | Class teacher off with long term sickness                                          | 17  | Child regulated and home and with tutor                                                           |
| 7   | Psychiatrist prescribes child anxiety medication                                   | 18  | Mother was going to appeal permanent exclusion but changed her mind                               |
| 8   | Educational psychologist recommends safe spaces via EHCP                           | 19  | Residential provision recommended by social care                                                  |
| 9   | School unable to provide safe space, child unable to regulate emotions             | 20  | Mother declines residential, requests respite                                                     |
| 10  | Child frequently restrained by school staff                                        | 21  | No respite available                                                                              |
| 11  | Child self-harms (biting) occasionally lashes out at others                        |     |                                                                                                   |

They need to understand the transitions from one school to another, one class to another, and what impact that has. They need to understand not just the strategies but how to apply them.

Sadie felt that a reason her son encountered difficulties was the lack of transition support to the junior school, despite her numerous attempts to meet with the school. The change in her son's class teacher, the day before the start of term compounded his anxiety: 'there was a complete lack of understanding of what impact that would have on him.' Furthermore, she was aggrieved that the successful support plan in the infant school was not adequately followed by junior school staff:

From my perspective, the underlying issue was the support plan that was in place in the infant school did not follow him adequately to junior school. The junior school did not put any support in for him from day one. They didn't find out from the infant school how they managed him.

A barrier to securing an EHC needs assessment was one head teacher's belief that the child would not meet the threshold for assessment. Justice: 'We suspected that something else is wrong, was she autistic or something, we had to push the school because she wasn't like the other children.' They quoted the head teacher as saying: 'We cannot meet his needs. He will never reach the thresholds for an EHCP.' Viv had a similar experience, as the school declined to support her in requesting an EHC needs assessment:

We went to the school and said that we would like to go ahead and try and get an EHCP. The head teacher tried to laugh it off. He said 'he hasn't got a learning difficulty, so I don't think he will be able to get a statement'. They were reluctant to apply for one, to do all that work.

Four caregivers shared the view that schools need more knowledge and understanding of effective practice for children with SEND. Olwen said, 'Schools need more trained staff, specific specialist staff, for ADHD autism and things like that.' She felt this included an understanding that children's reactions can be based on anxiety: 'It's probably something so easy to fix; a funny smell or somebody's getting on their nerves. Somebody's behind them scraping on the desk.' This compounded her child's anxiety, leading to the school using restraint as a method of 'keeping him safe'. The school had disclosed with her that this was their only way of dealing with him, wrongly claiming that it was a 'Team-Teach' method. 'They started holding him one person either side; they found the only method to keep him safe was to hold him in a

restraint face down in school as part of Team Teach. His head would be turned to the side face down with one member of staff checking he was still breathing.’

Sadie recalled that when her son hit the head teacher, she was asked to collect him from the middle of the playing field because they didn’t know how to approach him:

He was sat on the floor, rocking backwards and forwards, and sobbing. I asked what happened and he told me he hit the teacher. He said, ‘I can’t help it, mum, I can’t stop myself from doing it, I get so frustrated with them I’ve done it again, I’m a bad boy’.

Viv suggested that older teachers have a greater need for training: ‘They don’t believe in ADHD and the spectrum; they are just naughty children.’ Sadie added that for developing teacher understanding of children with autism, identifying who is in crisis, anxious and/or frustrated was important. She reflected that her son was disciplined for writing negative comments when asked to write his thoughts down: ‘He wrote “I hate school. I hate my teacher”. He did what he was told. He wrote down the things he wasn’t allowed to say out loud and they told him off. So it’s not just about the strategy in place; it’s about understanding what it means to that child.’

Sadie recalled a time that her son was given a fixed-period exclusion for hitting a teacher when he was seven:

They’d recognised he was getting anxious; they recognised he needed to calm down. They put him in a pop-up tent in the middle of the classroom of 64 children and then were surprised when he started hitting and kicking the inside of the tent. When the teacher went over to stop him, he hit her. He’s not thinking rationally at that point. The strategy was there; get him somewhere safe, allow him to vent a bit, but the execution of it lacked any kind of comprehension of what they were dealing with.

## **Psychological impact**

### ***The psychological impact of school exclusion on the child***

Three of the caregivers talked about their children disclosing suicidal thoughts. Sadie’s son received two fixed-period and one permanent school exclusion in the

space of ten days after starting junior school. She described that he was in a state of crisis when he left the school: ‘We haven’t told him that he was excluded. He was in crisis. Absolutely in crisis when he left school. He was saying things like “I want to live in heaven where I can be away from all the nastiness in school.” He was in pieces, it was dreadful.’

Viv also shared that her son accessed CAMHS, as his mental health was suffering following the transition to secondary school: ‘He was saying things like he didn’t want to be here. He didn’t fit in. Nobody liked him; he had no friends.’ By age eight, Viv’s son felt he was different from the other children, which was another factor in his deteriorating mental health: ‘There was nothing positive in his life. Apart from his home life. But there was nothing positive in his school life.’ On being told he had autism, he had responded: “‘I haven’t, I’m not. I’m not on the spectrum; there is nothing wrong with me.” Just denial, he didn’t want to be different. He wanted to be the same as everybody else.’

Olwen also identified that her son was struggling: ‘You can see the anxiety, and when your son says he wants to die that is hard to listen to. So, every day he would come home with this planner and it would be “he has done this and that ...” There would be no positives, nothing to bring his spirits up. So, he felt down all the time.’

## **Victimisation**

Viv and Sadie both recollected that other children victimised their children in school. Sadie said, ‘I think he was being teased, but because of his condition he was being bullied, he was seen responding to that ... and it just snowballed really rapidly.’ Likewise, Viv felt her son was targeted; other children would wind him up, knowing he would react by lashing out because he couldn’t cope:

They had a focus. Someone to bully, someone to wind up. They thought it was funny when he went ‘bang’. They knew that he couldn’t take it so they would do it. And they would call him names, like retard, spacker. All these awful names.

Viv shared that the psychological impact on her son, due to the constant victimisation, was that he was always anxious. She explained how another child dislocated his finger by pulling it back during a football match: ‘In the car on the way home I asked “are you okay?” and he said “yes” but he sounded upset.



I asked “what’s wrong?” At this point, he was 6 foot 2; a child in a man-sized body. And he just put his head in his hands and had a full meltdown. The awful thing was that he just wanted to have one friend, just to fit in. It was heart breaking, really.’

### ***Impact of restraint***

Lucy was the only caregiver whose son had experienced multiple restraints. During eight weeks in year 11, it was recorded by the school that he had 16–18 holds. The restraints progressed from one person either side to lead him away, to holding him face-down in what they wrongly described as the ‘Team Teach’ approved method:

When he was permanently excluded. I found out afterwards it would be up to seven male staff holding him down. His head would be turned to the side face down with one member of staff checking he was still breathing. You wouldn’t do it to a prisoner but you can do it to a young person with a disability, it is scary. As you can imagine, he was in a very anxious state if he had a bad day.

The reason for the restraint with seven adults was not explained; the school reported that he had ‘ruffled a child’s hair’ but it was not reported that he had hurt anyone. Lucy recalled that during a care, education and treatment review, social care raised concerns about the increasing restraints in school. The EHCP and educational psychologist report also recommended the use of safe spaces to support emotional regulation. However, the school was unable to make these provisions due to a lack of space. Since the restraint, Lucy’s son does not trust adults and is distressed if she holds his hand too tightly. She had initially appealed the exclusion but after accessing his records and reading about the extent of the restraints, she has decided to homeschool.

### ***Psychological impact on parent***

All caregivers recalled a detrimental effect on their mental health and well-being. Lucy had to end her three-decade career in the NHS due to taking time off to homeschool her son: ‘They said “you need to get back to work” and I can’t. I’m very upset. I’m going to claim benefits. I have no other income apart from child tax credit for my other son.’

Olwen described the dread of getting phone calls during work hours to collect her child: 'It would be "you have to come and get him immediately!" My heart starts racing, anxiety straight away. When I came back to my desk and I'd had, like four phone calls and a text message.' She shared how she would 'put on a brave face and go to work but ultimately inside you're almost dying because I'm sending him somewhere that is not able to meet his needs.'

Viv raised the emotional toll of victimisation experienced by her child and the many failed requests to gain an EHC needs assessment: 'I was shaking. I was so angry. I could have cried with anger. I was on medication and beta-blockers; it was such a bad time. We were totally failed by them (schools).' The EHC needs assessment was granted in year 11, following requests in years four, six and ten.

It's taken so long. It's been so hard, emotionally. Last year I was ill, it wasn't my son's fault. It was that he wasn't getting support. We weren't getting the support. I was ill with worry. I couldn't sleep. That's what happens when you get these poor children in the middle.

Justice agreed that parents need emotional support. He found that the level of care necessary for his daughter meant he would have benefited from support after school and on weekends. He also felt that the school was pressuring him to move his child with physical difficulties to a new school. 'They were saying that if Ofsted came, they would ask who had responsibility for looking after that child.'

Similarly, Sadie said that emotional support was needed, as caregivers cannot always fight the system or afford private assessments:

These children are being marginalised and treated in a way that is shoddy and unlawful, and there is no one stopping it from happening. It can't be the parents because they can't do it. It's not just about the money, it's about the ability to do it, and to figure out what the hell am I going to do now? Many parents wouldn't do that or couldn't do that or couldn't fight their way through the red tape.

## **Health imposed barriers to diagnoses**

Most caregivers felt that if health professionals had diagnosed their children's disabilities sooner, they might have been able to access better support and

more appropriate school provision. Justice claimed: ‘You need experts to diagnose children quicker. We had to pressure them; if she had been diagnosed earlier then she would have got that support, she could have gone to a specialist school.’ His daughter was kept in reception class for a second year due to her limited speech development. When Viv’s son was three and a half, she took him to a speech and language therapist but was told there were no concerns. At eight-years-old, he saw another speech and language therapist and a consultant, who diagnosed autism.

On being rejected by CYPS and learning about the 12-week waiting list for CAMHS, Sadie organised private observations and assessments of her son, driven by the belief that the junior school would have to consider his needs if he had a formal diagnosis. ‘They said “he’s very high functioning but on the autism spectrum”’. It was always borderline, always quirky.’ Olwen recalled that her son was discharged twice from CAMHS, who could not identify any underlying needs: ‘You can’t get into CYPS unless referred from CAMHS. You don’t just get that it’s not automatic because they kept saying, “he’s too young”’. Fixed period exclusions followed and she returned to health services for support:

Finally, they decided to refer because I kept going back, and I kept going to my GP saying he has been suspended again. So they referred him to CAMHS. We had to wait for ages for an appointment and eventually we got referred to CYPS. You’re talking years 4–4 1/2 years. It’s terrible really when I was crying on my knees for help.

## **Effective support**

All caregivers could identify periods where diagnosis, provision and practice were sufficient for their child.

### ***Meeting individual needs***

Sadie recalled the positive relationship she had with her sons’ infant school: ‘They were fantastic. I had a good relationship with his teacher. We spoke quite regularly because I picked him up from school ... His teacher was also the SEND coordinator, so that was helpful and we just had an eye on it.’ This gave Sadie and her son opportunities to ask the teacher questions.

They gave him a little they said to write it down, “we can’t talk to you all of the time. We’ll have 10 minutes to talk to you afterwards”, and that really settled him and he was absolutely fine. He didn’t need that book for very long; he sort of got into the swing of it and he was fine.

Viv felt alternative provision was effective for her son because: ‘This school takes children more as an individual. Because all the children in here all have different issues.’ They started the EHC needs assessment application when he arrived at the school: ‘They decided to help. Get evidence. Get an educational psychologist. Did all the groundwork. We had meetings; my son inputted; everyone put everything together.’

Lucy felt there was a lack of suitable provision in the local area so decided to homeschool, which she felt was best for her child’s mental health: ‘The majority of the time it’s him and me at home, and he’s quite happy; he likes just him and me. I have no problems taking him out; he’s mostly fine 99.9% of the time.’

### ***Health good practice***

Lucy and Olwen were both positive about health services. Lucy noted, ‘After his crisis [being restrained by seven adults], the psychiatrist came out to the house to discuss medication with us.’ Olwen also highly valued CYPS in securing support for her son: ‘They are great, I have to say. CYPS are brill! They are the most helpful professionals who work alongside children with ADHD and other issues.’

### ***Voluntary organisations***

Access to voluntary organisations has been helpful for the caregivers at varying points. Lucy named Sunderland Carers Centre, Young Carers and the National Autism Society as supportive organisations. Sadie felt that Autism Outreach was helpful, as they went into the school to put a comprehensive plan in place to support her son. Olwen commended the Sunderland SEND Information, Advice and Support Service: ‘She is an angel. She is just brilliant. She’s independent, she’s for the school and the parents. You know, she’s amazing. Sunderland Carers as well – they were really good just to talk to somebody.’

## Discussion

The study set out to determine the barriers and enablers to mainstream schooling for children with autism and to explore the effect of the journey to school exclusion on the child and caregivers.

The CAFA (2014) created a statutory duty for the involvement of caregivers in decisions that affect their children. Supporting caregivers via early identification, high quality provision, decision-making, choice and control, and agency collaboration are explicit in the (DfE and DoH, 2015) code. However, the findings from this study suggest that the caregivers met barriers to gaining prompt assessment and identification of SEND across education and health.

The caregivers encountered challenges gaining school support to apply for an EHC needs assessment, despite the child meeting the legal test of ‘has or may have an SEN’ and ‘may need special educational provision’ (IPSEA, 2020) while also having fixed-period and in some cases permanent school exclusions. The theographs (Figures 1–5) illustrate that, beyond infant school, the burden and responsibility was on the caregivers to seek and fight for support across health and schools. The weight of the evidence in this study and others (Pirrie *et al.*, 2011; Martin-Denham *et al.*, 2017; Horridge, 2019; Martin-Denham, 2020a, 2020b, 2020c, 2020d) affirm the importance of early identification to prevent disrupted pathways due to children’s disabilities, which remain misunderstood in some school contexts. A lack of early identification raises concerns as to the short- and long-term impact of disabilities on well-being and academic outcomes.

The caregivers in this study had noticed and reported concerns about their children’s development and behaviours as soon as they became apparent. Based on the children’s later diagnoses, this study supports other research findings, showing that caregivers can accurately predict when their child has disabilities (Glascoe, 1999; Tervo and Asis, 2009; Woolfenden *et al.*, 2014; Ireland and Horridge, 2017). The findings indicate an implicit understanding among caregivers that the burden of securing a diagnosis fell predominantly to them, and they believed this would be a gateway to support.

The analysis and the theographs (Figures 1–5) suggest that both education and health professionals often rejected these caregivers’ referral requests for

identification and assessment of needs. This finding echoes those of Hutchinson and Crenna-Jennings (2019) and Martin-Denham (2020a, 2020d), who declare that children are rejected by mental health services when they do not meet service thresholds. These results bring into question the level of knowledge and understanding of some schools regarding the legal basis for EHC needs assessment: ‘the child or young person has or may have SEN; and special educational provision may be required’ (IPSEA, 2020). The theographs also illustrate that children often must be in crisis and experience school exclusions to secure assessments of needs.

Caregivers of children in secondary education identified that mainstream schools were not equipped with the knowledge, skills, understanding and funding to provide robust evidence-based practice and care for their children. The tension between the needs of the child, available provision and evidence-based practice was clear, and creates a barrier to the successful implementation of the CAFA (2014) reforms. Despite medical and educational psychologist reports, and EHCPs explicitly stating that the child needed support from the school to be regulated and to therefore access learning, it was claimed that this did not consistently occur. However, good practice was identified in infant schools, perhaps due to the increased presence of teachers at school drop-off and pick-up, and collegiate working between all parties. In general, there is a need for ongoing training for schools to ensure that they understand and apply reasonable adjustments for children as required by the Equality Act 2010.

The findings from this study support the view of the Autism Education Trust (2020), that children with autism are at an increased risk of school exclusion. There appears to be a lack of understanding regarding the individual nature of autism and how it can cause a child to become overwhelmed due to unsupported transitions, learning environments, lack of reasonable adjustments, and the availability of highly trained and qualified staff.

This study also highlighted an illegal exclusion for a child with a disability who was unable to feed herself at lunchtime without support. This contradicts the DfE (2017) statutory guidance, which makes explicit that children can only be excluded for disciplinary reasons, and the DfE (2015) statutory guidance on supporting children with medical conditions to have full access to education. Continued efforts are needed to ensure that all mainstream schools across the age phases are accessible and inclusive for children and young people with autism and co-morbidities. The findings of this research indicate

that this lack of support and understanding was detrimental to the children's well-being and mental health. Consequences for these children ranged from being anxious to suicidal, which is of serious concern. Positive interventions from voluntary organisations and crisis psychiatrists were reported as making an impact. However, they are called upon when the damage is already done, after the children have been excluded and their mental health is adversely affected.

## Acknowledgements

The author would like to thank the children and caregivers who contributed to the research by participating in interviews and attending the advisory panel.

## Ethics statement

Ethical approval for the original study was granted from the University of Sunderland's Ethics Committee. Gatekeepers provided consent for the caregivers to be approached and voluntary informed consent was sought and gained from all caregivers in both written and verbal form, as per the British Educational Research Association guidelines (2018).

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