

**PROFESSIONAL PRACTICE REPORTS**

**by**

**KATE OLDALE**

**A thesis submitted to**  
The University of Birmingham  
for the degree of  
DOCTOR OF APPLIED EDUCATIONAL AND CHILD PSYCHOLOGY

The School of Education  
The University of Birmingham  
September 2009

UNIVERSITY OF  
BIRMINGHAM

**University of Birmingham Research Archive**

**e-theses repository**

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

## TABLE OF CONTENTS

<b>Chapter 1: Introduction</b>	<b>1</b>
References	7
<b>Chapter 2: Does the diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD) act as a sticking plaster for deeper social issues and systemic failures?</b>	<b>8</b>
Introduction	8
What is normal? - the problem of a relational diagnosis in SEBD	10
Aetiologies of ADHD	13
The disease metaphor	17
What is the point of an ADHD diagnosis?	19
The current case	25
The request for involvement	25
Description of the home situation and 'difficult' behaviour	25
Looking to understand the parents' perspective	27
Issues of transparency, reflexivity and information sharing	27
Discussion	29
References	32
<b>Chapter 3: A comparison of Madeleine Portwood's programme for young people with Developmental Dyspraxia and two alternative interventions</b>	<b>39</b>
Introduction	39

Professional practice background	39
Report plan	40
Terminology	41
Diagnostic criteria	42
Ambiguity of criteria A and B	43
Criteria C and D	44
Implications for assessment	45
The cut-off point	45
The impact of unique difficulties and circumstances	46
The lack of theoretical approaches represented in the criteria	47
Intervention	48
Madeleine Portwood's intervention	49
Cognitive Orientation to Daily Occupational Performance (CO-OP)	53
Task Specific Training	56
The evaluation of interventions	61
Concluding comments	67
References	69

<b>Chapter 4: A discussion of the implementation of a school-based group cognitive behavioural therapy programme for anxiety in a secondary school</b>	<b>77</b>
Abstract	77
Background information	78
Introduction	79
Cognitive Behavioural Therapy	80

A developmental perspective	81
A systemic perspective	84
Group versus individual therapy	87
The Cool Kids Programme	90
Empirical Support	91
Some criticisms	93
The implementation of the Cool Kids School Version in a secondary setting	94
The group: selection of participants	95
Implementing the programme	98
Outcomes	100
The evaluation tools	100
The Spence Child Anxiety Scale	100
Goal Attainment Scaling	102
Measured outcomes for the intervention	103
Discussion	104
Conclusions	108
References	110
Appendices	116
<b>Chapter 5: An analysis of a Team Around the School initiative being delivered in a local authority: multi-agency working and participation</b>	<b>118</b>
Introduction	118
The policy context – Every Child Matters	119
Different multi-agency models and terminology	120

Multi-agency panel	121
Multi-agency team	122
Integrated service	123
Evidence for the impact of multi-agency working	123
The current multi-agency intervention	128
The model	129
Evaluation of the model according to the literature	131
Working relationships	132
Multi-agency processes	135
Resourcing multi-agency work	135
Effective management and governance	136
Evaluation of the model with reference to young people and their families	137
The target group	137
The TAS meetings and participation	138
Local solutions for local needs	139
Consultation and evaluation	140
Consent and information sharing	141
Conclusions	146
References	148
<b>Chapter 6: An examination of specialist educational psychologist input into a school-based consultation for a Looked After Child</b>	<b>151</b>
Background of the case	151
Definition of 'Looked After'	152
Policy overview	153

The link between being in care and low achievement	154
What underlies low achievement for children in care	159
Resilience	159
Attachment	161
Critique of attachment theory in the classroom	167
The role of the Educational Psychologist in providing services for children in care	168
The consultation	170
The purpose	172
Description of the current situation	173
Strategies	173
Analysis of the specialist versus the generic role	177
References	181

**LIST OF TABLES**

Table 1: Triggers for graduated response in the code of practice	12
Table 2: Diagnostic criteria for Developmental Coordination Disorder	43
Table 3: A ladder of multi-agency involvement	120



## INTRODUCTION

This volume comprises of five reports relating to aspects of my professional practice as a trainee educational psychologist in the last two years of my doctorate training. The casework that forms the basis of these reports was undertaken while employed to work in a relatively large educational psychology service placed in Children's Services in a Local Authority in the north of England. The casework was located in urban areas of a major northern city with a generally high level of social disadvantage. The locality of the work has influenced the nature of these reports, both in terms the types of casework that I have been expected to undertake as a psychologist in this particular service, and in terms of the how the particular issues affecting the area have informed the perspective from which the subject matter is approached.

An important element of my development throughout this course has been an increased awareness of how my own ontological and epistemological assumptions influence my interpretation of the literature and my approach to casework. This theme is explored to a different extent in each of the chapters and also in Volume II of the thesis.

The overarching perspective that I have taken is interpretive. Reality is regarded as individually constructed understandings of the world that are embedded in the subject's cultural, historical, political and personal context. I have tended to advocate models that are dynamic and complex.

Critical theory is interested in the application of social justice through exposing inequality and dissolving power relationships (Habermas, 1984). A thread that runs through these reports attempts to address these themes in the different contexts. Much of the critical strand advocates a practical approach to effective service provision, that is informed by a democratic or emancipatory ideological stance. The need to evaluate and respond to locally identified and voiced need is supported throughout.

I hope to have been reflexive and have made challenges to my own theoretical approach to the subject matter, although limited word space and the cascading complexities of each of the subjects has limited the scope of discussion.

### **Professional Practice Report 1:**

#### **Does the diagnosis and treatment of ADHD act as a sticking plaster for deeper social issues and systemic failures?**

The first report directly tackles the relationship between my own epistemological and ontological perspective and the cultural and theoretical context of the Local Authority resource allocation system. The discussion takes place in the context of Attention Deficit Hyperactivity Disorder (ADHD) diagnosis and the local systems within which the casework was undertaken. The report looks at the dilemma faced when working within a system that adopts a medical, generally deficiency-based model as the mechanism through which resources are accessed by young people and their families.

In the report, I critically evaluate the research base supporting the medication of

young people with a diagnosis of ADHD, with particular reference to how ADHD is defined, alongside some discussion of how normal behaviour is construed and defined in government policy and research.

I then question my own critical theory based assumption that the medical diagnosis of undesired behaviour in children is disempowering. There is an exploration of the idea that, within the current system, a diagnosis of ADHD can be emancipatory for families, in so far as it increases choice and access to enabling resources, without focusing upon blame.

### **Professional Practice Report 2:**

#### **A Comparison of Madeleine Portwood's Programme for Young People with Developmental Dyspraxia and Two Alternative Interventions**

The second report is based upon a longitudinal piece of work that involved an intervention for young people with difficulties described by a diagnosis of Developmental Dyspraxia or Developmental Coordination Disorder (DCD). It is a comparison of three interventions, one of which was used in the casework that the report is linked to.

The report begins with a discussion of the diagnostic criteria for DCD from an interpretive perspective and a more holistic, ecological system is advocated. The interventions are evaluated with consideration of their theoretical and empirical underpinnings, as well as local delivery contexts. Criticism of the limitations of these evaluations leads to a wider perspective that takes account of some of the ideological principles regarding the provision of services to young people and families (such as

participation), as well as the stated requirements of relevant policy (such as The Code of Practice (DfES, 2002)). As a need for a range of interventions within complex systems is identified, the equation is challenged that 'evidence based' practice always leads to 'best' practice within the constraints of real-world contexts.

### **Professional Practice Report 3:**

#### **A discussion of the implementation of a school-based group Cognitive Behavioural Therapy programme for anxiety in a secondary school.**

The third report focuses upon the delivery of an 'off-the-shelf', Cognitive Behavioural Therapy (CBT) group intervention for young people with high levels of anxiety. As in the previous two reports, I take an interpretive perspective to draw attention to the way that terms used within research, medical diagnosis and evaluation are constructed rather than objective realities, and the implications for interpretation and generalisability of data within a positivist paradigm. In addition, the almost exclusive use of controlled randomised trials (CRTs) as the evidence base for CBT anxiety group intervention evaluation in the literature is questioned. However, conclusions drawn about the benefits of using qualitative, personally constructed intervention evaluation tools against a standardised checklist are mixed and a mixed methods approach is ultimately advocated.

The Critical Theory thread continues in a discussion about the ethical issues around bringing therapeutic work into a context that engenders explicit and implicit power relationships between staff and pupils. Other critical points include the way parents of young people in the casework group may have been excluded by the literacy levels required to access the course materials.

**Professional Practice Report 4:****An analysis of involvement in the second year of a multi-agency Team Around the School Pilot in two schools.**

Report four is a critical evaluation of the Team Around the School scheme currently being run in my employing authority. Unlike the above professional practice reports, most of the research in this area has used interpretive methodologies. However, the literature is criticised for its focus upon the impact of multi-agency working upon multi-agency professionals and not service users.

While the report initially assesses the scheme in terms of good multi-agency practice themes drawn from the literature, the main discussion is focused upon the extent to which the scheme meets participatory principles of Every Child Matters (DfES, 2003) and as described in the Targeted Youth Support paper (DCSF, 2008). Of particular concern are issues of information sharing between professionals, gaining informed consent and the absence of young people and their families at meetings. The report takes a critical theory perspective in its focus upon the disempowerment of young people and families through the incomplete adoption of the ideology of participation in the implementation of a model of multi-agency working.

**Professional Practice Report 5:**

The fifth report is based upon my work alongside a specialist Looked After Children's Educational Psychologist. The focus is extracted from issues surrounding a piece of work in which I adopted a consultation role and looks at the link between being in care and low achievement from an attachment theory perspective.

The piece of work is briefly evaluated with reference to the literature review and the unique contribution of educational psychology. The role of the specialist Looked After Child Psychologist is considered, with some attention to how working in this has effected work with other vulnerable children in the school setting in terms of the potential deskilling of generic educational psychologists.

## References

Department for Children, School and Families (2008). **Targeted Youth Support: Integrated Support for Vulnerable Young People: A Guide**. Nottingham: DCSF

Department for Education and Skills (DfES) (2002). **Special Educational Needs Code of Practice**. London:DfES

DfES (2003) **Every Child Matters**. London: DfES Publications

Habermas, J. (1984). **The Theory of Communicative Action. Volume 1: Reason and the Rationalisation of Society**. Boston: Beacon Press.

# DOES THE DIAGNOSIS AND TREATMENT OF ADHD ACT AS A STICKING PLASTER FOR DEEPER SOCIAL ISSUES AND SYSTEMIC FAILURES?

## Introduction

There is debate around the causes, ethical treatment and even the existence of ADHD (see Mellor, Storer, & Brown, 1996 for the debate in America; Timimi et al, 2004 and Barkely et al, 2004 for an international debate). Figures regarding prevalence rates are highly varied, ranging from 3% to 24% (Purdie et al, 2002), but seem to demonstrate that ADHD is a social construct that is widely used to understand and intervene with the behaviour of some children. This report is centred upon a piece of casework in which I felt challenged to re-examine my own perspective regarding the use of the ADHD label. My reluctance to describe children's behaviour within a medical framework that tends towards within child, deficit models, was challenged by the potential inequalities that such a stance might engender for the people I work with. How are families able to access resources and schools able to work preventively within a system that adopts a medical, deficit model for children's services delivery?

The current report will approach the question using the following structure:

- What is Normal? A brief discussion of some of the issues that pertain to how Social Emotional and Behavioural Difficulties (SEBD) in children and young people are defined. I will look at the consequences of viewing SEBD as a continuum of difficulties and at some issues raised by the subjectivity of the act of



labelling. There will be some consideration of the helpfulness of government policy in defining SEBD.

- Aetiologies of ADHD. Through consideration of the consequences of the medicalisation of behaviours linked to an ADHD diagnosis and how this might make ADHD particularly contentious, it will be argued that Attention Deficit Hyperactivity Disorder (ADHD) should be given special consideration within the SEBD spectrum. Cognitive behavioural, neurochemical, genetic and transactional neurodevelopmental conceptualisations of ADHD and their implications for treatment are discussed in light of this.
  - The Disease Metaphor. ADHD will be considered as a social construct, calling into question its objective existence through consideration of arguments about its validity as a discrete disorder. This is discussed with regards to cultural influences at a micro and macro level, such as the available assessment tools, the social/political environment and with particular regard to the perspectives of individual or groups of practitioners (relating partly to the conceptual model adopted).
4. What is the point of an ADHD diagnosis? This part of the report will attempt to address the question about whether a diagnosis of ADHD can be emancipatory. It will start by looking at the power relationships inherent within a medical model and will attempt to discuss some of the complexities around issues of responsibility, control and disempowerment that these arguments raise. Finally, after a brief discussion of the ethics of medicating/ not medicating children, diagnosis is discussed in the context of current systems, including access to resources.

5. The current case study will be described as the stimulus for the reflections within this report. It will include:
- Background
  - Assessment and formulation
  - The situation at the LA regarding access to resources for children with ADHD type behaviours
  - Feedback and outcomes
6. The discussion will centre around the ethical tensions in light of the current case with regards to: diagnosis; working within a system that medicalises behaviour; access to resources; the empowerment/ disempowerment of children, young people and their families. I will consider the implications for future practice and reconsider my own position in relation to ADHD as a result of this piece of work

### **What is Normal? - The problem of a relational diagnosis in SEBD**

In order to usefully conceive of social, emotional and behavioural difficulties, we need a definition of what is normal. A statistical approach would achieve this by comparing a child to other, similar children, using a measurable set of standards in order to determine whether or not the difficulties are outside of 'normal' or perhaps 'expected' boundaries. Where those boundaries or cut off points of normality lie within this definition have to be decided arbitrarily to some extent. In addition, choices have to be made regarding the types of behaviours we choose to use in order to operationalise 'normal' behaviour, meaning that our definition of SEBD will reflect our social constructs of the terms used to describe the behaviours.

We could choose to use a definition of SEBD that is based upon a judgement about

what is deemed socially acceptable behaviour, as opposed to judging what is statistically unusual. Such a social norm based definition is susceptible to changing trends and values in society over time. The changing social and legal conceptualisation of homosexuality over the past century is an example of how behaviour can be transformed from a criminal act, to an illness requiring psychological treatment, to a state condoned lifestyle choice. In fact, homosexuality was not removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973 (Cooper, 2004). A new disorder of ego-dystonic homosexuality was included in the 3rd edition in 1980 but was removed six years later (Wilson, 1999). Homosexuality was included as a psychiatric disorder in the International Statistical Classification of Diseases and Related Health Problems (ICD) until 1993 (Wilson, 1999). Social norms of acceptable behaviour may also differ between cultures and between contexts. Studies looking at domestic violence have shown how the problem is influenced by cultural beliefs and context to produce a range of issues about what is seen as acceptable and not acceptable (see Fernandez, 2006).

While defining what is 'normal' is clearly a complex problem, it remains that in order to inform an equal distribution of resources across the country, a clear definition of what is meant by SEBD would be needed. Guidance provided in government policy documents has attempted to address this need. The Code of Practice (2001) endorses the conceptualisation of SEBD as part of a continuum, that triggers graduated responses (school action and school action plus) according to the ability of the setting to manage the difficulties experienced by the child or young person.

Table 1: Triggers for graduated response in the Code of Practice

Triggers for school action – includes the caveat ‘despite receiving appropriate educational experiences’	Presents persistent emotional and/or behavioural difficulties, which are not ameliorated by the behaviour management techniques usually employed in the classroom.
Triggers for school action plus -includes the caveat ‘despite receiving an individualised programme and/or concentrated support’	Has emotional or behavioural difficulties which substantially and regularly interfere with the child’s own learning or that of the group.

*(Adapted from Code of Practice, 2001)*

Indicators of SEBD are presented in different paragraphs of the document (see paragraph 7:43, 7:60), giving a broad interpretation of how a child with SEBD might be identified. The arguably vague and generic quality of the descriptions of SEBD indicators and the graduated response triggers mean that children will be labelled as having SEBD in an unavoidably locality and experience-based relational interpretation of behaviour. This assumption is supported by Daniels et al (1999) findings that school staff tended to define SEBD by describing current or past pupils who had caused difficulties for the school, rather than giving a more general definition.

Referring back to the problems of subjectivity pertaining to relational definitions of abnormality, whether based upon statistical or social norms, it would appear that

these problems are further compounded by the subjective filters of the macro and micro systems within which the behaviours exist. As Ayers et al have commented:

“What constitutes a behavioural problem can vary according to differing perceptions depending on social context, moral codes, cultural norms and historic periods. Therefore it can be the case that an adult’s judgement may disagree with other adults’ judgements because of different social contexts, moral codes and levels of tolerance.” (Ayers, Clarke and Murray, 2000, p. 8)

For children and young people, the relative nature of definitions of behavioural problems may affect their access to resources within school and even what sort of educational placement they are given. I would argue that the same problems regarding the multi-systemic subjectivity of definition and measurement apply more or less to a diagnosable, ‘medical’ disorder such as ADHD and that arguably, in the case of ADHD, the stakes for children, young people and their families could be higher.

## **Aetiologies of ADHD**

Different models of ADHD provide differing, overlapping and sometimes complementary perspectives about the underlying causes of the disorder and consequently the most appropriate interventions. This section will consider a number of perspectives related to aetiology: cognitive behavioural; biological, including genetic and neurodevelopmental.

A cognitive behavioural explanation of ADHD is interested in the functional expression (symptoms) of the underlying biological processes. The dominant theory is that ADHD symptoms are the expression of an executive dysfunction (working memory, inhibition). Tannock describes it as “a failure to inhibit or delay a behavioural response” (Tannock, 1998, p.69). An alternative theory conceptualises the cognitive mechanism of ADHD as a motivational style – a functional response to avoid delay. If this view is accepted, then individual therapies aimed at changing the thought processes and behaviours are needed, such as desensitizing children against delay (Sonuga-Barke et al, 2003). It is difficult to provide conclusive evidence for either of these theories, as the cognitive mechanisms described are only indirectly observable through the presence or otherwise of ‘symptoms’ or behaviours.

Alternatively, some researchers have focussed upon describing the underlying biological processes. According to Purdie et al (2002), various genetic, neurochemical, neurobehavioural and neuroimaging studies have reported that links between ADHD and biological factors exist, while some have reported no such links. None of the studies uncovered definitive causal relationships, as different studies often identified different abnormalities in different areas of the brain (Baldwin and Cooper, 2000). Nonetheless, assumptions about the biological underpinnings of ADHD have led to the use of medication.

Drugs used to treat children with ADHD are believed to act by enhancing the dopamine activity in the frontal regions of the brain (see Tripp and Wickens, 2008, for a review). There has been an assumption by some authors (such as Jadad et al, 1999) that evidence of a reduction of the symptoms of ADHD when medicated

equates to evidence for the existence of ADHD as a medical disorder. However, more recent research has found that the same drugs have beneficial effects in terms of increasing attention and academic attainment on children without ADHD (Timimi et al, 2004), making research based upon this assumption of a causal link lack internal validity.

While it has been claimed that about 30 to 50% of variance in ADHD can be accounted for by hereditary factors (Goodman and Stevenson, 1989), Timimi (2002) has pointed out that ADHD type behaviours have common genetics with other behaviour disorders (such as conduct disorder) and so any heritability measured may not be specific to ADHD, but rather describe a more general vulnerability to SEBD type problems. Larsson et al (2004) describe the interaction between a genetic predisposition and the environment. The predisposition leads to the expression of the disorder under certain environmental conditions, such as parenting style. In their meta-analysis of over 74 studies, Purdie et al (2002) reported that alongside biological factors, the most frequently cited etiologic link to ADHD is parenting style and parental mental health. This has implications for claims about the high heritability of ADHD as distinct from the environmental influences.

The hereditary elements of the disorder might make it more likely that a child with ADHD symptoms will have a parent with ADHD symptoms. Having a parent with ADHD symptoms may help create the environmental conditions that may lead to the expression of any underlying predisposition, enhancing heritability effects. Some research has shown that parents' ADHD type symptoms have a detrimental effect upon levels of appropriate and effective parenting and responsiveness to parenting

interventions (Harvey et al, 2003). When the interaction between genes and environment can seem locked into a pattern in this way, Alban-Metcalf and Alban-Metcalf (2001) have suggested that the use of medication can provide a “*window of opportunity*’ for the child to benefit from teaching-learning experiences by teachers, parents and others’. However this is an area that requires further study.

Teeter (1998) takes a more eco-systemic approach with her transactional neurodevelopmental perspective. She describes the, ‘bidirectional nature of relationship between brain functioning and associated cognitive intellectual, academic, behavioural and psychosocial problems found in individuals with ADHD’ (Teeter et al, 1998, p. 18). She believes that the symptoms and challenges we face change throughout development and so the way the symptoms express themselves, changes. This type of bio-psycho-social approach should lead to interventions that are multi-modal, often involving medication and individual and/or family therapies, as well as educational interventions.

The aetiologies discussed here largely take a within child view of ADHD.

Purdie and colleagues’ (2002) meta-analysis of research studies looking at ADHD found that they mainly used a medical framework. The medical approach favours within-child, pathological explanations of ADHD, which in practice, often leads to within-child focussed interventions, such as medication or individual talking therapies. The approach can lead to an absence of more environmentally focussed aetiologies often associated with other SEBD, taking into account factors such as family background, peer relations, educational setting and other life circumstances. I will explore how ADHD is understood by exploring a ‘disease’ metaphor.



### **The Disease Metaphor**

McBurnett, Lahey and Pfiffner (1993) pointed out that there has been a major revision of the criteria for ADHD with every new version of the DSM, linking constructions of ADHD to the dominant psychological perspective of the time. While their critique does not directly challenge the validity of the disease metaphor - changes in definitions could reflect an increased understanding of mental health, obtained through the application of scientific methods – it does suggest that ADHD is at least partly a social construction, defined by the social context of the period.

Currently, a person is diagnosed as having ADHD if they meet the set of criteria as set out in the DSM-IV or ICD. The symptoms described by the DSM-IV (1994) for diagnosis are all essentially observable behaviours. As such, even though ADHD is a medical diagnosis, it cannot be based upon any measurable biological indicators, but relies upon people's perceptions of an individual's behaviour. Earlier in this report, in the context of SEBD, the issue of defining what is 'normal' in order to describe what is unacceptable was considered. In the case of ADHD diagnosis, this concern is highly pertinent, as the individual's deviance from acceptable into non-acceptable behaviour is now assumed to be the expression of an underlying pathology or disease (Purdie et al, 2002). Despite ADHD being a relative diagnosis and therefore at the end of a continuum of difficulties (Tymmes and Merrell, 2006), arbitrary cut-off points of acceptable versus unacceptable behaviour inform a definitive categorisation as ADHD or not ADHD. The cut-off points remain vulnerable to subjective interpretations of the terms involved in diagnosis (Christensen, 1996). This is particularly true when a limited range of views from non-medical health professionals (parents and teachers) is used, often via rating scales, to inform diagnosis.

Furthermore, a diagnosis of ADHD assumes measurability against an identifiable norm of behaviour. However, as there are no biological indicators of ADHD, assessment methods involve an unavoidable level of subjectivity as practitioners must use observation, checklists and rating scales. This means that judgements are made based upon parents', teachers', educational psychologists' and health professionals' *interpretations* of behaviours *believed* to operationalise the DSM's changing criteria. Anderson & Baldwin (2000) found that professionals were unable to recognise hyperactivity disorders reliably when presented with evidence of them.

The medical construction of ADHD as a disease is also reflected in treatment choices. Despite evidence to show that multimodal approaches (the use of medication alongside other non-medicating interventions) are the most effective way to treat ADHD symptoms (See Carr (2000) for a review), the most common treatment by far for children and young people diagnosed with ADHD is medication, usually in the form of methylphenidate, a psychostimulant. While such medication has been found to improve behavioural and cognitive outcomes, the drug remains a controversial treatment, not least because of claims that there remains insufficient data regarding its long term effects (Anderson & Baldwin, 2000, Timimi et al, 2004). In addition, the extent of positive outcome effects vary according to the outcome being measured, for example, Hanson & Hanson (2006) found that behaviour outcomes were much higher than cognitive ones.

Purdie and colleagues (2002) found that very few studies in their meta-analysis looked at educational outcomes for children and young people when evaluating the

success of interventions, tending to focus instead upon behavioural ones. The vast majority of the studies in Purdie's meta-analysis focussed upon medical interventions, with some looking at behavioural and psychological interventions as well. Very few looked at the effects of educational interventions. This apparent bias in the way ADHD has been researched and the way outcomes have been measured suggests that other ways of conceptualising these types of difficulties may not have been fully explored.

In my opinion, asking whether or not ADHD exists as an objective disorder is not as important as asking what the effects of the ADHD label are for children and young people. To what extent is the disease metaphor beneficial or otherwise to young people experiencing the types of behaviour and cognitive difficulties the ADHD label seeks to describe? In the next section I will try to explore this question from a critical standpoint.

### **What is the point of an ADHD diagnosis?**

From an emancipatory perspective, I am interested know the extent to which a diagnosis of ADHD can be empowering for young people and their families and the extent to which the predominantly medical system of diagnosis disempowers children and their families and maintains current inequalities in society.

The power relationships that are inherent in a medical model of disability may lead us to conclude that such a system could only be viewed as anti-emancipatory. This is the view represented in the paper 'ADHD does bad stuff to you' (Travell & Visser, 2006). However, some researchers have found that for most parents of 'hyperactive'

children, receiving a diagnosis of ADHD for their child had been a positive experience (Klasen & Goodman, 2000). This finding may be criticised for oversimplifying the complexity of the dilemma faced by parents. Hansen and Hansen (2006) report parents' accounts of periods of 'great guilt' when in a position of seeking help from professionals because of their children's behaviour difficulties, involving concern that they would be 'blamed' for their children's problems by their general practitioner. In light of this, it is not wholly surprising that the same parents might interpret positively a diagnosis that views their child's problem as medical rather than psychological in nature. This medical understanding of the problem means that blame no longer lies with the child or parents or teachers, as the difficult behaviours are now represented as biologically determined and out of everybody's control,

Timimi et al (2004) question whether a medical approach needs to be the only approach that does not apportion blame. By seeking to look for underlying environmental explanations of and meanings of ADHD type behaviours, they advocate wider perspectives that seek to empower children, parents and other stakeholders, condoning individualised family counselling and educational approaches to managing children's behaviour difficulties. However, I do not believe that Timimi et al (2004) have been fully critical of the medical approach. Overall, they reflect a view of behaviour that still focuses upon and around the individual children, their families and teachers, and advocate interventions that target these levels. Critically, this could be interpreted as detracting from the wider cultural influences, continuing to under represent issues of social responsibility on a macro level.

The pathologising of ADHD type behaviours may detract scrutiny of the communal and political systems that lead to behaviour problems such as those described by

ADHD according to a critical perspective. The social dilemmas that may lie at the root of the apparent increase in the number of children with ADHD type symptoms and/or diagnoses of ADHD are lost in the 'no blame', within-child perspective, serving to maintain a status quo. Cooper and Bilton point out that:

'Problems of impulse control, attention and hyperactivity only become problems in circumstances that require control of these faculties to an extent that is beyond the control of the individual.'

(Cooper & Bilton, 2002, p.24)

This Social Model of Disability perspective draws attention to the expectations and demands placed upon children and young people, particularly by the education system. It draws attention to how the academic values that underpin our education system may increase young people's experience of behaviour difficulties and our own perceptions of what behaviour difficulties are. By predominantly measuring the success and failure of children and young people academically, it seems inevitable that some children will be excluded from experiencing success. Diller (2006) argues that society is so anxious about the future consequences for children who are not academically successful (successful according to the values of our education system) that there has been an increase of pressure for teachers, families and young people to respond to the education system in a way that is not conducive for the positive development of all of our children and young people.

The situation is further complicated for parents and teachers if Timimi et al's hypothesis is correct. According to these authors, there has been a loss of childhood,

which has led to a breakdown of adult moral authority (Timimi et al, 2004). Timimi suggests that this has led to some children being perceived to be dangerous and therefore needing to be controlled and changed. Consequently, levels of anxiety in child rearing have increased as adults struggle to know how to control unruly children within the current system.

As has already been stated, the concept of ADHD shifts the focus of these complex social dilemmas to the individual child (Timimi, 2002, 2004). In my opinion, this shift of focus is supported by the emphasis upon parental choice in policy making since the Every Child Matters agenda has been in place.

Diller (2006) reasons that parents are likely to prefer the quickest, most painless solution to the problems their children face, and that this is what a medical perspective offers. He refers to the desire in parents to protect children's self-image and self-esteem that may be being put at risk by any ADHD type behaviours, as well as concerns about the effects of ADHD type behaviours upon educational outcomes. Parents must then face the dilemma of balancing the risk of jeopardising their children's educational success against the potential long term health effects of medication (discussed below). In this way, a seemingly empowering policy of parental choice becomes a further reinforcing mechanism for the continuation of the medicalisation of ADHD type behaviours.

Diller makes persuasive arguments regarding possible reasons for parental preference for medical interventions; however, these are largely intuitive rather than evidence-based. Hanson and Hanson (2006) note that there is little in the scientific

literature to address how parents make decisions about their children's treatment. They identify that most studies in the area take a quantitative, attitudinal survey approach, in order to collect parents' opinions of and satisfaction with treatment approaches. All the studies in Hanson and Hanson's analysis refer to Canadian and American parents, so lessening the validity of the points in a discussion of British medical and Educational systems, but the overall point is still relevant. While some studies have shown that parents were generally satisfied with medical treatment, this was more often after the child had been receiving the treatment for some time (dosReis et al., 2003; McNeal, Roberts, & Barone, 2000). Several of the studies indicated that parents preferred other approaches, such as counselling and behavioural management (Bussing, Gary, Mills, & Garvan, 2003; Corkum, Rimer, & Schachar, 1999; dosReis et al., 2003; Lui, Robin, Brenner, & Eastman, 1991). The results of these studies seem to be in conflict and deepen our understanding of how parents are making important decisions about their children's treatment.

As the current climate of parental choice places parents in the role of 'gatekeeper' (Hanson and Hanson, 2006), this would seem to be a neglected area of research.

It has been argued here that, from a critical point of view, the ADHD label and parental choice help to legitimise a medical view of behaviour, acting as a tool to maintain the status quo in society, protecting systems (particularly the education system, where most problems are identified) which sustain inequalities in society. It follows that the medical control of difficult behaviour through the use of prescribed drugs is also legitimised.

The medication of children with behaviour difficulties as a result of having been diagnosed with ADHD brings further ethical dilemmas, some of which have been touched upon already. Despite knowing that stimulants are thought to be potentially addictive with cardiovascular, endocrine and psychiatric side effects, and knowing little about the long-term effects of ADHD medications for children and young people, stimulant therapies continue to be widely and increasingly prescribed (Breggin, 2002). Some writers have suggested this situation is partly sustained by drugs companies and other professionals that have a vested interest in promoting the idea of the disorder because it is a lucrative business. This is the stance taken by Waters and Kraus (a law firm) on their website (Waters and Kraus, 2000), which is cited in a passionately anti-pharmaceutical article contribution by Steve Baldwin (Baldwin & Cooper, 2000).

Timimi et al (2004) are interested in the psychological effects of the use of medication to treat ADHD type behaviours. They are concerned that the approach promotes the idea of disability and deficit, encouraging children to believe that they are not able to control their own behaviour, leading to disempowerment or loss of agency. In addition, environmental factors may be overlooked. Cohen et al (2002) has commented that drug treatment may excuse stakeholders from finding other effective, long-term strategies for managing the behaviour and seeking better outcomes for the young people involved.

In contrast to these arguments, I would also suggest that the ADHD label can be seen as a way of creating more democratic and equitable opportunities for biochemically disadvantaged children and young people to access the education



system. There is an economical argument for the targeting of appropriate resources to groups of people with a similar range of needs, in a service such as the Liverpool ADHD Foundation. The Foundation relies upon the medical diagnosis of ADHD to target those that would benefit from the resources it has.

## **The current case**

### **The request for involvement**

A year one pupil, Lucy (not her real name), was discussed during a school planning meeting with the Special Educational Needs Coordinator (SENCO) and it was agreed that I would become involved. The case was different to the usual cases presented by schools within my patch in that the main difficulties, described as behavioural, were presenting in the home environment rather than at school. The school also asked if I could investigate Lucy's levels of cognitive functioning, as while they had little difficulty in managing her behaviour, there was some concern that she was not making the expected academic progress. Lucy was reported to be verbally bright and bubbly, but to be having some difficulties with reading, writing and maths.

The following section comprises a brief description and rationale of work undertaken, the outcomes of that work in terms of information gathered, conclusions reached and some overall reflections.

### **Description of the home situation and 'difficult' behaviour**

Mr and Mrs F attended an initial consultation in which they described the situation at home and their perceptions of Lucy's 'difficult' behaviour. I understood that the parents experienced the main problem as the tantrums that Lucy could throw, lasting

for between ten minutes and four hours, when she did not get her own way at home. This had created a situation at home where the family felt that they 'pussy footed around'. These tantrums were described as involving some or all of the following behaviours:

- Banging her feet (sometimes until she develops blisters)
- Crying
- Physical aggression towards her mother in particular, and sometimes towards her siblings.
- Accusations that her parents are 'starving' her – apparently Lucy sometimes refuses to eat her dinner after she has been 'told off' even when it is offered, insisting that she is not allowed.

Mr and Mrs F also said that Lucy was unable to sit still and concentrate on anything for any length of time.

Lucy's parents described exceptions to the above behaviour difficulties when Lucy can be very helpful, for example with the washing up. She has also recently begun to go horse riding, which she really enjoys and is 'well-behaved' for.

It was made clear that the family did not believe that they were coping very well and that Mrs F in particular was struggling (Mrs F reported being tired and suffering from headaches). The parents were quite open about this and recognised that their current approach to parenting may not be meeting Lucy's needs. Mrs F. reported that she had already attended a parenting course through school, but had not found it practical.

**Looking to understand the parents' perspective**

When I asked Lucy's parents what they thought the purpose of Lucy's behaviour was, they suggested that there was an element of manipulation or wanting to get her own way, and possibly some attention seeking behaviour. – Seemed quite negative towards Lucy, who was only 6.

Mr and Mrs suggested that Lucy seemed to have behavioural difficulties that would concur with a diagnosis of ADHD, having researched the disorder on the internet. They felt strongly that they would not want Lucy to receive drug therapy, but would like to access any support that might be offered the family and Lucy should this be the case.

**Issues of transparency, reflexivity and information sharing**

I felt that it was important at this stage in the meeting to be transparent about my own position with regards to ADHD at that time. I explained that I was concerned about the legitimacy of a diagnosis of ADHD in light of the controversy surrounding a) its existence and b) it's reported over-diagnosis (ref Vissar). We discussed what the potential advantages and disadvantages of pursuing a diagnosis might be for Lucy.

In order to investigate whether the language used and the preconceptions that were held by different stakeholders about what ADHD type behaviour might look like in a classroom and/or home setting, I decided to use a standardised test. I used the Conner's Teacher Rating Scale (Long Version) and Parent Rating Scale (Short Version). This scale is a subjective rating scale based on the perception of the person

completing the form. It gives an indication of how the parents and teacher understand the child and/or the child's situation. In this case, I was interested to see if the very different descriptions of Lucy's behaviour were actually describing the same or similar underlying behaviours by using the same language and concepts for the raters from both settings.

Results from both the parental and teacher form indicated several commonalities in terms of the ADHD index, with a high degree of concurrence between the two settings. The school only rated Lucy differently on the Oppositional Scale – (moderately atypical compared to markedly atypical), but a score that according to the Connors scoring system, still indicates a significant problem.

In discussing these results with the class teacher, it became clear that the teacher felt strongly about the need to speak positively about children and a reluctance to deal with any form of labelling. This strongly held principle of the class teacher's may have biased her discussion of the child in the initial consultation. In this way the Connor's Scale had been useful in ensuring that the same terms were being used.

The most appropriate support for Lucy and her family would come from the highly acclaimed and award winning Liverpool ADHD Foundation. The foundation would be able to offer a rounded package of support to the whole family, including parent skills training specifically designed to target parents of children with ADHD type behaviours. The foundation works on a referral system that uses a diagnosis of ADHD as a screening requirement for accessing their resources. This was discussed through consultation with the parents and school, leading to a decision to refer Lucy for assessment.

## Discussion

This paper presents a case that challenged my own assumptions as a non-medical practitioner. It engendered a re-evaluation of how I understood emancipatory practice to function within a system where diagnosis is the only route to accessing resources. In the case of ADHD, the government's proposal of a continuum of needs is subsumed by the more positivist dichotomy of the disease metaphor. Diagnoses are only available through the medical system, which inevitably lends positivist epistemological and ontological assumptions about the way in which ADHD is understood and treated and the way that 'normal' and 'abnormal' is defined and assessed.

Crucially for the family involved in this case, the Liverpool ADHD Foundation (an award winning charitable service available for children and young people with hyperactivity and attention difficulties and their families in the Liverpool area) can only be accessed following a medical diagnosis of ADHD. No label of ADHD means no access to the resources on offer. With some irony for myself at least, the Foundation told me that they run their service on a participatory basis, where sessions are run by trained parents of children diagnosed with ADHD and the children and young people themselves. A multi-modal approach to treatment is endorsed, that includes work with the whole family and not just the child. The Liverpool ADHD Foundation also engages in Action Research in order to better understand and provide for the different communities of Liverpool. While the approach of the foundation is essentially based upon participatory principles, with emancipatory aims, this does not exclude the adoption of a medical model for describing ADHD type behaviours, which can be

functional (in terms of targeting of resources) and normalising for children and their families when they meet other people with similar difficulties.

Despite the less than convincing evidence about the effectiveness of medicating children with ADHD in the long term, and the questionable validity of how and which outcomes have been measured, a diagnosis usually means that the young person will be prescribed some form of medication, according to the wishes of the parents. In the current case, it was clear that Lucy's parents were highly anxious about this. In light of Hanson and Hanson's work around the dilemmas parents face in this situation, transparency was highly important. The lack of research about how parents cope with the 'flux of dilemmas' they must negotiate in this process (Hanson and Hanson, 2006) highlighted the importance of parent advocacy, which Lucy's parents accessed through Parents Partnership.

From an emancipatory, post-modern standpoint, diagnosis of ADHD should involve the full and empowered participation of the person receiving the diagnosis. Scrutiny of the interests and operations of power involved in labelling children should occur and inform the development of democratic, transparent practice, that empowers, rather than controls, the subject. Where I had previously assumed that this stance was in some way juxtaposed with a medical approach, involvement in this case demonstrated that a practical approach was needed for working within the current system: a diagnosis (whilst clearly problematic from a critical standpoint) opened up choices for families and ultimately access to enabling resources. However, the extent to which this process was anti-emancipatory for this family is called into question by the fact that they had to have their child labelled in order to achieve

access to the appropriate services for meeting their own and their child's needs.

In my opinion, the current system enforces a philosophical stance that is only weakly empirically supported and is still much in debate amongst academics in terms of aetiology and treatment of ADHD (Baldwin and Cooper, 2000). The purely medical route to obtaining a label of ADHD can result in parents not being exposed to alternative views or possible courses of action. A multi-disciplinary pathway may help to redress this imbalance to some extent.

## References

- Anderson, R. & Baldwin, S. (2000). What's in a name? Amphetamine and methylphenidate. **Journal of Substance Use**, 5: 89-91
- Alban-Metcalfe, J., & Alban-Metcalfe, J. (2001). **Managing attention deficit hyperactivity disorder in the inclusive classroom**. London: Fulton.
- APA. (1994). **Diagnostic and Statistical Manual of Mental Disorders**, 4th ed, DSM IV. American Psychiatric Association, Washington, DC, USA.
- Ayers, H., Vlarke, D. & Murray, A. (2000). **Perspectives on Behaviour** (2<sup>nd</sup> ed.) London: Fulton
- Baldwin, S., Cooper, P. (2000). How should ADHD be treated? **The Psychologist**, 13 (12): pp. 598-602
- Barkley, R. A. and 20 Coendorsers (2004). Critique or Misrepresentation? A Reply to Timimi et al. **Clinical Child and Family Psychology Review**, 7 (1): 65-69
- Breggin, P. (2002). **The Ritalin Fact Book**. Cambridge, MA: Perseus.
- Bussing, R., Gary, F. A., Mills, T. L., & Garvan, C. W. (2003). Parental explanatory models of ADHD. **Social Psychiatry and Psychiatric Epidemiology**. 38, 563-575.
- Carr, A.(Ed.) (2000) **What works with children and adolescents? A critical review**



**of psychological interventions with children, adolescents and their families.**

London. Routledge.

Christensen, C. (1996). "Disabled, handicapped, or disordered: 'What's in a name?'"

In Christensen, C, & Rizvi, F (Eds.), **Disability and the dilemmas of justice**, 63-78.

Buckingham, UK: Open University Press

Cohen, D., Leo, J. L., Stanton, T., Smith, D., McCreedy, K., Laing, M. S., et al. (2002).

A boy who stops taking stimulants for "ADHD": Commentaries on a Pediatrics case study. **Ethical Human Sciences and Services**, 4, 189–209.

Cooper, R. (2004). What is wrong with the DSM? **History of Psychiatry**, 15 (1): 5-25

Cooper, P. & Bilton, K., M. (2002). **Attention deficit/hyperactivity disorder.**

**Resource materials for teachers: A practical guide for teachers** (2nd ed.)

London: David Fulton

Corkum, P., Rimer, P., & Schachar, R. (1999). Parental knowledge of attention-deficit

hyperactivity disorder and opinions of treatment options: Impact on enrolment and

adherence to a 12-month treatment trial. **Canadian Journal of Psychiatry**, 44,

1043-1048.

Daniels, H., Visser, J., Cole, T and de Reybekill, N. (1999). **Emotional and**

**Behavioural Difficulties in Mainstream Schools.** Research report RR90. London:

DfEE.

Department For Education and Skills (2001). **Code of Practice on the Identification and Assessment of Special Educational Needs**

Diller, L. H. (2006). **The Last Normal Child: Essays on the Intersection of Kids, Culture, and Psychiatric Drugs**. New York: Praeger.

dosReis, S., Zito, J. M., Safer, D. J., Soeken, K. L., Mitchell, J. W., & Ellwood, L. C. (2003). Parental perceptions and satisfaction with stimulant medication for attention-deficit hyperactivity disorder. **Journal of Developmental and Behavioral Pediatrics**, 24 (3): 155-162.

Fernandez, M. (2006). **Cultural beliefs and domestic violence: Part IV. Cultural and international perspectives on violence against women. Violence and Exploitation Against Women and Girls**, 1087: 250-260

Goodman, R., & Stevenson, J. (1989). A twin study of hyperactivity: II. The aetiological role of genes, family relationships and perinatal adversity. **Journal of Child Psychology and Psychiatry**, 44, 1025-1035

Hansen, D. L. & Hansen, E. H. (2006). **Caught in a Balancing Act: Parents' Dilemmas Regarding Their ADHD Child's Treatment with Stimulant Medication. Qualitative Health Research**, 16 (9): 1267-1285

Harvey, E., Danforth, J. S., McKee, T. E., Ulaszek, W. R. & Friedman, J. L. (2003) Parenting of children with attention-deficit/hyperactivity disorder (ADHD): the role of

parental ADHD symptomatology. **Journal of Attention Disorders**. 7, 31–42.

Jadad, A. R., Booker, L., Gault, M., Kakuma, R., Boyle, M., Cunningham, C, E., Kim, M., & Schachar, R. (1999). The treatment of attention-deficit hyperactivity disorder: An annotated bibliography and critical appraisal of published systematic reviews and meta-analyses. **Canadian Journal of Psychiatry**, 44, 1025-1035

Klasen, H. & Goodman, R. (2000) Parents and GP's at cross-purposes over hyperactivity: A qualitative study of possible barriers to treatment, **British Journal of General Practice** 50, 199–202

Larsson, J. O., Larsson, H. & Lichtenstein, P. (2004) Genetic and environmental contributions to stability and change of ADHD symptoms between 8 and 13 years of age: a longitudinal twin study. **Journal of the American Academy of Child and Adolescent Psychiatry**. 43, 1267–127

Lui, C., Robin, A. L., Brenner, S., & Eastman, J. (1991). Social acceptability of methylphenidate and behavior modification for treating attention deficit hyperactivity disorder. **Pediatrics**, 88 (3): 560-565.

Mayes, R. & Horwitz, AV. (2005) [DSM-III and the revolution in the classification of mental illness](#). **Journal of the History of Behavioural Science** 41(3): 249–67

McBurnett, K., Lahey, B. B., Pfiffner, L.J. (1993). **Diagnosis of attention deficit disorders in the DSM-IV: Scientific basis and implications for education.**

**Exceptional Children.** 60, pp 108-117

McNeal, R. E., Roberts, M. C., & Barone, V. J. (2000). Mothers' and children's perceptions of medication for children with attention-deficit hyperactivity disorder.

**Child Psychiatry and Human Development,** 30 (3): 173-187.

Mellor, D. J., Storer, S. P., & Brown, J. (1996). Attention deficit hyperactivity disorder: Perceptions, practice and politics. **Journal of Paediatrics and Child Health,** 32, 218-222.

Purdie, N., Hattie, J. and Carroll, A. (2002). A review of the research on interventions for Attention Deficit Disorder: What works best? **Review of Educational Research.**

72 (1): 61-99

Sonuga-Barke, E. J. S., Dalen, L. & Remington, B. (2003a) Do executive deficits and delay aversion make independent contributions to preschool attention deficit/

hyperactivity disorder? **Journal of the American Academy of Child and Adolescent Psychiatry.** 42, 1335–1342.

Tannock, R. (1998). Attention deficit hyperactivity disorder: Advances in cognitive, neurobiological and genetic research. **Journal of Child Psychology and**

**Psychiatry.** 39, 65-100

Teeter, P. A. (1998). **Interventions for ADHD: Treatment in developmental context**. New York: Guilford Press

Timimi, S. (2002). **Pathological child psychiatry and the medicalization of childhood**. Hove, UK: Brunner-Routledge.

Timimi, S. et al. (2004). A Critique of the International Consensus Statement on ADHD. **Clinical Child and Family Psychology Review**. 7, 59–63.

Tripp, G. & Wickens, J., R. (2008). Research Review: Dopamine transfer deficit: a neurobiological theory of altered reinforcement mechanisms in ADHD. **Journal of Child Psychology and Psychiatry**. 49 (7): 691-704

Travell, C., Visser, J. (2006). 'ADHD does bad stuff to you': young people's and parents' experiences and perceptions of Attention Deficit Hyperactivity Disorder (ADHD). **Emotional and Behavioural Difficulties**. 11 (3): pp. 205-216

Tymms, P. & Merrell, C. (2006). 'The impact of screening and advice on inattentive, hyperactive and impulsive children', **European Journal of Special Needs Education**. 21 (3): 321 – 337

Waters and Kraus (2000). Peake, A. (2003). **Ritalin Fraud** [Online}. <http://www.ritalinfraud.com>.

Wilson, I. (1999). The emerging gay adolescent. **Clinical Child Psychology and Psychiatry**, 4 (4): 551-565

Whalen, C. K., & Henker, B. (1991). Therapies for hyperactive children: Comparisons, combinations and compromises. **Journal of Consulting and Clinical Psychology**. 59, 126-137

# **A COMPARISON OF MADELEINE PORTWOOD'S PROGRAMME FOR YOUNG PEOPLE WITH DEVELOPMENTAL DYSPRAXIA AND TWO ALTERNATIVE INTERVENTIONS**

## **Introduction**

### **Professional practice background for the report**

During my second year of training as an Educational Psychologist, I was asked to oversee and evaluate the implementation of a motor skills programme based upon Madeleine Portwood's programme (2000). The child had been identified as having a Developmental Coordination Disorder (DCD) by the Educational Psychologist for the school. The programme was to be delivered by a Teaching Assistant in daily twenty minute sessions, with a long term commitment by the school to continue with the programme for as long as it was useful. The evaluation of the intervention included measures such as handwriting skills (Portwood, 1999, claims that the skills practised in the intervention improve the participants handwriting), the young person's self concept and confidence and, motor skills. Sources of evidence included a self-concept checklist, hand writing assessment, teacher and parent reports, progress through the stages of the programme, levels of skill maintenance and the young person's views.

While the evaluation measures indicated that the programme produced positive effects on the measures chosen, the evaluation was not robust enough to substantiate any definite claims about causality. In addition, real world events (such as absenteeism of the facilitator) determined that the intervention was not implemented in a form that would provide evidence to support or otherwise any

evaluation of the programme except for in the very specific circumstances in which it occurred.

The current report focuses instead upon the extent to which the use of Portwood's programme can be defended in light of some of the issues around DCD assessment and intervention.

### **Report plan**

The report begins by looking how DCD is defined, in terms of the terminology used and the diagnostic criteria applied, mainly through the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), but with some reference to the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). Some of the main controversies surrounding these criteria are discussed, including some of the implications for assessment and intervention.

Three specific interventions are discussed, with respect to their theoretical underpinnings, implementation and evidence base. The interventions discussed are:

- M. Portwood's motor skills intervention (Portwood, 1999)
- Cognitive Orientation to Daily Occupational Performance (CO-OP) (Polatajko et al, 2000)
- Task-specific training (Larkin and Parker, 2002)

A discussion follows that considers whether empirical and theoretical evidence are the only relevant sources of evaluation data. This leads to further evaluation of the three interventions based upon four points suggested by Sugden and Dunford (2007)



and in light of guidance presented in the Special Educational Needs Code of Practice (CoP) (DfES, 2002).

An argument is made that links the Dynamic Systems approach closely to the aims of the Code of Practice (CoP) as well as current theoretical positions regarding DCD. However, the benefits of Portwood's programme are recognised as potentially fit for purpose within the graduated response framework of the CoP framework. A multi-faceted approach to DCD assessment and intervention is advocated in concordance with the Leeds Consensus (Sugden, 2006)

### **Terminology**

The idea of a condition that specifically affects motor coordination has been recognised since the beginning of last century at least (Zoia et al, 2006). However, such a disorder only appeared in the DSM-III-R in 1987 (American Psychiatric Association (APA), 1987), where it was labelled as clumsy child syndrome. Wright and Sugden (1996) found that 'clumsy' was the term most often employed in the literature to describe children exhibiting these types of coordination difficulties. Other terms used to describe the disorder include developmental dyspraxia (Portwood, 1996), Specific Developmental Coordination Disorder (World Health Organisation, 1992) and more commonly, Developmental Coordination Disorder (DCD) (Zoia et al, 2006). DCD is the term currently used by the DSM-IV (American Psychiatric Association 1994, 2000) and the ICD-10 (1992) and will be the main term used in this report.

## **Diagnostic Criteria**

DCD has been described as a group of cognitive disorders characterized by the inability to perform previously learned skills that cannot be attributed to deficits of motor or sensory function (Adams et al, 1998). It is diagnosed in children who do not develop motor coordination skills at the expected rate and where there is no medical explanation for the lack of progress. As an idiopathic disorder, there has been controversy surrounding the definition of DCD, how it should be assessed and what the best interventions are. I will begin by discussing some of these issues within the context of the current DSM-IV diagnostic criteria (see table 1).

The Leeds Consensus is a group of professionals led by Professor Sugden, who sought to follow-up and update the work of the London Consensus in 1994. One of their aims was to 'provide a more detailed picture of this common disorder than was provided in (DSM-III-R, 1987/DSM-IV, 1994).' (Sugden et al, 2006, p. 2), with the financial backing of the Economic and Social Research Council and The Discovery Centre, Wales.

While the DSM-IV-TR (APA, 2000) was generally recognised as a basis for the definition and diagnosis of DCD by the Leeds Consensus in 2006, the diagnostic criteria were criticised for their vagueness and some amendments were proposed (Sugden, 2006).

Table 2. Diagnostic criteria for DCD (APA, 2000, p. 58)

- 
- Performance in daily activities that require motor coordination is substantially below that expected given the person's chronological age and measured intelligence. This may be manifested by marked delays in achieving motor milestones (e.g., walking, crawling, and sitting), dropping things, "clumsiness", poor performance in sports, or poor handwriting.
  - The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living.
  - The disturbance is not due to a general medical condition (e.g., cerebral palsy, hemiplegia, or muscular dystrophy) and does not meet criteria for a Pervasive Developmental Disorder.
  - If Mental Retardation is present, the motor difficulties are in excess of those usually associated with it.
- 

### **Ambiguity of criteria A and B**

According to the DSM-IV, a diagnosis of DCD should only be made if the four diagnostic criteria are met. The first two criteria are inclusive and state that motor coordination difficulties must have a significant impact upon the person's academic achievement or ability to carry out everyday activities (APA, 1994, 2000). The range of difficulties that are presented in the first criterion represent the core problems that may arise from fine and/or gross motor skills difficulties (Sugden et al, 2008), but are by no means exhaustive. Geuze et al found that in practice, practitioners tended only to refer to DCD where there were impairments in both areas of motor skills (Geuze et al, 2001), highlighting one aspect of the ambiguity of the DSM-IV diagnostic criteria

(Barnett, 2008). The ICD is even vaguer in this area, only referring to deficits in fine or gross motor performance (WHO, 1992).

The Leeds Consensus recognised the impact of DCD upon daily living and academic performance, as stated in Criterion B, but identified a potential overstating of the latter. It was argued that while handwriting was an important skill for negotiating the demands of our education system (particularly in secondary school) there should be no assumption that other aspects of academic ability should be affected (such as reading ability). This raises the question: are we intervening to help children fit into an education system that over emphasises the need for good handwriting, when perhaps we should be looking at how the curriculum could better serve to help young people make the most of the skills that they have? This question, which relates to a Social Model of Disability (Oliver, 1990) has implications for designing interventions that effect change in the child's environment, perhaps within ecological rather than more traditional, within child approaches.

### **Criteria C and D**

Criteria C and D are exclusive, stating that DCD cannot be diagnosed in the presence of certain medical disorders and that it should be viewed in relation to any other developmental delay. One previously held notion was that DCD occurred in children with abilities within the average range (Gubbay, 1975). In 1980, Gordon & McKinlay used a discrepancy-based definition of 'clumsy children', but did not specify a particular level of general ability. This appears to be the approach of the DSM-IV, which states that general delay may be present in a case of DCD, but the motor difficulties must be in excess of those usually associated with it.

## **Implications for assessment**

### **The cut-off point**

The Leeds Consensus defined a cut-off point within the Normal Distribution Curve for describing the point at which motor difficulties are 'substantially below that expected' in order to meet Criterion A (table 1), enabling practitioners to assess motor coordination with standardised tests. It was agreed that performance at or below the fifth percentile would be appropriate (Sugden, 2006). The fact that the ICD-10 places the cut off point for formal diagnosis at 2.5<sup>th</sup> percentile demonstrates the arbitrary nature of this mechanism. Neither the Leeds consensus (2006) or the ICD-10 give any justification for their cut-off point decisions (Barnett, 2008), or what this will mean for children and their families who might fall in the 6<sup>th</sup> percentile, but would benefit from professional intervention.

Many assessment tools have been criticised for their lack of construct validity and problematic reliance upon norm-referencing (see Wilson, 2005 for a review). This will inevitably raise issues about the standardisation of diagnosis as different practitioners make diagnoses based upon different measuring tools, with little direction from the DSM-IV about which skills should be being assessed in order to demonstrate motor ability. This has implications for the construct validity of assessments.

The discrepancy based definition used in Criterion A is reminiscent of that previously used for Dyslexia, which has been largely rejected, due to possible discrimination against people of lower general ability, for whom a discrepancy may be more difficult to demonstrate using an assessment based upon a normal distribution (BPS, 2005).

If diagnosis acts as a gate keeping mechanism for resources, a discrepancy-based system may lead to an unfair distribution.

### **The impact of unique difficulties and circumstances**

Criterion B sets out a requirement to assess the extent to which the core difficulties described in Criterion A impinge upon the subject's life – however, Milloy (1988) refers to the holistic nature of Developmental Dyspraxia. It is not simply a coordination disorder, but may affect many areas of a person's functioning. While Zoia et al make the claim that DCD 'symptoms are consistent across culture, race, socio-economic status and gender.' (Zoia et al, 2006, p. 613), other authors have commented that despite some common features of the disorder, the range and nature of the difficulties experienced varies not only from child to child, but across one person's lifespan (Barnett, 2008). Cousins and Smyth describe a prognosis for adolescence and adulthood that includes medical and psychiatric consequences as well as social problems and motor difficulties (Cousins and Smythe, 2005). A number of research studies have substantiated the Gordon and McKinlay's (1980) description of secondary emotional and social problems (see Miyahara & Cratty, 2004, for a review).

It is important to recognise that the range of difficulties that this broad category may include will present differently for different children. A standardised test of motor coordination may be too crude a measure to facilitate a holistic view of the disorder.

The problems relating to the use of a cut-off point, a discrepancy model and the reduction of the holistic effects of DCD to a small defined set of criteria suggest that

assessment in relation to a standardised test is not sufficient for the diagnosis of DCD: the actual impact of each individual child's unique range of difficulties upon their unique circumstances need to be considered. This has implications for evaluating the effectiveness of interventions and will be discussed later in the report.

### **The lack of theoretical approaches represented in the criteria**

A final point to consider is that the DSM-IV criteria are very much based upon observable, everyday activities that may not reflect the different theoretical approaches to understanding, assessing and intervening for the disorder. As DCD is an idiopathic disorder (Zoia, 2006), a range of theories have emerged about the disorder's etiology. According to Barnett (2008), different theories should be applied concurrently to afford a deeper understanding of the disorder in individual case or research settings, as long as the influence of the epistemological and ontological assumptions made in a particular approach upon the subsequent actions of the practitioner are recognised.

Barnett's (2008) suggestion that a multi-level explanatory framework may be more useful than the current diagnostic criteria is apparent in the diverse range of assessment techniques that have been used to explore aspects of motor behaviour in DCD research. In research generally, the methods selected respond to the requirements of a specific research question, born from a particular theoretical and epistemological perspective (See Wilson, 2005 for an over view of assessment techniques). For example, the Internal Modelling Deficit Theory predicts that children with DCD have difficulty imagining a movement, leading to difficulties in accounting for external space in coordinating movement (Williams et al, 2006). In order to test

their hypothesis, the researchers employed a mental rotation test. Research such as this is subject to the double hermeneutic effect described by Usher, (1996), whereby the research is bound to the frameworks and schemas in which meaning is given. The experiments conducted do not prove a causal relationship, but may identify a contributory factor. A multi-faceted explanation might be more effective.

The same is true in the context of intervention planning. Practitioners may develop interventions and define goals to address young people's needs as described by the initial assessment (Wilson, 2005). These assessments may well be based upon restrictive theoretical assumptions (such as the mental image rotation test) that do not address the holistic nature of the disorder. The possible outcomes will be restrained by the theoretical framework, and may lead to interventions that are too narrowly focused.

The next section of this report will examine three of the theoretical bases that might contribute to a multi-level framework, considering the extent of the contribution each approach might make.

## **Interventions**

Approaches can very broadly be divided into two categories: task orientated approaches that aim teach the functional skills that will enable the young person to reach activity and participation goals; and process orientated approaches that aim to identify and address underlying cognitive impairments, leading to an improvement in the related coordination difficulties (Coster, 1998). This review will look at three interventions based upon theoretical approaches under these broad categories.



### **Madeleine Portwood's intervention**

The intervention that was employed in the piece of casework that gave rise to this report was developed by Madeleine Portwood. It is a process-orientated approach that lies broadly within a neurodevelopmental understanding of DCD. The theory assumes that behaviour is an indication of a child's neurological state and that early neurological markers, such as sensimotor function and other learning indices, can predict the occurrence of DCD. Unlike some other neurodevelopmental approaches, Portwood sees this neurological state as repairable (Wilson, 2005).

The assessments used by Portwood are eclectic, including cognitive assessment, developmental histories and developmental stage referenced behaviour observation, reflecting the assumptions of this largely medical perspective. However, the intervention Portwood describes does not seem to be dissimilar from other motor skills interventions developed from very different theoretical models.

#### Theoretical Basis

"Dyspraxia results when parts of the brain have failed to mature properly" (Portwood, 1999, p.5).

Portwood's approach views DCD (Developmental Dyspraxia is the preferred term used in her work), from a neurodevelopmental perspective. Put simply, the condition is viewed as resulting from a failure to strengthen or reinforce the neurological pathways that are responsible for motor coordination during early development. According to Thelan (1989), during 'normal' development, the baby makes random

movements until it achieves purposeful movement. The neural activity that leads to purposeful movement reinforces the neural pathways involved, making it more likely that the pathway is used on a subsequent occasion. As this process continues, pathways that are not useful start to become redundant and are 'pruned'. The brain then has fewer options to explore when it needs to make a movement, leading to more efficient and reflexive movements. Edelman (1989) describes the process as a form of neural 'natural selection'.

According to Portwood (2000), the parts of the cerebral cortex responsible for the motor coordination of young people with DCD, remain at an immature state of development, in which 'pruning' of redundant pathways and the reinforcement of appropriate neural pathways has not occurred sufficiently. This leaves much longer and complex routes for neural messages to travel down, increasing processing time. There is also the increased risk that the message may not arrive at its destination at all.

### The Intervention

The intervention presented by Portwood involves progression through a series of tasks. The programme consists of a number of activities that are divided into skill areas, such as; finger, arm and hand movements; hand-eye coordination; whole body coordination. Activities are selected according to the child's performance on an initial assessment in which emerging skills are identified. The skills are practised by the young person on a daily basis until a specified aim rate is reached and the child is able to progress to the next level of skill. Portwood's assumption is that by repeating certain tasks, neural pathways will be reinforced and the young person will be able to

produce the same movement more accurately and fluently in the future. Portwood also claims that the tasks will be generalised into other motor skill areas that are assumed to be linked, so handwriting is said to improve.

#### Empirical basis

The basis of many of the assertions made in Portwood's books has been questioned (McKinlay, 2001). The empirical basis for Portwood's theory is largely taken from her own index sample of 600 cases that she has assessed over a number of years. Reports regarding developmental indices of Developmental Dyspraxia (such as hyperactivity; feeding difficulties; delayed language acquisition) are all based upon parents historical reports and are therefore of questionable reliability.

She is also criticised for over stating the case for a metabolic basis for DCD, which McKinlay describes as 'speculative-worth but not generally accepted' (McKinlay, 2000, p.466). In addition, the neurophysiological profiles that she describes at length in her books (Portwood, 1999, 2000) are presented without information about any selection factors or any controls being described.

Portwood's claim that smaller-sized babies are more prone to DCD assumes a causality that she does not provide evidence for. The higher incidence amongst smaller babies may reflect an early motor coordination difficulty that affects feeding, rather than feeding difficulties causing DCD (McKinlay, 2001).

The theoretical basis for Portwood's intervention has been largely superseded by more sophisticated theories engaging in ideas about motor imagery/ internal and timing control modelling (Wilson, 2005). Technological advances in neuroimaging and

lesion studies have allowed researchers to provide supporting data for such theories, while the empirical support claimed by Portwood seems largely questionable. In fact, approaches like the one presented by Portwood have been shown to have only moderate or no effect (Polatajko et al, 1995; Sims et al, 1996 – from Wilson) and claims about the generalisation of skills to handwriting and other areas are not sufficiently validated by Portwood's evidence base. Other theorists and researchers making claims for alternative approaches have only shown task specific skill improvement with only small amount of cross-skill generalisation (see the discussion below).

While my own experience as a facilitator of the delivery of this approach by a learning support assistant to a young person could in no way be regarded as providing any empirical data in support or otherwise of Portman's intervention, I was able to note some positive advantages to the approach in a real world setting. Firstly, the approach is specifically designed to be used by school-staff. It is uncomplicated and easy to deliver on school premises with minimal cost requirements. This means that it can be delivered as part of a school's graduated response, rather than requiring recourse to external agencies.

The short, daily sessions provide a structure for progression through clearly defined stages that allowed the young person to experience success in an area in which she would normally fail. Confidence increased, and the effect was reportedly generalised to other areas of the child's performance in school, including social interaction and participation in class.

On this unempirical evidence, it could be argued that the approach does address at least some of the secondary symptoms associated with DCD. However, this does not provide evidence that would support the idea of a neurological basis for DCD, as suggested by Portwood, 1999, as effects could be due to practice of motor co-ordination skills within an over-learning model and the confidence building experience of regular one-to-one contact with an adult. The merit of the intervention may lie in the practicality of its delivery, particularly within the graduated response framework described by the Code of Practice (DfES, 2002).

**Cognitive Orientation to Daily Occupational Performance (CO-OP) (Missiuna et al, 2001, Polatajko et al, 2001a, 2001b)**

Functionally relevant tasks

An alternative intervention to the one taken in the current piece of case work is the CO-OP approach. CO-OP is grounded in what Wilson (2005) calls the *normative functional skill approach*. Given the internationally agreed recommendations of the Leeds Consensus that assessment should “contain activities that are functional and are based on those that are relevant to daily living” (Sugden, 2006, p. 8), product-orientated interventions would seem to better reflect current dominant thinking around DCD than Portwood’s process-orientated intervention.

Theoretical Basis

The normative functional skill approach is essentially a developmental, cognitive approach that adopts a Piagetian type staged framework, in which normal development occurs through sequential sensorimotor and cognitive age-related milestones. Like Piaget, the approach emphasises the importance of self-directed

activity in the learning process (Wilson, 2005).

The ideas underlying the normative functional skill approach eventually developed into a cognitive approach to intervention, from which CO-OP has emerged. CO-OP is a hybrid of cognitive, developmental and motor control theory, in which motor control is goal directed behaviour, defined by cognitive and developmental constraints. This approach had suffered from a lack of empirical study until the development of the CO-OP intervention described below (Wilson 2005).

While assessment and measurement of the CO-OP intervention is constrained by the limitations of the available assessment tools (for example, the main assessment tool, the Movement Assessment Battery for Children (MABC), has norms that only go up to twelve to fourteen years and there are only limited tests available for under fours (Wilson, 2005), there is good construct validity for the scales when compared to process orientated measures. This is because product-orientated assessments ask whether the subject is able to perform the task, not what the underlying processes are, resulting in directly observable dependent variables.

### The Intervention

The CO-OP approach is child centred, with the goal for intervention being decided by the child, encouraging the targeting of functional, age-relevant skills. It is a top down approach, in that it starts by defining the goal, then facilitates mediated learning to build motor skills. The investment of the child in setting the goal is intended to increase motivation to change. This contrasts with the prescribed sequential

approach of the Portwood intervention.

As a normative approach, CO-OP assumes that a child's development can be norm referenced. This in turn implies a quantitative element to assessment in order to describe progress.

Whilst being child-centred, the approach still requires a trained mediator between the child and the learning task. The mediator's role is to design tasks to fit with the child's level of competency and the defined age appropriate functional skills. Verbal prompts are used to help the child develop and evaluate correction strategies within the context of the problem-solving framework: Goal, Plan, Do, Check (Missiuna et al, 2001). The programme covers twelve sessions (as described by Mandich et al, 2001) and should involve parents so that skills are generalised across settings and maintained over time. The emphasis is upon the cognitive element of the training, rather than assuming an unseen change in neural pathways.

#### Evaluation/Empirical basis

The 2006 Leeds Consensus states that the onset of DCD: "is apparent in the early years but would not typically be diagnosed before 5 years of age. It has a varying, but significant impact throughout the lifespan." (Sugden, 2006, p. 5). This reflects the developmental perspective taken by normative functional skill approach, giving it a direct relevance to current thinking in this area. The self-directed nature of the intervention should increase its' ecological validity, as it is tailored to address the individual needs of the young person in their real world context, rather than taking Portwood's prescribed approach.

Evaluation data shows good results for the CO-OP intervention (Wilson, 2005) with some maintenance effects (Polatajko et al, 1997). However, these are likely to be task specific (Polatajko et al, 2001) and not generalised. This is somewhat counter-intuitive, as a top-down approach would presumably be more likely to explicitly target meta-cognitive skills than other approaches. Despite this, Portwood makes more claims for the generalisability of her own approach to untargeted skills such as handwriting.

Like Portwood's programme, CO-OP presents as a practical approach. Unlike Portwood, CO-OP requires a trained mediator for its implementation. This is a potentially important disadvantage in the context of the SEN Code of Practice graduated response framework (DfES, 2002) as fewer young people would have access to an intervention that required a higher level of specialised resources.

### **Task Specific Training**

A third intervention that could have been selected for the case in which I was involved is Task Specific Training. In this instance, a dynamic systems approach to understanding development is employed.

#### Theoretical Basis

A dynamic systems approach, as applied to the study of movement, is interested in the way that functions are performed (process). It emphasises the biomechanical elements of movement, and considers them as part of a number of cooperating heterarchical dynamic systems (as opposed to the hierarchical systems that had



been described in previous models of motor learning (see Missiuna and Mandich (2002) for a historical account). In addition to the cooperating biomechanical subsystems, there is an interaction between other subsystems of the child, the task and the context. In the child, the influencing factors will include not only the child's biomechanical, neural and physiological capabilities (Missiuna and Madich (2002), but their cognitive problem-solving abilities and previous experience and other factors such as the child's motivation (Wilson, 2005). Other physical, psychological and cultural influences may also contribute.

In DCD, it is assumed that the child has not had sufficient or appropriate opportunities to develop the synergies between movement systems through interaction with tasks and the environment.

This dynamic systems approach embraces the possibility of individual differences in terms of how a task or problem is approached most efficiently. Each problem is solved differently by different individuals because of the unique heterarchy of interplay between the subsystems within which they are solved. The same task is also approached differently by an individual at different developmental stages, as constraints such as muscle development and cognitive skills development change over developmental stages.

### The Intervention

As with all the interventions described here, the basic principles are practice and feedback. In common with the CO-OP intervention, Task Specific Training is a child-centred intervention, with the tasks chosen for each child being 'culturally appropriate

and personally meaningful' (Larkin and Parker, 2002, p.234), addressing their specific needs, but from within a dynamic systems framework.

Unlike those working from a normative functional skill approach, dynamic systems based interventions are also interested in the processes involved in achieving the focal task. They would adapt their intervention strategy depending upon the type of learning that was being facilitated. The two types of learning, as proposed by Gentile (1998), are: explicit (conscious decision making in order to complete the task, mapping the interaction between the child, task and environmental factors); and implicit (changes in the more specific underlying processes, such as the biomechanics behind responses to forces like gravity etc.). The explicit learning of the focal task should lead to implicit learning that may be generalised to other related tasks. The sensimotor element of movement is emphasised so that the child can recognise good quality movement, by focusing the child's attention with utterances such as, 'How does that feel?' or 'Feel the stretch.'

A Task Specific Training intervention needs to take account of the complex interactions between the subsystems of child, task and environment (see table 2). The systems framework should allow the programme to assess the factors that are open to change and therefore enable the system to progress to a greater level of performance (Burton and Miller, 1998), giving rise to an intervention approach that is task-focused, but also emphasises the need for individual programme design.

## Evaluation

Pless & Carisson (2000) have found that the intervention approach produces strong

task-specific learning effects (like CO-OP). Again, similarly to the CO-OP approach, other authors have commented that there is a need for more evidence regarding the generalisation of some fundamental skills (Larkin & Parker, 2002).

Also in common with the CO-OP intervention, Task Specific Training requires a specialist or expert in order to implement it. Larkin and Parker (2002) have noted that the quality of feedback provided to the young person depends upon the facilitator's deep knowledge of the skill being focussed upon, an ability to observe the fine detail of movement and to reinforce small gains, and constant teaching and reteaching. As with the CO-OP approach, this has implications in terms of resources that are not necessarily attached to Portwood's programme.

Larkin and Parker (2002) make claims about the social benefits of this approach. These appear to be more structured and defined than those that might be claimed as an additional effect of the other two approaches. The participant makes a structured movement from an individual and teacher to paired and then group play. This helps to develop the social skills needed for game situations, one of the daily activities that may be negatively affected by DCD Page 246. In addition, the individualised planned progression is designed to allow for frequent experiences of success and a sense of advancement. These two elements should lead to an increase in confidence and self-esteem; however, such claims for the additional benefits of task-orientated motor skills training approaches have not gone uncontested. Peens et al (2007) found that motor training (using a combination of task focused motor training techniques) had long lasting positive practical effects, but did not have a discernable effect upon self-concept. The generalisability of this finding is compromised by the small sample size

and the fact that the participants were initially measured as having self concept that was in the low average range, making potential improvements less sensitive to measurement than if they had started from a lower base point.

Because DCD is seen a disorder of a heterarchical system rather than a top-down system, the dynamic systems approach can encompass the many variations in children's experience of DCD within the individualised development of strategies in Task Specific Training. However, Larkin and Parker (2002) suggest that identification of different coordination patterns (such as rigid and stiff versus unstable) would lead to more effective intervention strategies. Such enhancements would be supported by advances in technology for analysing biomechanical basis of movement.

In comparing the Portwood intervention to the CO-OP and Task Specific Training interventions, it seems that the later two are supported by a more robust evidence base, are better grounded in the theoretical approaches from which they have been developed and encompass a more holistic view of the effects of DCD than Portwood manages. In general, such task-orientated, functional approaches are considered to be better supported empirically (Wilson, 2005). However, it is interesting to note the fundamental procedural similarities between the approaches described. All involve:

- The application of teaching principles within a hierarchy of learning that moves from acquisition, to maintenance, to generalisation of the new skill.
- Close monitoring of progress through small incremental stages of increasing skill.
- The adaptation of tasks to physical and environmental constraints.
- Consideration of the child's motivation.

## **The evaluation of interventions**

According to the Leeds Consensus Statement, interventions should:

‘Be evidence-based and grounded in theories that are applicable to understanding children with DCD. These theories should take into account the nature of the learning process in the developing child, the structure of the task and the environmental conditions that support skill acquisition.’

(Sugden, 2006, p. 6)

This description would seem to advocate a dynamic systems approach to intervention, such as Task-Specific Training. However, Sugden & Dunford (2007) state that practitioners need to look to a number of sources of evidence when evaluating a programme of intervention, including, but not exclusively theory and empiricism. They suggest that other sources might include the experiences of the practitioner, children and their families. An evaluation should also take into account the current national and local policy context (Forsythe et al, 2008).

I believe that this is especially important in evaluating the Portwood programme in the current context. An evaluation of the intervention that is purely based upon theoretical and empirical evidence would be biased by the methodological flaws in Portwood’s original study designs and subsequent claims for her intervention. This would ignore some of the potential advantages of the actual programme, as a process at least.

Sugden and Dunford (2007) claim that their analysis of the range of evidence

collected from the described the diverse sources described above presents some key points upon which to evaluate successful interventions. The following section will discuss some of these points as they relate to the current interventions under consideration, and attempt to link this evaluation to the guidance given in the SEN Code of Practice (DfES, 2002) and the Leeds Consensus Statement (Sugden, 2006).

### **Provision of Child and Family Centred Services**

The 2006 Leeds consensus states that DCD intervention should “involve the child’s wishes as key parts of the intervention process” (Sugden, 2006, p. 8). The CoP states that parents have:

‘unique strengths, knowledge and experience to contribute to the shared view of a child’s needs and the best ways of supporting them. It is therefore essential that all professionals (schools, LEAs and other agencies) actively seek to work with parents.’

(DfES, 2002, p. 16)

The involvement of parents and families in the design and implementation of an intervention should not only provide an opportunity to respond realistically to the dynamics of each individual’s lifestyle (found to have longer and more lasting effects by Sugden, 2006), but also improve motivation.

Task-orientated approaches, including cognitive (such as CO-OP) and dynamic systems theory (such as Task Specific Training) have a theoretical, conceptual underpinning in child-centred goal-setting. Tools have been developed that facilitate

self-evaluation and goal setting for children (Missiuna, Pollock, Law, Walter, & Cavey, 2006). Within the dynamic system in which DCD presents, family lifestyle is considered in assessment and intervention as an important subsystem. Portwood's programme does not explicitly involve parents or seek the views of the child.

### **The involvement of other professionals in the implementation of a programme**

Sugden et al (2008) found that a number of different professionals from differing disciplines may be able to contribute to the provision of effective intervention for children with DCD. They suggest that consideration is given to producing materials that might be accessible to people who may have 'little or no post-compulsory formal education' so that a flexible approach might be applied (Sugden et al, 2008, p.182). This approach would have clear resource saving implications.

Portwood has already adapted her programme to be easily implemented by non-specialists (Portwood, 1999). The prescribed nature of the approach does not require the same level of specialist training as the task-orientated interventions.

### **The identification of functional outcomes as the end goal**

It could be argued that this point addresses the diagnostic Criteria A and B (see table 1) that highlight the assessment of performance in daily activities as part of the diagnostic process. It could also be said to relate to the SEN Code of Practice in terms of meeting individual needs of children.

While it might be assumed that all DCD interventions have a functional outcome as the end goal (Sugden et al, 2008), this aim is more explicitly expressed in task-

orientated approaches, where everyday functionality defines the goals that are set according to individual needs.

Portwood's programme makes claims about the far-reaching generalisability of the skills practised in her intervention to more functional skills than those being practised (so that handwriting is improved despite that particular skill not being taught). These claims are possible because of the assumptions she makes about the underlying processes involved in movement, although her evidence base has been strongly criticised (see the discussion in the section about her programme).

### **Participation as the goal of intervention**

This point suggests that interventions should be evaluated according to the extent to which they empower young people with DCD to engage in everyday activities. Polatajko and Cantin (2006) note that this is particularly difficult as tools for measuring participation are relatively undeveloped and none of the interventions discussed have an evidence base that looks at this issue. However, Sugden et al (2008) suggest that if participation is to be the goal of intervention then an ecological approach that is framed on the interaction between the child, task and the environment is best suited to the meeting this aim. They recommend that changes to the environment that accommodate the child's participation will be needed, in addition to focussing upon the child's skills. This is in accordance with the government's view that schools: 'must anticipate where barriers to learning lie and take action to remove them as far as they are able.' (DfES, 2004, p. 28). For this to occur, it might be necessary to carry out interventions in the young person's natural settings (such as the home and school) rather than a clinic.



In the CO-OP intervention, participation is increased to some extent because the young person sets the intervention goal. This does not ensure that improved participation will become the goal of the intervention and the primary focus is still upon changing the young person's ability to adapt to the environment rather than the other way around.

Portwood (1999, 2000) also addresses issues of participation in the formulation of her theories, in particular those outlined by Sugden et al (2008) as participation in: school work (especially handwriting); leisure activities; physical recreational activities (such as sport); and self-care. Portwood's programme encourages social interaction with peers, suggesting that support may come from the participation of classmates in the implementation of the programme. The non-empirical, experiential evaluation reports that emerged from the real case from which this report has emerged, support the idea that the programme encourages participation in each of these areas, although the reason why this occurred is unclear. The process of the intervention may have affected improvement in these areas as much as or more than the actual content of the programme.

While Portwood's programme occurs in the child's natural setting of the school, it is still very much focussed upon individual abilities rather than the environment within which the DCD is manifest. Even so, there may be intrinsic advantages to carrying out the intervention in school, such as: minimal disruption to the child's participation through reducing the necessity to spend time travelling to a clinic; the child may

associate positive experiences of success and a positive relationship with the environment in which they occur, increasing confidence; perhaps an association between the skills learned and the environment of the school might encourage generalisation. These are all hypothetical benefits.

A dynamic systems based approach is, by definition, an ecological approach that takes interaction between the child, the task and environment into account when designing interventions. As such, task-specific training can be expected to meet the requirements of this fourth point, at least indirectly.

In addition to the four points described, the interventions need to be evaluated according to the national framework of SEN practice within which they exist.

### **Evaluation with reference to the graduated response framework of the CoP**

In concordance with idea of graduated response, Sugden and Chambers (2003) point out that the presentation of DCD differs in terms of symptoms and response to intervention. In their research, they asked the question of how often an intervention should occur. Not surprisingly, they found that it depends upon the individual. For some children, improvement could occur after minimal intervention, while for others no improvement made after adequate intervention (3 times a week). Others may have more complex difficulties and so need more specialist intervention.

Portwood's programme could be criticised for the prescribed nature of the intervention activities. The programme does not have the same flexibility as the other interventions, where the specialist facilitator negotiates the design of the programme

to match the individual needs of the young person. However, for some children, the benefits incurred by inclusion on a Portwood Programme may be sufficient, or even preferable (as an intervention that is easily resourced, can occur within natural settings rather than in a clinic and will be easy to maintain) to other more specialised programmes. Sigmundsson et al (1998) have suggested that the effects of interventions may be due to the teacher and the underlying teaching principles rather than specific intervention, meaning that outcomes could be attributed not to the scheme itself but to the regular attention the child receives: the encouragement and interest in the progress of the child (Wilson, 2005).

In the current case, the Portwood programme facilitated daily individual contact with the 'teacher' within a positive teaching scenario. Benefits for the child in terms of self-esteem and confidence in the classroom were reported by the child, parent and teacher. There is no obvious method for evaluating whether these effects were because of the programme content, or because of the attention the young person received from the facilitating Learning Support Assistant, but it is unlikely that she would have received such intensive and ongoing intervention through other, more specialised and expensive routes.

As such, it makes intuitive sense that the programme could be implemented as a first stage, School Action response within the CoP framework.

## **Concluding Comments**

Maldonado-Duran et al's (2002) suggestion that no intervention is better than another seems unlikely to describe the complete picture. While it might be most important to ensure that whatever approach is adopted, the procedures have a positive effect

(Sigmundsson et al, 1998), it may still be that some interventions are better suited to fulfil the requirements of the particular ecological systems within which a young person sits. A dynamic systems framework may be the most useful approach to understanding the importance of different interventions in different cases, but within this approach is a recognition that the Task-Specific Training approach alone, whilst seemingly comparatively robust in its formulation and implementation, may not be the best intervention to meet the wider needs of the dynamic system in all cases, particularly where limited resources within a system of graduated response apply. Instead, a multi-faceted and multi-level response that promotes a range of interventions should be employed. As we have seen, under such a framework, the ease of facilitation of Portwood's motor skills programme might allow it a place at the School Action stage of the graduated response framework.

## References

- Adams, R. D. (1998). ***Principles of Neurology***. 6th ed. By Raymond D. et. al. New York: McGraw-Hill Professional Publishing.
- American Psychiatric Association (1987). **Diagnostic and Statistical Manual of Mental Disorders**, 3rd revised ed. American Psychiatric Association: Washington, DC, USA.
- American Psychiatric Association (1994). **Diagnostic and Statistical Manual of Mental Disorders**, 4th ed. American Psychiatric Association, Washington, DC, USA.
- American Psychiatric Association (2000). **DSM-IV-TR. Diagnostic and Statistical Manual of Mental Disorders**, 4<sup>th</sup> ed., text revision. American Psychiatric Association, Washington, DC, USA.
- Barnett, A. L. (2008). Motor assessment in DCD: From identification to intervention. **International Journal of Disability, Development and Education**, 55 (2): 113–129.
- Bishop, D. V. M. (2007). Curing dyslexia and attention-deficit hyperactivity disorder by training motor coordination: Miracle or myth? **Journal of Paediatrics and Child Health**, 43: 653–655.
- British Psychological Society (BPS) (2005). **Dyslexia, Literacy and Psychological Assessment**. Leicester, BPS,

Burton, A.W., & Miller, D.E. (1998). **Movement skill assessment**. Champaign, IL: Human Kinetics.

Coster, W. (1998). **Occupation-centred Assessment of Children**. 52 (5): 337-45

Cousins, M. & Smyth, M. M. (2005) "Progression and development in Developmental Coordination Disorder". *In*: (eds D. A. Sugden & M. E. Chambers), **Children with Developmental Coordination Disorder** 119–134. London, UK. Whurr Publishers

Department For Education (DfE) (1994). **Code of Practice on the Identification and Assessment of Special Educational Needs**. London: DFE.

Department for Education and Skills (DfES) (2002). **Special Educational Needs Code of Practice**. London: DfES

DfES (2004) **Removing Barriers to Achievement - The Government's Strategy for SEN** (White Paper), London: DfES

Edelman, G., M. (1989). **The Remembered Present: A Biological Theory of Consciousness**. New York: Basic Books.

Forsyth, K., Maciver, D., Howden, S., Owen, C., & Shepherd, C. (2008).

Developmental coordination disorder; a synthesis of evidence to underpin an allied health professions framework. **International Journal of Disability, Development**

**and Education**, 55 (2): 153–172.

Geuze, R. J., Jongmans, M. J., Schoemaker, M. M., & Smits-Engelsman, B. C. M. (Eds.). (2001). Developmental coordination disorder: Diagnosis, description, processes and treatment [Special Issue]. **Human Movement Science**, 20 (1): 1–210.

Gordon, N., & McKinlay, I. (1980). **Helping clumsy children**. New York: Churchill Livingstone.

Gubbay, S. S. (1975). Clumsy children in normal schools. **Medical Journal of Australia**. 1: 223-236

Larkin, D., & Parker, H.E. (2002). “Task-specific intervention for children with DCD: A systems view” In S.A. Cermak & D. Larkin (Eds.), **Developmental Coordination Disorder** (pp. 234–247). Albany, NY: Delmar.

Maldonado-Duran, M., Glinka, J. & Lubin, S. (2002) Motor skills disorder. **EMedicine Journal**, 3: 1–16.

Mandich, A.D., Polatajko, H.J., et al. (2001). “Cognitive strategies in motor performance in children with developmental coordination disorder” In C. Missiuna (Ed.), **Children with Developmental Coordination Disorder: Strategies for success**. Binghamton: The Hawthorn Press Inc.

McKinlay, I. (2001). Book Review: Understanding Developmental Dyspraxia: A

Textbook For Students and Professionals. **Child: Care, Health and Development**, 27 (5): 463-467

Milloy (1988). **Developmental Dyspraxia: General Considerations**. The Dyspraxia Trust.

Missiuna, C., & Mandich, A. (2002). "Motor learning approaches to intervention" In D. Larkin and S. Cermak (Eds.), **Developmental Coordination Disorder: Theory and practice**. Singular Publishing Company

Missiuna, C., Mandich, A., Malloy-Miller, T., & Polatajko, H.J. (2001). "Cognitive orientation to daily occupational performance (COOP): Part I Theoretical foundations" In C. Missiuna (Ed.), **Children with Developmental Coordination Disorder: Strategies for success**. Binghamton: The Hawthorn Press Inc.

Missiuna, C., Pollock, N., Law, M., Walter, S., & Cavey, N. (2006). Examination of the Perceived Efficacy and Goal Setting System (PEGS) with children with disabilities, parents, and teachers. **The American Journal of Occupational Therapy**, 60: 204–214.

Miyahara, M. & Cratty, B. J. (2004). "Psychosocial functions of children and adolescents with movement disorders". In D. E. Tupper & D. Dewey (Eds.), **Childhood Movement Disorders: A Neuropsychological Perspective**, 427-442. New York: Guilford Press.



Oliver, M. (1990). **The Politics of Disablement**. London: MacMillan.

Pless, M., & Carlsson, M. (2000). Effects of motor skill intervention on developmental coordination disorder: A meta-analysis. Adapted **Physical Activity Quarterly**, 17: 381–401.

Polatajko, H. J., Mandich, A., Miller, L. T., Macnab, J. J., & Kinsella, E. A. (2000). **Cognitive orientation to daily occupational performance (CO-OP): The therapist training manual**. School of Occupational Therapy, The University of Western Ontario, London, Ont., Canada.

Polatajko, H.J., Mandich, A.D., et al. (2001a). “Cognitive orientation to daily occupational performance (COOP): Part II The evidence” In C. Missiuna (Ed.), **Children with Developmental Coordination Disorder: Strategies for success**. Binghamton: The Hawthorn Press Inc.

Polatajko, H. J., Mandich, A., Missiuna, C., Miller, L. T., Macnab, J. J., Malloy-Miller, T., & Kinsella, E. A. (2001b). “Cognitive orientation to daily occupational performance (COOP): Part III The protocol in brief” In C. Missiuna (Ed.), **Children with Developmental Coordination Disorder: Strategies for success**. Binghamton: The Hawthorn Press Inc.

Polatajko, H.J. and Cantin N. (2006). Developmental coordination disorder (dyspraxia): An overview of the state of the art. **Seminars in Pediatric Neurology**, 12: 250-258

Portwood, M. (1996). **Developmental Dyspraxia**. Durham: Durham County Council

Portwood, M. (1999). **Developmental Dyspraxia: Identification and Intervention: A Manual for Parents and Professionals**. London: Fulton.

Portwood, M. (2000) **Understanding Developmental Dyspraxia: A Textbook for Students and Professionals**. London: Fulton.

Sigmundsson, H., Pederson, A. V., Whiting, H. T. A., & Ingvaldsen, R. P. (1998). We can cure your child's clumsiness: A review of intervention methods. **Scandinavian Journal of Rehabilitative Medicine**, 30: 101-106

Sugden, D. A. (Ed.). (2006). **Developmental Coordination Disorder as Specific Learning Difficulty. Leeds Consensus Statement**. ESRC Seminar Series, 2004–2005. Cardiff, UK: Dyscovery Trust.

Sugden, D. A. (2007). Current approaches to children with developmental coordination disorder. **Developmental Medicine and Child Neurology**, 49: 467–471.

Sugden, D. A. and Chambers, M., E. (2003). Intervention in children with Developmental Coordination Disorder: The role of parents and teachers. **British Journal Of Educational Psychology**, 73: 545-561

Sugden, D., Kirby, A. and Dunford, C. (2008). Issues surrounding children with developmental coordination disorder. **International Journal of Disability, Development and Education**, 55 (2): 173-187

Usher, R. (1996). "A critique of the neglected epistemological assumptions of educational research" In Scott,D.& Usher,R.(Eds), **Understanding Educational Research** London: Routledge pp79–95.

Wilson, P. H. (2005). Approaches to assessment and treatment of children with DCD: An evaluative review. **Journal of Child Psychology and Psychiatry**, 46: 806–823.

Wooton, R. (1991). **Developmental Dyspraxia: Some Questions and Answers**. Sth Glamorgan: Special Children's Centre

World Health Organisation. (1992). **The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines**. Geneva, Switzerland: Author.

World Health Organisation. (2001). **International Classification of Functioning, Disability and Health**. Geneva, Switzerland: Author.

Wright, H. C. and Sugden, D. A. (1996) The nature of developmental coordination disorder: inter and intra-group differences. **Adapted Physical Activity Quarterly**, 13: pp 357-371

Zoia, S., Barnett, A., Wilson, P. & Hills, E. (2006). Developmental Coordination Disorder: current issues. **Child: care, health and development**, 32 (6): 613-618.

# **A DISCUSSION OF THE IMPLEMENTATION OF A SCHOOL-BASED GROUP COGNITIVE BEHAVIOURAL THERAPY PROGRAMME FOR ANXIETY IN A SECONDARY SCHOOL.**

## **Introduction**

This paper discusses some of the issues emerging from an attempt to implement an 'off-the-shelf', school-based cognitive behavioural therapy (CBT) intervention programme with a group of secondary school pupils. There is an established and growing evidence base for the efficacy of cognitive behavioural therapy for a range of mental health disorders (Southam-Gerow and Kendall, 2000). Anxiety in young people is one area where 'off-the-shelf' CBT packages like Cool Kids (Lyneham, 2003) have been developed as a way of treating young people in clinical and school-based settings. The current paper gives an overview of some of the main issues in the literature about effective cognitive behavioural intervention for secondary school age pupils with anxiety, including: developmental considerations, particularly with reference to the adolescent age group; the advantages of a systemic approach for young people that considers both the school and the level of participation of parents in therapy; group as opposed to individual therapy; and some general methodological criticisms of the research in the area of cognitive behavioural treatments for young people with anxiety problems.

The report then describes and critiques the 'Cool Kids' programme (Lyneham et al, 2003) and the author's experience in co-facilitating the implementation of this 'off-the-shelf' programme for young people with anxiety disorders in a secondary school. A comparison is made between the guidance given by the programme and the actual

implementation of the programme in this case.

The usefulness of the two employed evaluative measures in a non-research context is discussed and the outcomes for the young people involved in the study is considered on an anecdotal, rather than empirical level, due to the small sample size (n=5) and the lack of experimental design. Further reflections refer to some of the ethical issues arising from the piece of work and the main themes discussed in the literature review. In conclusion, implications for future practice are considered.

### **Background information**

I was asked to joint-facilitate the 'Cool Kids' cognitive behavioural therapy package in a secondary school with the school's educational psychologist. I was not involved in the psychological formulation of the project as my involvement only began once the group members had already been selected. The school had identified a number of young people across a range of year groups who they believed would benefit from such a programme and who loosely fit the criteria for selection given by the school psychologist. Some criteria were not met by some of the participants (notably a good level of literacy). Despite intentions, a number of compromises were necessary throughout the running of the programme that led to inevitable diversions from the guidance in the programme manual. However, the overall outcomes of the project appeared to be positive and provided an opportunity to reflect upon the many complicating factors that exist in intervention implication in schools as well as the potential of CBT as a school-based group intervention.

## **Wider Context**

Government policy places the emotional health of children as key to its Every Child Matters agenda (DfES, 2003). This has been reflected in recent policy changes, such as the 2007 Mental Health Act, and new projects such as The Targeted Mental Health in Schools Project (DCSF, 2007). The Mental Health Foundation report that about 20% of children have a mental health problem in any given year, and about 10% at any one time (Mental Health Foundation, 2005). According to the Office for National Statistics (ONS), one in ten children between the ages of 1 and 15 has a clinically diagnosed mental health disorder (Green et al, 2005). Four percent of these are described as emotional disorders (depression or anxiety). These figures have remained similar to those of the previous ONS survey in 1999.

The prevalence and persistence of emotional disorders such as anxiety amongst young people warrants government attention, as research shows that the ability to respond adaptively to stress in school children has an important effect upon a variety of outcomes, such as: social adjustment; academic achievement; family life (Monga et al, 2009); and future emotional health (Ollendick and King, 1994). Anxiety disorders in adolescence have also been identified as a risk factor for other potentially detrimental outcomes, such as substance abuse (Kendall and Ollendick, 2004). Substance abuse may possibly act as a form of self-medication, allowing young people to reduce their own anxious symptoms (Manassis and Monga, 2001)

According to Kendall (1994), anxiety disorders are unlikely to spontaneously remit without intervention and have a high level of recurrence (Monga, 2009). For these

reasons, practical, evidence-based interventions are needed to meet the government's policy aims for children and young people's mental health.

## **Cognitive Behavioural Therapy (CBT)**

CBT has consistently received support from the research community as an effective approach to treatment (see Southam-Gerow and Kendall, 2000b, for a review) and has been endorsed by the government as an evidence-based approach (DCSF, 2008).

Beck is a highly influential theorist in the field who developed the original Cognitive Behavioural model. Beck et al. (1979) described how cognitions and information processing strategies might produce distorted views of self, the world and the future.

He identified three main areas of cognition:

- schemata or dysfunctional beliefs
- automatic thoughts
- cognitive distortions (such as: over-generalisation; discounting positive events; catastrophising)

CBT aims to identify problems within the areas of cognition and then facilitate the client in developing alternative, functional cognitions and information processing skills. In doing so, the theory stipulates that the client's feelings and behaviour should change (Beck et al, 1979).

Stallard (2002b) describes how the broad conception of CBT as concerned with the cognitive processes underlying feelings and behaviour has led to the term being



used as an 'umbrella term' for a wide range of interventions. He suggests that, in research terms, it would be more useful to look at separate applications of CBT for different disorders, particularly when addressing its usefulness in the area of child and adolescent mental health.

Graham (2005) has suggested that the interaction between thoughts, feelings and behaviour may not be as linear as Beck's original model suggests. He advocates the idea of a more dynamic system of interactions may exist that allows for the causation of a problem to lie at any point: somatic, behavioural, cognitive or emotional processes. He suggests that the different processes may be more or less important in the psychological formulation of a problem when working with children at different developmental stages (for example, younger children may need a stronger emphasis upon the behavioural elements of the system than more sophisticated cognitive elements).

## **A Developmental Perspective**

The large evidence base supporting the effectiveness of CBT for children and young people has also led to consideration of the need for a developmental perspective. This should lead to greater effectiveness and increase the age-range for which its core principles can be adapted in order to be developmentally accessible (Stallard, 2002b; Graham, 2005). This is particularly important in light of the new Mental Health Act (2007), which stipulates that primary care trusts now have a responsibility to provide 'age appropriate' services for young people, including the assessment process.

In the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV), the diagnostic criteria for anxiety disorders in children and adolescents are not separated from the adult criteria (American Psychiatric Association, APA, 1994). There are no developmental considerations for panic disorder and only cursory information for other anxiety disorders, such as the guidance that fear or anxiety should not exceed “normal development”. As the nature of anxiety disorders for children and adolescents appears to be an under-researched area (Kendall and Ollendick, 2004), ‘normal development’ is a subjective judgement.

Adopting a developmental perspective implies the aim of changing the trajectory of a young person's developmental course and applying interventions that are moderated by the developmental level of the young person (O'Connor and Creswell, 2005). In the first case, it is a shift from viewing intervention as a way of alleviating symptomatic expression of a within-child disorder to helping the child develop the skills that will help them to meet the particular challenges of the phase of development that they are in. In the second case, considerations need to be made about the level of cognitive strategies that the child may be able to access and utilise, and even the level of cognitive sophistication that presentations of anxiety may require. O'Connor and Creswell use the example of separation anxiety and generalised anxiety, which are both linked to different developmental onsets (separation anxiety being more expected in younger children, perhaps later becoming more generalised). In addition to different presentations of anxiety at different stages, it is likely to mean that more anxiety or more intensity of difficulties might be expected at certain phases of biological, emotional, social and cognitive development (Stallard, 2002b)

This idea is supported by evidence that suggests that 'non-productive coping strategies increase with age' (Graham, 2005, pge 19), and statistics published by the ONS that show an increase in rates of mental health problems among children increase as they reach adolescence. According to the ONS, disorders affect 10.4% of boys aged 5-10, rising to 12.8% of boys aged 11-15, and 5.9% of girls aged 5-10, rising to 9.65% of girls aged 11-15 (Meltzer et al, 2003).

A number of researchers have looked at the effect of age upon children's responses to CBT, and different forms of CBT (that may, for example, give a stronger weighting towards the cognitive or behavioural element in an intervention). There is a mixed, contradictory set of results (Hudson et al 2002) that may be explained by the construction of age as a sufficiently sensitive variable. Chronological age may be too crude a measure to assess 'the complex social, cognitive, emotional and physical changes that occur across normal development throughout childhood and adolescence.' (Kendall and Ollendick, 2004, p. 66). Kendall and Ollendick (2004) describe the knowledge base for the adolescent age group as insufficient for the concept of 'normal' development criteria to be defined. They describe paucity in our current understanding of the social, cognitive and emotion-regulation factors that affect this complex and unique stage of development. A truly useful normative, developmental model needs to be sensitive to the wide variations in patterns and rates of development for individuals across age groups.

The need for a better understanding of adolescent development may be particularly pertinent, as a number of authors have theorised that adolescence may be an

optimal stage for young people to benefit from intervention. It is described as a critical (Steinberg, 2002), transitional period (Kendall and Ollendick, 2004, Cichetti and Toth, 1996); during which children may be more receptive to change. Southam-Gerow et al. (2001) disagree, arguing that pre-adolescence may be an easier period during which to change cognitive behaviour as faulty processes and thinking will be less firmly entrenched than with older children. It seems probable that different young people will experience differing levels of susceptibility to the effects of treatment depending upon the convergence of a whole range of factors that could not be described by chronological development alone.

### **A Systemic Perspective**

While adult services have been described as sometimes acting as though people receiving treatment exist in a 'social vacuum' (Graham, 2005, p. 3), in treating children, it is more likely that there will be resistance to change unless influences in the wider environment are addressed. A systemic perspective would suggest that the peer group, school, family and community environments all need to be considered, however, most of the research in the area seems to emphasise the role of parents at the expense of other aspects of a young person's social context. While the potential importance of parent-child interactions in the maintenance of anxiety is deserving of study (Kendall and Ollendick, 2004), it is notable that, particularly in clinic-based intervention studies, a wider systemic assessment appears to be missing.

#### *Schools as part of the systemic evaluation and intervention delivery*

As part of 'The Targeted Mental Health in Schools Project' (DCSF, 2008), each participating local authority and corresponding primary care trust must support

children and young people who are at risk of developing or who already have a mental health problem in their schools. Given the amount of time that young people spend there, schools are potential settings for the delivery of programmes that promote good coping strategies. They are in a good position to sustain therapeutic interventions and potentially reduce the need for expensive clinic-based therapies (Misfud and Rapee, 2005). Perhaps the greatest value of a school-based setting might be the psycho-education of staff members, helping to effect change on a systemic level.

However, using school as the setting for the delivery of therapy may produce social and emotional barriers for some young people. It is possible that the context may carry certain connotations for young people that lead to sense that the adult therapist is an authoritative figure, somehow connected to the school (Schmidt, 2005). It is natural for adolescents to undergo a period of separating their identity from adults, which may result in their feeling rebellious against such figures (i.e. the therapist) (Schmidt, 2005). It is also likely that young people are put forward for participation in therapy by an adult, rather than self-referring. In this way, school-based programmes may promote a sense of attendance being just another thing that they are expected to do within the school day, which may have implications for levels of commitment and engagement.

Nonetheless, emerging evidence suggests that school-based interventions can be successful (for example, Misfud and Rapee, 2005 and Bernstein et al, 2008). This research is discussed in more detail in the 'Cool Kids' section of the report below.

### *Parental involvement*

Part of a systemic approach to treatment would involve working with parents and possibly other family members. Graham (2005) emphasises the need to work on the cognitions of parents when implementing an anxiety treatment programme in order to halt the cycle of the transmission of fears between child and parent (Allen and Rapee, 2005). Stallard (2002b) suggests three ways that parents can be included in the process; as facilitator, co-therapist or client. Woolpert et al (2005) define the role thus:

- Facilitator – parents aid the skills transfer from the programme to home setting
- Co-therapist – parents take a more active role in sessions and are encouraged to help young people in transferring skills to home environment.
- Client – parent receives intervention directly (e.g. parenting skills or skills for coping with their own anxiety)

Woolpert et al (2005) discuss the advantages and disadvantages of each approach, which make each of them more or less appropriate for individual cases. They make an experience-based assertion that having parents play a facilitative (rather than a more involved) role is particularly suitable for cases where the children are older, highly motivated and with a supportive family. The government also recommends a reduced level of parental involvement when delivering CBT to older children (DCSF, 2008).

General support for the positive effects of parental participation in CBT is given by a number of studies that have found that a family component in addition to child-directed CBT is more effective than child-directed CBT alone (O'Connor and

Creswell, 2004). However, Barrett (1998) found that while this was the case for younger children (7-10 years), it was not the case for children in early adolescence (11-14). Kedall and Ollendick (2004) point out that different forms of parent training may be more or less relevant to different developmental ages of children. In Barrett's 1998 study, one of the training components involved parenting strategies based upon rewarding courageous behaviour. It may be that younger children are more likely to respond to this type of reinforcement strategy and that a parenting training programme more specifically targeted at the adolescent age range may have produced more positive effects.

Another issue with studies of parent participation is that parents may be more likely to report positive outcomes (subject to rater bias) if they have been involved in the research (Bernstein et al, 2008). Their understanding of the language and concepts used in pre- and post-evaluation measures, may also have been changed by the experience of participation in treatment courses, leading to different responses in the post-evaluation that did not necessarily reflect actual changes in behaviour or feelings.

### **Group versus individual therapy**

Another consideration in the development of CBT therapies is whether it is more effective to deliver on a group or individual level. There are clear resource implications that make this an important factor in the design of interventions within public service budgets.

Some studies comparing the effects of individualised and group interventions have

shown no difference between the two types (for example, Flannery-Shroeder and Kendall, 2000). Others have delivered a more complex picture. Manassis et al (2002) found that individual family treatment showed less improvement on clinician ratings of general improvement than those receiving group family treatment. Children with high levels of social anxiety contradicted this pattern, suggesting to the researchers that the group situation may have been overwhelming for them. This finding highlights the large number of variables involved in these broad studies of a complex group of disorders under the umbrella term of anxiety disorders and makes their generalisability questionable, particularly when considered alongside the potential effects of developmental differences.

Given the inconclusive nature of studies into the effects of individual versus group treatments, and in light of the clear cost effectiveness implications of delivering services on a group basis (Allen and Rapee, 2005), further research in this area is needed. In particular, research should aim to identify the affect of different variables upon outcomes for young people, such as the affects of alternative group treatments across the range of developmental levels (Monga et al, 2009).

#### The Evidence Base – Randomised Control Trials

The evidence base for Cognitive Behavioural Therapy has come from studies that have used randomised control trial formats. This is the case for all of the studies that have been discussed above. There are a number of points that need to be considered when interpreting such evidence.

1. Many of the studies discussed did not use a control group for follow up trials (for



example, Barrett et al, 1996, Flannery-Shroeder and Kendall, 2000, and Kendall, 1994). Clearly, in light of the previous discussion about the complexities of assessing an adolescent demographic that is in a continual rapid state of development, a control group would be highly important for tempering the very positive results generally reported (see Graham, 2005).

2. The research has tended to be clinic-based, with the exceptions of Bernstein et al (2008), Misfud and Rapee (2005) and Dadds et al (1997). Using clinic-based samples reduces the generalisability of findings to a wider population. In addition, the clinic-based sample does not allow for data to be collected from a population where early identification and intervention may be possible at a point before symptoms have become severe enough to be clinically significant (Bernstein et al, 2008).

Dadds et al (1997), Misfud and Rapee (2005) and Bernstein et al (2008) addressed the problem of follow-up controls and clinic-based populations by conducting school-based, intervention studies, where treatment for the waiting list controls was deferred until after the follow up trials. For Bernstein et al's study, this allowed for two follow-up trials under his three conditions of group treatment: with and without parental involvement and no treatment. Bernstein and his colleagues circumnavigated the obvious ethical dilemma in withholding treatment by encouraging the control group to seek other treatment for their children. None of them actually did, allowing the researchers to confirm the positive maintenance effects found by Dadds et al (1997).

3. All the studies referred to in the sections above measure outcomes predominantly by using rating scales and clinical interviews. The validity of such measures is

compromised by their reliance upon self-report, parent report and/or teacher report (such as the Spence Child Anxiety Scale, which is discussed in detail below). In addition, the rating scales do not actually directly assess whether cognitive changes have taken place, only whether behaviour or response to the items has changed.

4. The validity of randomised control trials is also compromised when used to evaluate interventions, as it is not possible to ensure that the features of daily practice are replicated across trials.

Overall, while there is a body of supporting research that endorses CBT as an effective treatment for anxiety, future research needs to establish an evidence base that addresses some of the methodological weaknesses described here and looks at models of treatment delivery as they relate to specific developmental stages and systemic factors such as training for parents and schools, location and individual versus group formats.

### **The Cool Kids Programme**

For this piece of work I was directed to co-facilitate the implementation of The Cool Kids Programme Schools Version that was developed at Macquarie University Child and Adolescent Anxiety Clinic, Sydney (Lyneham et al, 2003). It is based upon Kendall's Coping Cat programme and the Coping Koala programme (Barrett et al, 1996a) and takes a cognitive behavioural approach.

The main facets of the approach are:

- It is intended for use in school settings with individuals or groups

- It consists of eight to ten sessions of one hour that can be completed in a term
- There are two group parent information sessions (two hours long) and one to two individual parent consultations
- Homework tasks are assigned each week
- Therapists select from a range of activities designed to develop a skill
- Each child has an in-school coach to help them to practice their skills.

It uses the following strategies:

- psycho-education
- cognitive restructuring
- graded exposure
- parent management

Other optional modules are also available that look at:

- social skills
- teasing
- assertiveness

### **Empirical Support**

Some support for the effectiveness of the approach comes from Kendall's treatment studies of the original 'Coping Cat' programme (Kendall, 1994; Kendall et al, 1997): an individual treatment. 64% of participants no longer met the diagnostic criteria following the 16 session intervention, compared to 5% of waiting list controls. Improvements were still maintained a year later in a follow-up trial. Flannery-Schroeder and Kendall (2000) have provided further supporting evidence for the

approach when implemented on a group basis, with a greater improvement on child and parent reports of anxiety when compared to waiting list controls and 50% of children no longer meeting their pre-treatment diagnostic criteria after the group intervention.

Rapee (2000) has investigated the effectiveness of the 'Cool Kids' programme directly, although not the school-based version. Children aged 7-16 (n=95) with a variety of anxiety disorders undertook a nine-session intervention, with significantly better improvements compared to waiting list controls.

The first school-based version of the programme appeared in 2001 (Lyneham et al, 2003). A major difference was the reduction in parental involvement. Previously, parents had been expected to attend weekly sessions. In the new version, parents are only required to attend two educational sessions and to follow and support their child's progress through the Parent's workbook. Even with this reduced requirement, Misfud and Rapee found that parental involvement was low in their controlled, randomised trials in socially disadvantaged secondary schools (Misfud and Rapee, 2005). The low attendance level may reflect parents' reduced perception of the importance of an intervention when conducted in a school context. As the study focused upon schools from socially disadvantaged areas (as opposed to previous studies that tended to focus on more advantaged areas), other possible explanations may be that the programme assumes a level of literacy in parents as they must be able to read the quite wordy parents' workbooks and manual. This may be more problematic when parents are expected to work independently rather than attend weekly, supported group sessions (as in the clinic-based programme). In my own

piece of work, the literacy requirement was considered unreasonable and potentially exclusionary for some of the parents of young people at the school because of their known literacy difficulties.

Despite the low level of parental involvement, Misfud and Rapee (2005) found significant improvement in 9-10 year-olds (n=50) from a socially disadvantaged background, that were sustained in a four-month follow-up, lending support to the programme even in this watered-down form.

#### Some Criticisms

A benefit of having standardised programmes such as Cool Kids is that they are cost-effectively, widely implementable. According to Hansen et al. (1998), such programmes are also useful for research purposes, in that they allow for broader evaluations of variables other than the programme content because procedures can be replicated. A criticism of prescribed programmes is that it compromises the therapist's freedom to tailor treatments to meet the individual needs of children, which is regarded as good clinical practice (Donavan and Spence, 2005).

In its defence, Cool Kids includes some opportunities for tailoring the programmes to meet the needs of individuals within the group and the group as a whole. The programme includes a choice of activities within each session outline, activities that encourage young people to look at their own personal issues, a mechanism for ongoing reflection of the facilitators regarding the needs of the group and optional modules that, again, allow the therapist to tailor the programme to the specific needs of the group.

The programme also distinguishes between children and adolescents, providing different material for each, and a reduced level of parental participation for the adolescent group, in response to some of the findings in the literature. However, this is quite a broad, two stage split across a wide age range, that may need to be more sensitive to the rapid developmental changes in childhood.

Perhaps most notably, there is a lack of analysis of young people's social context, other than the limited involvement of parents, in assessment and in intervention. As such, Cool Kids cannot really be described as a systemic approach, as recommended by Stallard (2002a), as it still mainly focuses upon within-child problems rather than the wider environment. Links to the wider environment of the young person are made through the use of coaches and practice tasks. The parents and school staff are expected to play a facilitators role, described by Woolpert (2005) as aiding the transfer of skill to another setting. It may be that this process provides some level of psycho-education for parents and educators, although this assumes parental involvement is not diminished by the issues discussed above.

## **The implementation of the Cool Kids School Version in a Secondary Setting**

The intervention we ran could not be used as the basis for an evaluation of the Cool Kids programme for a number of reasons:

- There was only one trial
- The sample size was too small to draw generalisable conclusions for any wider population

- There were too many deviations from the original Cool Kids programme, including:
  - Selection of participants, in terms of assessment for anxiety and age range
  - The timing of the programme over 8 weeks
  - Lack of parental involvement
  - The lack of availability of the school coach
  - Reduced homework demands (due to low levels of literacy in the group)

An attempt was made to evaluate the intervention as it occurred in this real world context, both according to the guidance given in the programme (comparing pre- and post- intervention scores on the Spence Child Anxiety Scale (SCAS)) and using Goal Attainment Setting techniques. These tools are discussed below. Because of the small sample size, data obtained through these measures have not been analysed statistically. In fact, using these tools with a small group illuminated some of the limitations of checklist measures in individual cases, both for assessment and evaluation purposes, as it was clear how unreflective of individual experiences it could be.

The following is a discussion of the procedure and issues surrounding implementation that arose, with only limited reference to the actual effects of the intervention.

### **The Group: selection of participants**

O'Connor and Creswell (2005) state that little is known about what cognitive

predictors there might be to allow the most effective selection of participants in CBT therapy, nor which contextual factors are most likely to improve or reduce therapeutic outcomes. In this way, they suggest that recommendations can only be based upon theory, not evidence. They make the following recommendations for selection criteria:

- basic language and intellectual ability
- the child's emotional understanding and reflective capacity: their ability to link thoughts, feelings and behaviour (although it is noted that there are no established measures of this to date)
- Assessment of the parent's symptomology and the parent child relationship (see O'Connor, 2002 for a discussion of which elements of this relationship are worth assessing)

The Cool Kids Therapist Manual stipulates that students who have 'met the criteria for a principle diagnosis of any anxiety disorder' should be selected (Lyneham et al, 2003, pge. 3). A caveat is added for young people who do not meet the criteria but may still benefit from the programme; however a shortened programme is suggested for such cases. No reference is made to cognitive or emotional development or any more systemic assessments. According to my initial assessment for evaluation, the young people in our group were a mixture of the two possible types of candidate described by Lyneham et al (2003).

Lyneham et al (2003) suggest that a practical alternative to resource intensive clinical interviews for identifying suitable anxious students for the school version of the Cool Kids Programme, is the screening of a whole school group using a standard measure of anxiety such as the SCAS, alongside teacher nomination of student's they identify



as anxious.

In the current case, the school's Special Educational Needs Co-ordinator (SENCO) selected appropriate pupils, based upon her own judgement. While it could be argued that teachers are in a good position to identify young people who might benefit from intervention, Kendall and Ollendick (2004) recommend that we examine how such judgements are made. Without a clear idea about which behaviours lie within the normal range of development and which are a normal response to environmental factors, perceptions of abnormality are based upon the subjective assumptions made by the adult referrer. Mifsud and Rapee (2005) criticise their own study on the basis that they used teacher nomination for 26 of the children included in their overall trials (n=91), as they felt that this meant that some of the children included were not appropriately selected. In particular they mentioned some children whose anxieties were based upon 'genuinely dangerous situations that required more social interventions' (p. 1002).

As in Mifsud and Rapee's study (2005), it is likely that the use of teacher nomination for participant selection resulted in some inappropriate participants taking part. Only three of the participants were within the specified age range for the programme (6-12 years), with two participants fitting the age criteria for the upper age range programme. The pre-treatment SCAS assessment identified one participant to be within the normal range of scores for all measures of anxiety on the scale, although this pupil was still able to identify personally meaningful, stress related targets using the Goal Attainment Setting system (this process is described in detail below). It may be that the spectrum of levels of difficulties may have reduced the effectiveness of

the group, and that two separate approaches would have been more appropriate.

Like Misfud and Rapee (2005), some of the participants seemed to be experiencing anxiety associated with real, threatening situations, particularly regarding issues around bullying and the handling of medical problems in school. In these cases, it was necessary to report to the school for further, systemic action. The young people remained in the group, though this may not have been wholly concurring with Lyneham et al's criteria (2003).

A final point is that, while Lyneham et al (2003) do stipulate that anxiety should be the priority diagnosis in participants, there is no screening for other difficulties in the assessment process.

### **Implementing the programme**

As already stated, a number of issues meant that the Cool Kids Programme was not followed according to the guidelines provided in the therapist's manual (Lyneham et al, 2003), but had to be adapted to fit flexibly around the presenting real world practicalities. Within the programme, I found that there was a helpful amount of flexibility so that the group's needs could be met. I will now describe the ways in which the programme delivery was altered.

#### **1. The timing of the programme over 8 weeks**

The group met once a week for five weeks. After this time, sessions were cancelled on two occasions prior to the summer break because of school trips and events. A further two follow-up sessions were conducted after the summer break (over two

months later), which included revision and evaluation of the programme.

## 2. Lack of parental involvement

We offered the suggested parental education sessions as recommended by Lyneham et al (2003), but only two parents attended the first session. This has implications for how the group were supported at home in the generalisation of skills across contexts. Low parental involvement had been predicted by the school and the Educational Psychologist, based upon their previous experience of running such groups.

## 3. The lack of availability of the school coach

Despite the original commitment of the school to the involvement of a teaching assistant as a co-facilitator and subsequent 'coach', this commitment became a lesser priority than other demands on the teaching assistant's time in response to changing circumstances within the school. This meant that the group did not receive support in their practice tasks at home or at school.

## 4. Reduced literacy demands

In addition to low levels of adult support outside of the group, other independent homework demands were reduced because of the low levels of literacy in the group. During the group sessions, activities were adapted to reduce the amount of literacy required, particularly in terms of filling in worksheets and/or writing and support was offered. As the sessions progressed, the young people's initial embarrassment when asked to write seemed to reduce as they started to worry less about their spellings and to ask for help more frequently and openly. Some of the young people preferred to use symbols or drawings to record their work.

## **Outcomes**

As has been stated, this report does not claim to be an evaluation of the Cool Kids programme, but rather a discussion of an attempt to implement an 'off the shelf' CBT group therapy programme in a school context. The evaluation performed would not meet the requirements for an empirical piece of evidence because of the small sample size, lack of controls and difficulties in controlling for extraneous variables in this context, making any inferences about causality highly speculative. As such, the outcomes for young people as measured by the SCAS and GAS will be discussed in discursive, rather than empirical terms.

I will begin by giving a critique of the evaluation tools I decided to use.

## **The Evaluation Tools**

### **The Spence Child Anxiety Scale (Spence, 1997, 1998)**

The SCAS is a questionnaire measure of anxiety, available in parent and child versions. It consists of 45 items that assess for: generalised anxiety (GAD); panic/agoraphobia; obsessions/compulsions; social anxiety; separation anxiety; fear of physical injury; and social desirability. The combined SCAS score has been shown to have good internal consistency (with the exception of the physical injury fears subscale; Whiteside and Brown, 2008) and test-retest reliability (Morris et al, 2004). Spence (1997) found that the SCAS had good concurrent validity with the Revised Children's Manifest Anxiety Scale (RCMAS: Reynolds and Richmond, 1978). Good concurrent validity between child and parent reports and the ability to discriminate between clinically anxious and non-clinical children has also been demonstrated

(Whiteside and Brown, 2008).

The use of self-report questionnaires is cost- and time-effective. However, they assume a certain level of literacy, that cannot always (as in this case) be assumed in either children or parents. This was particularly important in the current intervention as some of the anxiety experienced by the young people in the group was in fact linked to their inability to meet the literacy demands placed upon them in the classroom.

Self-report questionnaires provide normative data that can be particularly useful in evaluating outcomes. The SCAS is standardised against gender and two age-groups, allowing for variations between these population groups, however, evidence suggests that culture also needs to be taken onto account in the interpretation of self-report scales, with culture-specific norms (Whiteside and Brown, 2008). It also seems unlikely that given the broad age range targeted by the questionnaire, that the items are developmentally sensitive enough to capture the differing experiences of anxiety and levels of emotional and cognitive development needed for a truly sensitive assessment, for example, what could be seen as a normal fear of dogs when young can become something clinically significant in later life (O'Connor and Creswell, 2005). As already discussed, young people are in a continual state of change (Kendall and Ollendick, 2004) and it might be expected for them to acquire skills at different rates as part of 'normal' development. This makes it difficult to apply normative measures when there is a large amount of individual variation in levels and rates of skill acquisition. The SCAS makes some attempt to account for levels of variation by providing separate standardisations based on gender and age, but these

are still quite broad.

Nonetheless, for the purposes of evaluating an intervention that is interested in pre- and post-evaluation scores rather than a comparison to a wider population, the SCAS should be sufficient and is recommended in the programme's therapist's handbook.

### **Goal Attainment Scaling (Kiresuk and Sherman, 1968)**

GAS was initially developed as a tool for evaluating the outcomes of mental health programmes, but has been used across a range of fields (Dunsmuir, 2009). The following criteria apply:

- Five levels of outcome for each goal
- Advanced specification of those goals
- At least three goals defined
- Independent review/assessment of levels gained

(Smith and Cardillo, 1994)

However, these strict criteria are seldom adhered to, with most users adapting the GAS to be fit for purpose (Dunsmuir et al, 2009). Dunsmuir and colleagues give an account of an adaptation of the GAS in their 2009 study.

Measures of the reliability of GAS have tended to look at inter-rater reliability, using the change score. This has resulted in high measures of reliability (Austin et al, 1976), found a mean inter-rater reliability estimate of 0.93, for example). The validity of the GAS is strong in that the client defines their own measures for progress, but

compromised in that this may not directly represent the standard concepts of anxiety. In this way, effects may not be generalisable. Because the intervals in the measure scores are also defined by the therapist and the client, it is vulnerable to being ill-defined or unevenly distributed. However, these limitations within a positivist paradigm may be superseded by the usefulness of the tool from other qualitative, participatory aspects.

I decided to use this evaluation tool alongside the SCAS for a number of reasons. It would allow me to assess individual priorities and possibly to identify personal anxiety issues that the SCAS was not sensitive to. It would hopefully also help to motivate the participants as they set their own personal goals for the duration of the course and give them a meaningful way of evaluating their own progress that is not based upon a standardised or age defined external conceptualisation of their anxiety. An example of the adapted scale is included in the appendix.

### **Measured Outcomes for the intervention**

Overall, positive effects were reported by participants and the school. During the evaluation session, the group demonstrated that they had retained some of the CBT strategies for coping with anxiety that were drilled during the course and all reported having perceived benefits, some more dramatic than others. The positive effects were reflected in most of the participants' SCAS scores, however, these scores were gathered by me, also acting as the therapist, potentially incurring some researcher effects upon people's reported outcome scores. It is possible that there were effects upon young people's immediate perceptions of the SCAS items following a group experience where a positive relationship with the therapist was nurtured. This may

also have led to social desirability effects, as the participants returned the score sheets directly to me, or actually completed them with me where literacy difficulties required support.

GAS measures showed a more mixed response. One problem was the specific nature of the targets. For some participants, the targets were no longer relevant because of changes in circumstances over the four months in between pre- and post-evaluations (such as changes in classes). For some, anxiety seemed to have transferred to another area, which the GAS was not sensitive to (as shown on the SCAS). However, for two of the participants, the GAS scale offered a powerful measure of their progress on very personal targets.

A dual approach to assessment would seem to be the most effective. The main drawback of using the GAS seems to be that the targets set may lose relevance to an adolescent's life in light of their rapid development changes and the dynamic environmental factors such as school year transition. While the SCAS may be general enough to encompass this, it does not necessarily identify the individual presentations and therapeutic priorities of young people.

## **Discussion**

This discussion will look at the implementation of the programme with reference to some of the specific ethical considerations that occurred, and to the main themes emerging from the literature review.

### *Ethical considerations*



During the implementation of the programme, a number of ethical considerations, specific to the school-based, group treatment scenario were apparent.

The setting of the treatment on school premises raised its own particular problems. It would be interesting to evaluate to what extent participants viewed session attendance as voluntary, expected (i.e. with an element of coercion) or obligatory, despite initial information given by the therapist about the voluntary nature of the programme. Pupils may have felt some level of pressure as the sessions took place in lesson time, within an authoritarian institution (the school) in which they are generally expected to conform to the instructions of adults. In addition, young people were selected by adults who are based within that institution and who have authority over them in their every day school life. It may be that the young people's investments in their relationships with these adults meant that they felt pressure to please them by attending: a pressure that might not be as apparent in a clinical situation.

During the programme, some of the school staff may have reinforced the perception of obligatory attendance through a variety of possibly institutionalised, almost automatic behaviours. Examples of this that I observed included the authoritative, displeased tone of voice used to question young people who might have forgotten to attend (or not wanted to) and had subsequently had to be 'sent for' and other, more subtle uses of body language that may have communicated disapproval. An investigation into the perceptions of adults over the course of the intervention would also be useful. The selection of participants through teacher nomination may have emphasised the power relationship that normally exists in the school context and

brought it to the sessions to some extent.

If there is a level of coercion, this raises an important ethical issue in terms of the young people's perception of their freedom to withdraw from the therapy at any point. It is especially pertinent when the young people are then invited to discuss potentially difficult and sensitive issues either in front of other group members who are not truly committed to the group, or if they feel a pressure to contribute when they are not comfortable with the group themselves. If this dynamic goes wrong, and trust is not sufficiently established, the potential consequences for individuals disclosing personal information in a school-based group are worsened by the fact that pupils are in the setting where they attend on a daily basis in their normal lives. The consequences for young people in the group regarding breaches of confidentiality are accentuated.

In the current intervention, time was allowed after sessions if young people wanted to discuss particularly sensitive issues that may have been brought up during the group work. However, I could not assure that all needs were met.

Levels of coercion may also have implications for the effectiveness of a group in terms of levels of real commitment and ownership of the problem. Very careful selection of participants is needed in order to obtain good group dynamics.

#### *Developmental perspective*

The fact that the group constituted a mix of pupil's from four different year groups meant that the developmental sensitivity of the programme was compromised. The

materials may have been aimed at too low an age group for one or two of the participants, perhaps causing a reduced engagement. The lack of understanding of adolescence in the literature, as described by Kendall and Ollendick (2004), limits our ability to theoretically evaluate this. During the sessions, the young people did respond to the flexibility of the activities, as they mostly drew upon the participants' own experiences for content. To some extent, this meant that the materials became sensitive to the developmental stage of the young people. It may also be that this and other aspects of the intervention that increased individual tailoring of the programme (such as the use of GAS target setting) increased its effectiveness as suggested by Donovan and Spence (2005).

The mix of ages meant that the young people from Years 9 and 10 may have felt awkward about being in a group with younger children, while potentially some of the younger children may have felt intimidated (although this did not appear to be the case).

### *Systemic perspective*

I do not think that the implementation of this programme made any substantial efforts to intervene on a systemic level, either in assessment or treatment. The already limited ecological perspective of the Cool Kids Programme was further reduced by the lack of parental involvement and a school coach. The result was that the main focus of the programme was very much within-child, as if they existed within Graham's 'social vacuum' (2005).

The time investment of the school was limited, with teaching assistant support being

withdrawn. Some discussions did take place within the confines of confidentiality and the potential for some environmental changes for one or two of the participants was acknowledged.

## **Conclusions**

Overall, the implementation of the Cool Kids Programme in a secondary school produced positive effects in relation to levels of anxiety for most of the young people involved. This is despite a number of real world intrusions upon the way the programme was delivered. It is clear that there are a number of important advantages to delivering an intervention in school, although not all of them were realised in the current case.

However, a number of ethical considerations need to be addressed to assure the longer term well-being of young people in such groups, including their right to withdraw; confidentiality of the group. This may be particularly pertinent in school settings, where power differentials between adults and pupils and the daily proximity of the other group members may add an extra level of complexity to these issues for young people. There need to be very clear guidelines about the voluntary nature of participation and the confidentiality of information. Further investigation into young people's perceptions of the level of true voluntary, coerced or obligatory participation would help to guide adults wishing to bring therapeutic work into the school setting without an automatic adoption of the institutional power relationships.

Future intervention design also needs to consider how parents are supported in becoming involved in school-based interventions, particularly in schools where

general parental participation in school life may be low. This might involve a more personal, non-literacy based approach that is sensitive to the potential for learning needs and/or the negative emotional connections that adults may have with schools, particularly anxious parents. These same principals can be applied to the participants, and forethought about how to adapt programmes with a high literacy content for young people with anxieties connected to this skill area should be given.

Other practical considerations, such as the time of year that the programme is run (to avoid times when schools become less stable in their timetabling because of other end of year or Christmas activities), the commitment of school staff and the careful selection of participants under the guidance of the therapist and using triangulated data rather than teacher nomination alone, should inform programme facilitation.

**References**

Allen, J. L and Rapee, R. M. (2005). "Anxiety disorders" In P. J. Graham (Ed.) **Cognitive Behaviour Therapy for Children and Families**. Cambridge: Cambridge University Press

APA (American Psychiatric Association) (1994). **Diagnostic and Statistical Manual of Mental Disorders**, 4th ed. American Psychiatric Association, Washington, DC, USA.

Austin, N. K., Liberman, R. P., King, L. W. & Derisi, W., J. (1976). A comparative evaluation of two day hospitals: goal attainment scaling of behavior therapy vs. milieu therapy. **The Journal of Nervous and Mental Disease**, 163 (4): 253-262

Barrett, P. M. (1998). Evaluation of cognitive-behavioural group treatments for childhood anxiety disorders. **Journal of Clinical Child Psychology**, 27: 459-468

Barrett, P. M., Dadds, M. R. and Rapee, R. M. (1996). Family treatment of childhood anxiety: a controlled trial. **Journal of Consulting and Clinical Psychiatry**, 64: 333-342

Beck, A. T., Rush, A. J., Shaw, B. F. and Emery, G. (1979). **Cognitive Therapy of Depression**. New York, NY: Wiley

Bernstein, G., A, Bernat, D., H., Victor, A. M. and Layne, A. E. (2008). School-based interventions for anxious children: 3-, 6-, and 12-month follow-ups. **Journal of American Academy of Child and Adolescent Psychiatry**, 47 (9): 1039-1047.

Cicchetti, D. and Toth, S. (Editors.). (1996). **Adolescence: Opportunities and challenges**. Rochester, NY: University of Rochester Press.

Dadds, M. R., Spence, S., H. & Holland, D., E. (1997) Prevention and early intervention for anxiety disorders: a controlled trial. **Journal of Consultation Clinical Psychology**. 65: 627-635.

DCSF (Department for Children, Schools and Families) (2008). **The Targeted Mental Health in Schools Project**. London: DCSF Publications

DfES (Department for Education and Skills) (2003) **Every Child Matters**. London: DfES Publications

Dobson, K. S (1988). **Handbook of Cognitive-Behavioural Therapies**. New York, NY: Guilford Press

Donovan, C. L. and Spence, S. H. (2005). "Children's interpersonal problems" In P. J. Graham (Ed.) **Cognitive Behaviour Therapy for Children and Families**. Cambridge: Cambridge University Press

Dunsmuir, S., Brown, E., Iyadurai, S. & Monsen, J. (2009). Evidence-based practice and evaluation: from insight to impact. **Educational Psychology in Practice**. 25 (1): 53-70

Flannery-Shroeder, E. G. and Kendall, P. C. (2000). Group and individual cognitive-behavioural treatments for youth with anxiety disorders. **Cognitive Therapy and**

**Research**, 24: 251-278

Graham, P. (2005). **Cognitive Behaviour Therapy for Children and Families**.

Cambridge: Cambridge University Press

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). **Mental health of children and young people in Great Britain, 2004**. London: Office of National Statistics.

Hansen, D. J., Nangle, D. W. and Meyer, K. A. (1998). Enhancing the effectiveness of social skills interventions with adolescents. **Education and Treatment of Children**, 21, 489-513

Hudson, J. L., Kendall, P. C., Coles, M. E., Robin, J., A. and Webb, A. (2002). The other side of the coin: using intervention research in child anxiety disorders to inform developmental psychopathology. **Development and Psychopathology**, 43, 819-841

Kendall, P. C. (1994). Treating anxiety disorders in children: results of a randomized clinical trial. **Journal of Child Psychology and Psychiatry**, 65, 724-730

Kendall, P. C. and Ollendick, T. H. (2004). Setting the research and practice agenda for anxiety on children and adolescence: a topic comes of age. **Cognitive and Behavioural Practice**, 11, 65-74.

Kendall, P. C., Flannery-Schroeder, E. C., Panichelli-Mindel, S. M., Southam-Gerow, M., Henin, A. and Warman, M. J. (1997). Therapy for youths with anxiety disorders: a second



randomized clinical trial. **Journal of Consulting and Clinical Psychology**, 65, 366-380

Kiresuk T. J. & Sherman R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. **Community Mental Health Journal**. 4 (6): 443-453.

Manassis, K. and Monga, S. (2001). A therapeutic approach to children and adolescents with anxiety disorders and associated comorbid conditions. **Journal of the American Academy of Child and Adolescent Psychiatry**, 40, 115-117

Manassis, K., Mendlowitz, S. L., Scapillato, D. *et al.* (2002). Group and individual cognitive-behavioural therapy for childhood anxiety disorders: a randomized trial. **American Academy of Child and Adolescent Psychiatry**, 41, 1423-1430

Meltzer, H., Gatward, R., Goodman & R., Ford, T. (2003). Mental health of children and adolescents in Great Britain. **International Review of Psychiatry**, 15 (1): 185-187.

Mental Health Foundation (2005). **Lifetime Impacts: Childhood and Adolescent Mental Health.**

Misfud, C and Rapee, R., M. (2005). Early intervention for childhood anxiety in a school setting: outcomes for an economically disadvantaged population. **Journal of Child Psychology and Psychiatry**, 44 (10): 996-1004

Monga, S., Young, A and Owens, M. (2009). Evaluating a cognitive behavioural therapy group programme for anxious five to seven year old children: a pilot study. **Depression and Anxiety**, 26, 243-250.

Morris, T. L., Hirshfeld-Becker, D. R. Henin, A.,& Storch, E. A. (2004). Developmentally sensitive assessment of social anxiety. **Cognitive and Behavioral Practice**, 11 (1): 13-28+127.

O'Connor, T. (2002). Annotation: the "effects" of parenting reconsidered. Findings, challenges and applications. **Journal of Child Psychology and Psychiatry**, 43, 555-572

O'Connor, T. and Creswell, C. (2005). "Cognitive behavioural therapy in developmental perspective". In P. J. Graham (Ed.) **Cognitive Behaviour Therapy for Children and Families**. Cambridge: Cambridge University Press

Ollendick, T. H., & King, N.J. (1994). Assessment and treatment of internalizing problems: The role of longitudinal data. **Journal of Consulting and Clinical Psychology**, 62, 918-927.

Rapee, R. M. (2000). Group treatment of children with anxiety disorders: outcome and predictors of treatment response. **Australian Journal of Psychology**, 52, 125-130

Reynolds, C. R. & Richmond, B. O. (1978). What I Think and Feel: A Revised Measure of Children's Manifest Anxiety. **Journal of Abnormal Child Psychology**, 6:2, 271-279

Schmidt, U. (2005). "Engagement and motivational interviewing". In P. J. Graham (Ed.) **Cognitive Behaviour Therapy for Children and Families**. Cambridge: Cambridge University Press

Southam-Gerow, M., Kendall, P. C. and Weersing, V. R. (2001). Examining outcome variability: correlates of treatment response in a child and adolescent anxiety clinic. **Journal of Clinical Child Psychology**, 30, 422-436

Stallard, P. (2000a). **Think Good-Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People**. Chichester: John Wiley and Sons  
(2000b). Cognitive behaviour therapy with children and young people: a selective review of key issues. **Behavioural and Cognitive Psychotherapy**, 30, 297-309

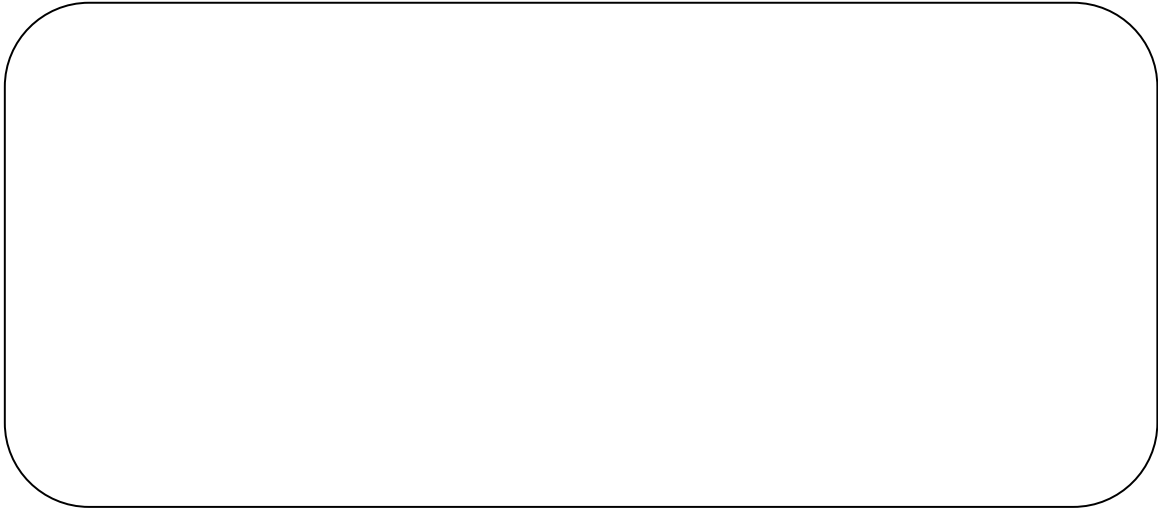
Steinberg, L. (2002). **Adolescence** (6th edition). New York: McGraw-Hill

Whiteside, S. P. and Brown, A. M. (2008). Exploring the utility of the Spence Children's Anxiety Scales parent- and child-report forms in a North American sample. **Journal of Anxiety Disorders**, 22, 1440-1446


Woolpert, M., Elsworth, J. and Doe, J. (2005). "Working with parents: some ethical and practical issues". In P. J. Graham (Ed.) **Cognitive Behaviour Therapy for Children and Families**. Cambridge: Cambridge University Press

## **Appendix 1: Goal Attainment Scaling The Cool Kids Programme**

What the problem looks like:

A large, empty rounded rectangular box with a thin black border, intended for the user to describe the problem they are addressing.

How we would know if the problem went away:

A large, empty rounded rectangular box with a thin black border, intended for the user to describe how they would know if the problem had been resolved.

<b>NAME:</b>	<b>Measurable Outcomes of the Coping Kids Programme</b>	
<b>Much better than expected + 4</b>		
<b>Better than expected +3</b>		
<b>Expected level (programme goal) +2</b>		
<b>Less than expected +1</b>		
<b>Much less than expected +0</b>		

## **AN ANALYSIS OF A TEAM AROUND THE SCHOOL INITIATIVE BEING DELIVERED IN A LOCAL AUTHORITY: MULTI-AGENCY WORKING AND PARTICIPATION.**

### **Introduction**

The Local Authority (LA) within which this Team Around the School (TAS) initiative was being developed had recently divided itself into five neighbourhoods. The neighbourhood in which my patch of schools was located for my third year of study had been running the initiative for one year in all of its secondary schools. My role as an Educational Psychologist was to attend meetings in a consultative capacity. As such, I was in a position to observe and contribute to the development of the TAS structure through TAS meetings at of the two secondary schools in the area and have access to the evaluative comments of team members and the TAS Handbook produced by the LA.

Throughout the report, the TAS model is discussed from a participatory perspective. I start by placing the focus of this report firmly into the policy context of Every Child Matters and related publications. Two models of MA working are considered in order to establish a shared understanding of terms used in the report. This is followed by a discussion of three main areas of impact identified in a recent literature review of MA working research and how they relate to the TAS model adopted by the authority that I worked for at this time. Further analysis of the TAS model is then undertaken according to the main themes extracted from the literature regarding aspects of good MA practice. There is some consideration of how limitations in the evaluation of MA

working in the literature may have affected the implementation of a local model.

The participatory approach is most strongly addressed in the last section of the report, which focuses upon where young people and their families have been placed in the TAS model, with particular emphasis upon consent and information sharing.

### **The policy context – Every Child Matters**

While multi-agency working has been around for a long time in children's services, the current focus is upon more recent work since the advent of the Every Child Matters (ECM) Agenda. The 1989 Children's Act introduced a statutory requirement for professionals to 'work better together' through inter-agency collaborations. Every Child Matters (2003) and the Special Educational Needs Code of Practice (2002) both promote joint working between different agencies. The ECM agenda was born out of the systemic failings that led to the tragic death of Victoria Climbié (DfES, 2003). Much criticism was levied at the lack of information sharing and poor coordination between services. In response, the ECM paper proposed the commissioning of children's services through a multi-disciplinary Children's Trust and multi-agency teams that are linked to extended schools and children's centres. Proposals included: support for families through improved access to services; prevention; accountability and integration of services. Importantly, the paper described the five outcomes for children and young people that provide a common framework for the planning and evaluation of all services, supporting a move towards more integrated working.

The requirement to work in an integrated way was strengthened in the 2004 Children

Act, which charged Local Authorities (LAs) with improving information sharing between agencies and facilitating collaborative work through the commissioning and delivery of services. The government has continued to endorse MA working through subsequent papers. 'Targeted Youth Support' (DCSF, 2008) is part of the Youth Matters green paper (DCSF, 2005). It identifies multi-agency working as one of three key factors for its delivery, alongside a strong emphasis upon responding effectively to local context and sustainability. The importance of listening to vulnerable young people and their needs is advocated strongly. The TAS model is the current LA's attempt to meet government requirements in a large and complex authority.

### **Different Multi-agency models and terminology**

There is a wide variety of practice that is positioned under the umbrella term of multi-agency working, with a wide range of terms in use, somewhat interchangeably (Davies et al, 2008). For the purposes of space, I will briefly present two main frameworks: the DCSF three level model (apparently based upon Atkinson et al's comprehensive literature review in 2007) and the ladder structure suggested by Hughes, 2006 and based upon a continuum of integration, as suggested by Walter and Petr (2000).

The continuum or ladder of integration in figure 1 represents increasing levels of joined up working against which multi-agency work can be measured. It separates out some of the terms that are often used interchangeably in the literature and in practice (Hughes, 2006).



Table 2: A ladder of multi-agency involvement

Increasingly joined up ↑	Integration	Full multi-agency joint work (e.g. joint training, review meetings in a school, joint casework, supporting the development of an emotionally healthy school, projects, research...)
	↑	
	Collaboration	Full discussion between professionals from different agencies – exploration, hypothesis-sharing....
	↑	
	Co-ordination	Multi-agency review meetings over individuals
	↑	
	Co-operation	Liaison – information exchange by phone
		Single agency involvement e.g. EP assessment of a child, art therapy

from Hughes (2006)

The model focuses upon the extent of multi-agency working, implying a hierarchy of practice. I would like to stress that while the ladder gives a framework for measuring levels of integration, I would not accept that this represents a hierarchy of quality of service. Instead, it represents a possible way of distinguishing between common terms used in the area.

The Children's Workforce Development Council has produced a worksheet that simplifies the variety of multi-agency working into three main models (CWDC, 2007), that I will describe with reference to some local examples. The models are informed by three 'principal dimensions': organisation; joint working and integration (Atkinson et al, 2007, page 2).

### 1. Multi-agency Panel

In this scenario, members of the panel meet regularly to discuss children and young people with additional needs, but remain employed by their separate agencies. In the

authority I work in, this would include various panels that commission services across the authority, such as the Provider Panel (responsible for outreach provision), and the moderating panel (responsible for some placement decisions and the decision to assess for a statement of special educational needs or not), and some specialised teams such as the Adoption Panel. It also refers to the Team around the Child (TAC) Model, in which involved professionals and families would meet to discuss further actions for a young person. These panels often work at a level of collaboration, although with less commitment from agencies and less regular meetings (such as with the TAC), they can often end up as co-ordination level work.

## **2. Multi-agency Team**

This describes an arrangement where members of the team are actually line-managed by the team leader, instead of or as well as through their home agencies. In the current authority this would include services such as the Behaviour and Education Support Team and the Youth Offending Team. Work from these teams is more likely to occur at an integration level.

## **3. Integrated Service**

Integrated Service refers to the delivery of integrated support to children and families from a centre in the community. This would usually be a school or early years setting and can include the full range of services. This type of working is partly set up to address the challenge of providing non-stigmatised access for families. This includes children's centres and extended schools. My experience of these settings is limited, but certainly co-location does not necessarily lead to integrated MA work.

It is possible that within any of the three ways of working, different levels of integration, as describe above, might apply, depending upon how the model is interpreted by those delivering it. I have found that often the three models described above can lead to more co-operation level liaison between agencies in a wider context. Unlike the integration ladder, the DCSF model does not acknowledge these more informal practices that form an important everyday part of joined-up working in my own LA.

As Atkinson et al (2007) note, there is a lack of studies that have managed to provide evidence to link the different models of working with better outcomes for service users. A more circular model would have better represented different forms of multi-agency working without making judgements about effectiveness that are implied by the more linear, hierarchical models. However, both models are useful in their moves towards a greater clarity and shared understanding of the terms that are used in this area.

### **Evidence for the impact of MA working**

While the principles underlying the ECM are widely accepted and are unlikely to be argued against, the purpose and modes of service employed to deliver practically upon those principles should be critically considered (Hughes, 2006). The government's endorsement of multi-agency working assumes that the practice will lead to better implementation of the principles of the ECM:

'More integrated children's services will mean children and young people will: be safeguarded from harm; have better opportunities

to develop and reach their full potential; receive effective support earlier if they experience difficulties; and be better able to access targeted services faster and with less stigma as a result of closer links between these targeted services and universal services. Parents and carers from whatever background will: have more and better information, advice and support; and have access to targeted support when needed.'

(DfES, 2004)

However, the evidence base that supports this endorsement is not so conclusive.

In 2007, Atkinson et al conducted a review of the literature with regard to MA working on behalf of the CfBT Education Trust, in order to provide 'an up-to-date analysis' (p.7). They selected sources from a range of educational databases and through direct contact with organisations, according to their set criteria (for example, articles had to be empirically based and relevant to their research questions) and a quality analysis. This reduced the source sample from 1385 to a final 29 studies. The omission of such a large number of sources should suggest that an element of caution might be necessary when making broad generalisations from the review, as the sample has been filtered through a number of criteria and quality analyses that have been defined by the reviewers, and therefore may reflect some of their own biases.

While the search strategy used controlled for the quality of the research, it did not

control for the quality of the MA work that the research was studying. This is not problematic if investigating the scope and range of MA working (as in the discussion about different models) but is more problematic when trying to make generalisations about impact. A more targeted approach would be more appropriate.

Despite these issues, the review has been selected as a basis for the discussion of the TAS model used in the host LA because it provides a current, quality controlled meta-analysis. It identifies three categorisations for the discussion of the quality of MA working: the impact upon professionals; the impact upon services and agencies; and the impact upon service users. I will briefly consider some of the more recent findings in the area under these three headings.

#### *Impacts on professionals*

Atkinson et al (2007) found that studies tended to report positive effects for professionals in terms of work being rewarding and stimulating. One positive effect of MA working has been the development of better professional relationships and the opportunity to share different professional perspectives (Norgate et al, 2008). It is possible that the effects of this could be far reaching, leading to benefits outside of the multi-agency forum in more informal, co-operative working (see figure 1). According to Norgate et al (2008) this leads to a better quality of discussion and consequent decision-making.

Norgate's study adopted a survey method to thematically analyse responses from large variety of professionals involved in Looked After Children teams across the country. There are some problems with this method. Most relevant to this discussion,

the evaluation of the impact of MA working does not gather any data from young people or birth parents, thereby creating a near self-evaluation of MA working that effectively ignores the participatory principle underlying the ECM's multi-agency guidance. In addition, it is likely that some interesting data may have been lost in the attempt to look for generality across very different teams responding to different and complex local systems and area needs.

#### *Impacts on agencies/services*

Atkinson et al (2007) found that there were mixed reports in the literature about the level of demand made upon service resources. Atkinson et al's review of the literature was wider reaching than Norgate's study: it did not limit its search to a particular type of MA working (such as LAC panels). The mixed findings highlight one of the problems of meta analysis, particularly one with such a broad remit. It would be surprising to find a homogeneous effect when the possibilities for the interpretation of multi-agency working are diverse.

#### *Impacts on service delivery and/or users*

According to a number of authors, there is still little evidence of improved outcomes for young people and their families (Sloper, 2004, Atkinson et al, 2007). This may be partly because the holistic nature of multi-agency working makes it difficult to isolate any cause and effect relationship between multi-agency intervention and outcomes. However, the lack of empirical evidence suggests that many authors and policy makers are making an assumption about the 'goodness' of MA working (Hughes, 2006, Atkinson et al, 2007). This does not sit comfortably with the current climate of evidence-based practice, or with a participatory approach to service delivery in which

the service user's voice is supposed to be heard at every level, from planning to evaluation (DCSF, 2008).

The respondents in Norgate et al's 2008 study commented that MA working leads to 'faster, more efficient and effective response to the needs arising' (pge. 8) 133). As already stated, this did not include responses from birth parents or young people, but other stakeholders may still have a valid, if incomplete view of the effectiveness of services for service users. In accordance with Norgate et al's finding, other research has shown that respondents perceived that MA working can afford a group the ability to respond to complex issues that a single agency could not be expected to have the knowledge and skills to address alone (Hughes, 2006). This is in line with the ECM agenda (DfES, 2003), as each of the ECM outcomes is achieved through the interplay of factors that spread across all aspects of a young person's situation and cultural context and which are unlikely to be contained within a single discipline.

This does not mean that MA working should be an unquestioned default mode of service delivery. The level of integration that is needed to support young people towards the five outcomes of ECM needs to be considered. It may be that a full multi-disciplinary approach is not always the most effective or appropriate response to a problem. In fact, an effect coined 'collaborative inertia' has been described (Sengputa et al 2003) in which a group's effectiveness is less than the effectiveness of an individual would have been.

One of the main problems emerging from this analysis of the research is the lack of consistency in understandings of the terms. Atkinson et al (2007) could be seen as

trying to address this through their ambitious review, however, it is difficult to make generalisations from such diverse, qualitative studies, particularly where there is an uneven representation of stakeholders' voices (for example, Nortgate et al, 2008).

The ironic juxtaposition between multi-agency working and the participation of young people and their families will be the main focus of the critique of the Team Around the School model.

### **The current multi-agency intervention**

In the following section I will attempt to place the TAS model adopted by the LA into a policy and local context. I will give an overview of the model as adopted by the LA and described in its Handbook and make some comparisons between this and my own experience as a member of two teams over the last year.

The host local authority for this initiative set up a Children's Trust according to the government guidelines. The TAS Handbook produced by the LA directly links the initiative to the implementation of the Targeted Youth Support agenda (DCSF, 2008).

The TAS approach was adopted to facilitate the delivery of children's services according to the DCSF's 'vision' of 'progressive universalism'. This means that the stigmatisation of young people can be avoided through the delivery of targeted additional support through integrated working in schools and settings such as Children's Centres (DCSF, 2008). In light of the LA's claims, I will use some of the principles described in The Guide to Targeted Youth Support to evaluate the TAS alongside some of the themes drawn from the literature from Atkinson et al's 2007 review, after briefly describing the model.



## **The Model**

The local authority has recently divided itself into 'neighbourhoods' within which services will be managed, complementing the adoption of the TAS model, which has been rolled out one neighbourhood at a time. My neighbourhood was chosen to pilot the TAS model in the secondary sector. The model had still not been rolled out to the Primary sector at this time.

The model is based upon three tiers: Team Within the School (TWS), Team around the School (TAS) and The Locality Team.

### *The Team Within the School*

The Team Within the school consists of a range of school staff who meet regularly to discuss young people that they may be concerned about. This is a structure that the schools I worked with already had in place for challenging cases.

### *The Team Around the School (secondary level)*

The Team Around the School involves a group of professionals who support the school in regular meetings that work towards agreed priorities and supporting pupils as required. The current list of potential members of the group in the handbook tends to be professionals who are already directly linked to the schools, such as:

Educational Psychologists; Connexions; Educational Welfare Officer; Police Officer.

This has been a criticism of the model, where some questions have been raised regarding added value, particularly where there is no representation from Health Services, such as Community Paediatricians, Child and Adolescent Mental Health Service (CAMHS) and Social Services. Some of the meetings have expanded over

the year to include a wide range of other professionals, including:

- Clergy
- Youth Project workers
- Parent support partnership
- Link Fire Officer

In the terms used by the Children's Workforce Development Council (CWDC, 2007), the TAS have been operating more like a multi-agency panel than a team. This may partly be because team identity is still developing while people negotiate their roles and the role of the team. The result is that the teams are fulfilling a consultative role for schools, as well as making decisions about which services are best placed to provide interventions. Presently, this does not extend to joint or collaborative TAS working between meetings. This may be because of the current minimal level of resources dedicated by different agencies, which limits the amount of time that professionals are able to commit to developing interventions. It is unclear how this will develop.

The potential to develop the 'Team' element of the TAS lies in the format for meetings that has been adopted by the schools in which I work. The format of the agenda has space for the discussion of preventative work looking at group concerns within the schools and whole school issues, as well as individual cases. There is also an agenda item for sharing good practice. This format does not actually exist in the Handbook, but was disseminated at some earlier point in the pilot. It opens up the potential for work that fits the CWDC criteria of doing 'not just individual children and

young people, but also small group, family and whole-school work'. As services are increasingly required to commit resources, they will need to develop shared understandings of the team's remit, either through the locality teams' direction or within each individual TAS.

### *The Locality Team*

Each of the five neighbourhoods in the Authority has a locality team that is responsible for overseeing the delivery of the TAS and for strategic planning in response to data received from the TAS meetings in their areas. An important element of this might be the identification of gaps in provision (for example, there is currently only very limited and specialised provision for young women with emotional or behavioural difficulties). The core locality team consists of the Neighbourhood Learning Director, service managers and/or representatives and Head Teacher representatives. Other more specialist services where regular attendance on a TAS level may be impossible to resource (such as the sensory team) would be represented at the locality team when required.

Like the TAS, the locality teams currently work more like the MA panels described by the CWDC (2007), at a collaborative, rather than integrated level.

## **Evaluation of the model according to good practice described in the literature**

When Atkinson et al (2007) reviewed the available MA working literature, not only did they describe where impact should be measured (impact upon professionals, agencies and service users), but they identified four key elements of good practice

that were well evidenced in the literature for their positive influence upon the quality of MA working: working relationships; multi-agency processes; resourcing MA work; and effective management and governance. I will now briefly use these principles of good practice to structure my evaluation of the current TAS practice as I have experienced it.

### **Working Relationships**

One key area identified for effective working relationships was the clarification of roles and responsibilities within the team. At the beginning of the TAS pilot scheme, the team members in both my schools were asked to provide a summary of their professional roles. These have been published in the TAS handbook and team members have commented upon the usefulness of this information. In a feedback exercise run by the Learning Network Director, 'knowing about other services in the area' and 'making links between services' was reported as a benefit by TAS members. Another benefit of these increased links mentioned was the 'improved understanding of thresholds for access to services' and an 'opportunity for services to learn more about the planned provision maps used inside schools'.

It should be noted that this feedback was not collected empirically, but by asking for opinions during meetings which were recorded in the Learning Director's notes. As such, the reported views will be vulnerable to many bias effects. In addition, there is no analysis regarding the weightings of these opinions, either quantitatively (number of people reporting this) or in terms of the relative importance of the factor.

Nonetheless, the comments do provide some insights to the local scenario and so are relevant to this discussion.

The improvement in working relationships reported above does not move beyond Hughes' integration ladder level of co-operation (see figure 1). It suggests that the TAS supports better liaison between professionals that may well benefit better working outside of the TAS forum. One concern that this has raised for me is the potential danger of creating a it's-not-what-you-know-but-who-you-know style of network. If this is the case, then the TAS forum will not provide fairer access to resources than the current provider panel system.

In addition, the need to demarcate professional roles may become limiting. Norgate et al (2008) found that educational psychologists working in MA teams felt restricted by expectations of others who still saw the educational psychologist's role as being about (cognitive) assessment and SEN. It is possible that more creative work might be stifled by the need for role clarity in the maintenance of complex relational aspects between team members (Dennison et al, 2006).

Another aspect of good practice in working relationships identified in the Atkinson report was 'securing commitment at all levels'. This refers specifically to the importance of senior level commitment. This has been built into the design of the TAS framework, although at this point, not all services have embedded the necessary administrative and resource allocation structures into their service plans to the same degree. This can be frustrating for services that have been able to comply, but are hampered by waiting for others. There is a danger that the lack of coordination between timings could lead to a loss of momentum. This situation should be helped by the requirement that all seniors and/or managers attend the Locality Team

meetings.

The third aspect is 'engendering mutual trust and respect'. It is suggested that this is achieved by sharing skills and expertise and through equal resource distribution. Sharing skills and expertise is certainly one of the main purposes of the TAS meetings. Equal distribution of resource is more difficult to achieve. The different services around the table have a wide range of levels and types of funding and time allocations. In addition, with the TAS meetings working more or less like a commissioning service for the individual cases and with a particular criteria currently being applied to the type of cases being brought to the team, there is a distinct bias in the services that are being called upon to deliver (for example, in one school, the YOT representative was asked to intervene in three out of four individual cases presented). Hopefully, as the teams become more integrated and develop a more shared understanding of the purpose and nature of TAS, more joined up working will be possible, taking some of the pressure from one or two services. For instance, in the same meeting, it became clear that there was overlap in some of the services that different people could offer, allowing a more creative distribution of resources for individuals, and/or a more multi-faceted form of intervention.

Finally, Atkinson's review of the literature uncovered 'fostering understanding between agencies ' as an integral part of achieving good working relationships, most importantly, 'an explicit and shared value base' (Walter and Petr, 2000, p.496). The TAS initiative attempted to address this through some joint training and/or launch days. However, these have tended to be one-off events at the beginning of the process, with an absence of follow-up. I think it would have been very helpful to run

more of these training events once team members had become more familiar with each other and the TAS format in order to strengthen shared understandings and aims in delivering the TAS.

### **Multi-agency processes**

The second key aspect was the need to develop effective multi-agency processes (Atkinson et al, 2007). One element of this aspect that the literature referred to centred around information sharing and communication. The TAS meetings have provided a forum for professionals to share information directly and clearly. In addition, the Locality Team meetings allow TAS teams to feedback information through the meetings' minutes. Lines of communication are more transparent, unlike in the more typical informal practices. However, evaluating the TAS on this basis does not account for the more complex issues that working within government guidelines for a participatory approach engender when sharing information between professionals. This topic is discussed in more depth in the next section.

### **Resourcing Multi-agency work**

Resourcing was found to be key to effective multi-agency working. In an initiative as far-reaching as the TAS, this is quite a complex issue. While funding has been allocated to resource work at a Locality Team management level, and some administrative staff have been funded, individual services have different levels of budget that put different kinds of constraints upon their ability to release staff for this kind of work. I understand that levels of commitment are still being negotiated with services, although the EPS and some other services have already made a time allocation commitment to the initiative.

### **Effective management and governance**

A number of points related to the structure of the TAS model should influence the effectiveness of the management of the process. Firstly, the locality teams are comprised of a neighbourhood learning director and service managers from the agencies involved. This should allow for resource decisions to be made that are realistic and sensitive to different agencies capacities. In addition, there has been a commitment to consultation with the professionals involved in the pilot teams throughout the development of the TAS handbook as well as through the feedback mechanism built into the meeting agendas (discussed above). The neighbourhood learning director has also been present at many of the TAS meetings, demonstrating the LA's commitment to the process, giving TAS members a direct source of information, opportunities to feed back straight to the LA and facilitating the reiteration of aims and goals across the different teams. All of this has certainly created a sense of participation and transparency for the school teams, but as yet, has not accessed the voice of the service users: young people and their families.

Evaluation of the TAS against Atkinson's key aspects of MA working provides an overview of the quality of the initiative in terms of its impact upon the professionals involved and to some extent the services too (although this is still a developing area). However, as Atkinson et al (2007) point out, there is a lack of evidence regarding the impact of multi-agency work on service users (in this case young people and their families) themselves. So far, no clear indication has been given as to what performance indicators will be employed to evaluate impact. In my opinion, this is highly problematic for an initiative that positions itself within the ECM and TYS



agenda for MA working.

## **Evaluation of the model with reference to young people and their families**

### **The target group**

I argued earlier that a full multi-disciplinary approach is not always the most effective or appropriate response to supporting young people towards achieving the five outcomes of the ECM. Debate has occurred within the TAS meetings with regard to which young people and groups of young people are appropriate cases to bring to the group. The criteria that has eventually been published in the TAS handbook has been that these should be the more complex cases that the Team Within the School has not been able to make progress with. Salmon (2004) states that children with complex problems 'do not fit neatly into the health, education or social service categories' (Salmon, 2004, p.157), perhaps making them appropriate cases for MA intervention. Similarly, Hughes (2006 p.67) describes multi-agency working as 'holistic rather than reductionist' and 'circular as opposed to linear causality', lending itself to those cases where a single approach may not be adequate.

In addition, the TAS handbook directly links itself to the guidance given in the Targeted Youth Services literature (2008), which sets out its own criteria, closely matching the stated target group of the TAS: 'young people who may not meet traditional thresholds for statutory or specialist services but who, without help, are at future risk of further problems such as substance misuse, youth offending, teenage pregnancy and homelessness.' (p.4).

The target group for the TAS seems to support the TYS agenda. However, LA representatives for the TAS implementation and the Handbook have suggested that the ultimate aim of the model is to replace current referral systems and be a universal pathway for access to all services. In my own analysis, these two conceptions of service users seem to contradict each other. Using a targeted MA forum to process universal service referrals may create a number of issues about fair and equal access to resources, particularly as each secondary school runs its own TAS.

This has resource implications that limit the number of meetings a professional would realistically be able to attend, particularly where the person may work in a number of schools. With limited meetings, it is difficult to see how the forum would cope with the volume of cases that would be generated from a universal service referral route. This also has implications for the efficient use of resources, considering the wide range of professionals in attendance at these meetings for whom many cases would be irrelevant. The operational challenges that such a MA system would present warrant further discussion, but for the purposes of space such an analysis cannot occur here. The main concern relevant to this report is the absence of young people and their families at the meeting and how this contradicts a participatory approach to MA working.

### **The TAS meetings and participation**

The Every Child Matters agenda not only supports collaborative working, but also advocates a participatory approach. ECM policy states that young people and parents should be regarded as supported partners in the development, delivery and evaluation of services (DfES, 2003). The TYS (which the LA handbook directly links

its TAS scheme to) gives a commitment to multi-agency working, but with an emphasis upon the importance of participation:

'Targeted youth support aims to ensure that the needs of vulnerable teenagers are identified early and met by agencies working together effectively in ways that are shaped by the views and experiences of young people themselves.'

(DCSF, 2008, p.23)

This participatory approach is echoed in the LA's TAS handbook, which states that, 'Children, young people and their parents/carers will participate in decisions regarding services they receive, and will be consulted regarding wider service planning.' (pge. 5)

Until this point, much of the evaluation has looked how the TAS process relates to multi-agency working itself, rather than the impact upon the service user and their place in the process, particularly from a participatory perspective. It is equally, if not more important to ask how the TAS model meets the aims of the ECM agenda and subsequent policies in terms of participation. I will present some criticisms of the TAS model, unpicking some of my concerns as an attendee of the TAS meetings regarding the lack of participation of families and young people.

### **Local solutions for local needs**

Part of a participatory approach is based upon the principle that local solutions should be found for local needs. The TYS guide states that, 'Reforms to targeted youth support in each area need to be based on a comprehensive understanding of

local needs and circumstances.' (DCSF, 2008, p.13). In accordance with the TYS principles, the tiered neighbourhood model means that the Locality Team should be able to make strategic decisions that are based directly upon local needs analysis and the identification of gaps and/or overlap in provision. It should encourage strategic joint planning across services, feeding into operational plans by the Locality Team and the whole LA.

In addition, schools and other services should have a much better knowledge of services in the area, particularly as the TAS members have asked for the LA to produce electronic, updated sources of this information. It has also been suggested that the forum will offer an opportunity to review pathways for access to services. In these ways the forum should support increased access to local solutions for local needs; however, this alone does not address other aspects of a participatory approach.

### **Consultation and evaluation**

According to the Children and Young People's Unit (CYPU, 2001), children and young people's participation requires action on three levels:

- Where individual decisions are being taken about children's own lives.
- Where services for, or used by children are being developed or provided locally.
- Where national policies and services are being developed or evaluated.

So far, the TAS has only extended its consultation and evaluation of the programme to the professionals working within it. While this seems contrary to the CPYU

guidelines, perhaps of more concern is that young people are not invited to attend meetings where they are being discussed and decisions are made and there is no system in place for assuring that parental consent is obtained.

Part of the difficulty for the TASs may be identifying exactly who the service users are: are they the schools or young people and their families? Certainly, when working at a preventative or group level, naming the school as the service user could perhaps be justified, although the CYPU guidance suggest that we should be seeking children's voices even on wider issues involving the development of services. At an individual level, young people and their families are clearly at the centre of the work, which raises the question of why they have not been involved in the consultation stages of the process.

### **Consent and information sharing**

ECM wants multi-agency based work to treat families as supported partners, however in the current TAS model, not only are young people and their families not involved in consultation or currently evaluation, but they are not normally invited to attend meetings where their needs and possible actions are being discussed. Whilst not ideal, there are a number of forums where this kind of practice already occurs in education and other services, particularly where there are resource allocation or placement panels. However, these do not usually include professionals with whom the young people have daily contact. Even if it is accepted that young people and their families are not invited to be present at such forums, the issues of gaining consent and the level of information sharing amongst professionals are still crucial to supporting participation.

In a TAS meeting, young people and their families are discussed in the presence of a wide range of individuals from different professional backgrounds (from social services to the local priest). These different professionals all work within different protocols for gaining consent, sharing information and access routes to services. Initially, and as stated in the TAS Handbook, the Common Assessment Framework (CAF) was intended to be used as the cross-agency document to refer young people to the TAS. This would have the benefits of putting the onus upon the school to work with the family in order to record all the necessary information to be shared. It would ensure that consent was gained for this information to be shared amongst the professionals at the meeting (although it is difficult to predict which professional will attend which meetings). However, this referral route has proved to be unpopular with schools and I have only known of one young person being presented to the groups attended where a CAF has been raised.

Some of the reasons why the CAF has not been popular in the schools in which I worked included the perception that it is a time consuming process that delays action. The form used was described as overly lengthy, despite the fact that only the relevant parts of the form needed to be completed for each individual case. Another issue raised by one school was that in completing the form with a parent or carer, the group then only had consent to discuss aspects of the case that are raised by the parent or carer, which may not correspond with those issues that the school feel are most relevant. I think that the increased time commitment that supporting parents and carers and potentially young people to prepare a CAF might engender for some schools where parents are not already supported in an equivalent way needs to be

balanced against the importance of taking a participatory, empowering approach to intervention, and the consent giving role that the CAF plays. Certainly, the issue of parents choosing which information to share emphasises is an important aspect of informed consent and information sharing in a non-child protection forum. This point is explored further later in the report.

Another potential difficulty raised regarding the use of the CAF was cases where parents refuse to complete a form, thereby effectively blocking the provision of the service to potentially vulnerable young people. An ethical dilemma emerges around the balance of parental right to refuse services with the stated intent of TYS to stop those young people who are considered vulnerable, but who do not meet social services criteria, from slipping through the net.

The TAS members generally felt that the form was also not fit for purpose where a group of young people are being discussed.

The unpopularity of the CAF form has led to a reconsideration of it as a referral route. The TAS handbook (page 28) seems to contradict its earlier identification of the CAF as the preferred referral documentation in a section headed 'Pathways'. In this section the Handbook states that the TAS might consider a number of cases or referrals at a meeting and make a decision about whether or not to seek parental consent to complete a CAF.

Again, there seems to be some confusion in interpreting different aspects of the TAS handbook. In a section entitled 'Information Sharing', the Handbook states that it

intends to make a Joint Information Sharing Agreement available to the TAS and Locality Teams, but that the seven 'Golden Rules' for information sharing published by the government (DCSF, 2008) should be referred to in the meantime. However, the pathway described above does not seem to adhere to the guidance regarding consent provided in the seven rules.

Rules two and four relate directly to the issue of consent, and state that practitioners should:

'2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.'

'4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to to share confidential information.'

(DCSF, 2008, pge. 11)

The referral pathway described in the handbook does not seek parental consent before the case is presented to the TAS, supposedly for a decision about opening a CAF to be made, and yet detailed information has been shared between professionals from a wide field. In addition, none of the young people and their families that referred to meetings I have attended have been discussed with regards to a future CAF being initiated. The need for professionals to contribute the



information that they hold and to be able to contact the families regarding the implementation of actions agreed at the meeting, has made keeping anonymity impractical. It is not clear in the Pathways section of the TAS Handbook or in observed practice that any consent is required, meaning that it is possible that young people and their families do not even know that they are being discussed. This clearly does not meet the guidelines for obtaining consent published by the DCSF or the Educational Psychology Service.

In the case of the TAS teams that I have worked with, if consent is not forthcoming, then there may be a case to be made for continuing regardless, on the basis that it is in the public interest. However, such cases are likely to be directed towards specialist services such as Social Services and/or the Police Service following their usual and stringent protocols.

The issue of consent to share information is particularly important given the potential range of people around the TAS table and the different protocols they may follow. There is also a danger that members of the team may assume that the body is following a set of protocols when these have not actually been defined as yet. An example of a concerning situation arose when a police officer present at a meeting offered to investigate the family's history of involvement with the community police and report back to the team. Without a very clear 'public interest' justification (of which I do not believe that there was) this would be a highly inappropriate piece of information sharing. There is the potential for a range of community members (from the local priest to youth service workers) to be party to confidential information about a local family without their knowledge or consent. Again, this practice would not sit

within the guidelines of the DCSF, which state that professionals should, 'Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it'. (2008, pge. 11).

Clearly, while as the DCSF guidance states, the 'Data Protection Act is not a barrier to sharing information' (2008, pge. 11), it is about sharing information 'appropriately'. In the context of ECM and MA working, this means supporting young people and their parents/carers in participating in the making of decisions regarding the services they receive. I believe that the use of the CAF or an equivalent, locally developed method of obtaining consent according to Rule 2 of the DCSF guidelines would be a first and fundamental step towards achieving that aim. Where consent is not forthcoming or inappropriate, the young person and/or their family should at least be aware that their case will be brought to a meeting and ideally, should be invited to participate. The current system seems in danger of disempowering families and reinforcing traditional power relationships between professional experts and service users.

## **Conclusions**

In considering the implementation of the TAS model, a number of positive evaluations have been made in relation to the themes drawn from the literature. It is hoped that the TAS model will help the LA to provide 'faster, more efficient and effective response to the needs arising.' (Norgate et al, 2008), through better links across agencies and more effective access to the range of local services. However, a lack of evaluation regarding the impact upon MA service users suggests a limitation in the evidence-base that could undermine the participatory principle of the government's

endorsement of MA working in the ECM and TYS agenda.

The participatory limitations of the evidence base are reflected in the non-participation of service users in consultations about the development of the TAS model in this particular LA so far. Furthermore, young people and their families have not been invited to meetings and do not seem to have been asked to provide consent in many cases.

The TAS is still very much in a developmental stage. The initiative will need to allow time for the evolution of TAS working, whilst providing clarity and direction through a working document such as the TAS Handbook (which describes itself as ongoing and up for review). However, ethical considerations about consent and information sharing need to be thoughtfully considered and formalised to protect vulnerable young people and their families and professionals in their work. I believe these two issues are critical to practice that has the ECM agenda at its heart.

## References

Atkinson, M., Jones, M. & Lamont, E. (2007). **Multi-Agency Working and its Implications For Practice: A Review of the Literature**. Reading: CfBT

Bullock, R. (2003). Child protection post Laming: The wider agenda. **Journal of Integrated Care**. 11, 13–17.

Children's Workforce Development Council (CWDC) (2007). **Multi-Agency Working**. Factsheet. London: CWDC

CYPU (2001) **Learning to Listen: Core Principles for the Involvement of Children and Young People**.

Coleman, A. (2006) **Collaborative Leadership in Extended Schools. Leading in a Multi-Agency Environment**. Nottingham: Nottingham College School for Leadership.

Davis, B., Gayton, K. & O'Nions, C. (2008). The involvement of educational psychologists in multi-disciplinary work: Sure Start local projects. **Educational Psychologists in Multi-Disciplinary Settings**. Durham: The Association of Educational Psychologists

Dennison, A., McBay, C. & Shaldon, C. (2006). **Educational & Child Psychology**. 23 (4): 80-90

Department for Children, School and Families (DCSF) (2008). **Targeted Youth Support: Integrated Support for Vulnerable Young People: A Guide**. Nottingham: DCSF

DCSF (2008). **Information Sharing: Guidance for Practitioners and Managers**. Nottingham: DCSF

Department for Education and Skills (DfES) (2002). **Special Educational Needs Code of Practice**. London: DfES Publications

DfES (Department for Education and Skills) (2003) **Every Child Matters**. London: DfES Publications

DfES (2004) **Every Child Matters: Change for Children**. London: DfES Publications

DfES (2005) **Youth Matters**. Nottingham: DfES Publications

Hart, R. (1992). **Children's participation: From tokenism to citizenship**. Florence, UNICEF, ICDC.

Hughes, M. (2006). Multi-agency teams: Why should working together make everything better? **Educational & Child Psychology**. 23 (4): 60-71

Norgate, R., Trail, M. & Osborne, C. (2008). Educational psychologist involvement in

multi-disciplinary work in relation to fostering and adoption. **Educational Psychologists in Multi-Disciplinary Settings**. Durham: The Association of Educational Psychologists

Salmon, G. (2004). Multi-agency collaboration: The challenges for CAMHS. **Child and Adolescent Mental Health** 9 (4): 156–161.

Sengupta, S., Dobbins, C. & Roberts, J. (2003). Multi-agency training for quality: Reflections and recommendations. **Journal of Interprofessional Care**, 17 (1): 57–68.

Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. **Child: Care, Health and Development**, 30 (6): 571–580.

Tomlinson, K. (2003). **Effective interagency working: A review of the literature and examples from practice**. LGA Research Report 40, NFER.

Walter, U.M. & Petr, C.G. (2000). A template for family-centred interagency collaboration. **Families in Society**, 81, 494–503.

# **AN EXAMINATION OF SPECIALIST EDUCATIONAL PSYCHOLOGIST INPUT INTO A SCHOOL-BASED CONSULTATION FOR A LOOKED AFTER CHILD.**

## **Background of the case**

This report stems from a piece of casework that I undertook as part of my allocated trainee time while working for a Local Authority in the North of England. In addition to my normal duties as a generic Educational Psychologist (EP), I was able to gain experience of working with an educational psychologist with a specialist role for working with children and young people who are 'Looked After', or cared for by the Local Authority (LA). I had observed and undertaken supervised work with the EP and had interviewed her regarding aspects of the role, but worked independently on this particular case. Like most Looked After Child (LAC) cases, it was an ongoing concern and the final outcomes were unknown. As such, the case study focus is upon a discrete consultation, although the final discussion will take a broader perspective of the specialist role.

This report will consider the link between being in care and low educational achievement. According to some authors, education has been 'ignored or devalued when considering the needs of young people in care' (Dent and Cameron, 2003, pge. 11). Historically, there has been a tendency to prioritise placement needs at the expense of education. Changes in research and policy direction mean that the importance of school in a Looked After Child's life is now recognised as fundamental to narrowing the achievement gap between children in care and other children. I will discuss some of the relevant theories exploring poor educational outcomes and

being 'Looked After'. In particular, I will consider the link between attachment theory and low achievement within a broader multi-systemic model of resilience in order to better understand some of the possible issues faced by this group of young people. While I do not suggest there is a single correct theory for understanding relationships and educational disadvantages of children in care, attachment theory provides useful framework for a number of reasons. The challenging behaviours that could be rooted in attachment difficulties may restrict access to education, thereby contributing to low levels of achievement. Having a conceptual framework to interpret behaviour may help people to develop empathy for young people's more challenging behaviour (Berridge, 2006). A further advantage to adopting this particular approach is that the concept of attachment is referred to in policy documents such as Care Matters: Time for Change (DfES, 2007).

The role of the educational psychologist in the LAC context and subsequently in the current case will be described in light of the research and of educational and health policy. The piece of casework and resulting actions will be discussed and finally, the advantages and disadvantages of the specialist role will be reflected upon.

### **Definition of 'Looked After'**

According to the Department for Education and Skills (DfES), a Looked After Child (LAC) is a young person who fulfils the following criteria, taken from the white paper, Care Matters: Time for Change (DfES, 2007):

- A Care Order has been given under section 31 of the Children Act 1989, meaning that a court has placed the young person into the care of the Local



Authority (LA)

- Those looked after on a voluntary basis through agreement with their parents under section 20.

However, it should be borne in mind that probably not all the studies and papers referred to in the report will have used the same criteria. As with all statistics, the subjective defining of terms weakens objectivity. Some of the specific issues relating to LAC data are discussed later in this report.

## **Policy Overview**

It was not until the 1989 Children's Act that the Local Authorities were officially described as corporate parents, raising the profile of the disadvantage faced by such young people. In 1998, the Quality Protects programme was launched and the subsequent 'Guidance on the education of children and young people in public care' (DfEE/DoH, 2000) was published. The paper reemphasised the principle of 'corporate parenting' and described the role in more detail. There was an endorsement of a joint approach across services, with a greater emphasis on educational attainment as a measure of corporate parenting success. The government set targets for educational attainment, placement stability and reduction of the amount of time that young people in care spent out of school. This represented a shift in the importance given to education.

In 2003 another piece of research, commissioned by the Prime Minister, proposed ways of tackling the gap between outcomes for children in care and their peers, which persisted, despite prior changes to policy. This paper was called 'A Better

Education for Children in Care' (Social Exclusion Unit, 2003).

The 2004 The Children Act legislated that local authorities have a duty to promote the educational achievement of children who are looked after.

Most recently, the 2007 Care Matters White Paper sets out the steps to be taken in order to improve outcomes for young people in care. It recognises the barriers faced by children who are 'Looked After', places more responsibility on LAs for monitoring outcomes and champions the importance of education in providing 'the foundation for transforming the lives of children in care'. (Department for Education and Skills, 2007, p. 8). Changes mean that now:

- children in care have priority in admission arrangements, even when a school is fully subscribed;
- the importance of education in care planning has been increased, particularly during examination years when care plan arrangements must not disrupt educational placements;
- the role of designated LAC teacher has statutory status
- there is extra funding available for young people at risk of failure

### **The link between being in care and low achievement**

Despite numerous changes in policy with regards to young people in care, the Department for Education and Skills (DfES) still reported that a persistent gap between the outcomes of young people in care and their peers remained in 2006.

Measures included indicators of education (only 12% of children in care achieved 5 A-C GCSE grades compared to 59% of children nationwide); health (10% of the

general population are assessed as having a mental health disorder compared to 45% of young people in care); access to positive activities (with 50% of young people in care reporting difficulties in accessing positive activities. No comparative figures for the normal population were reported); conviction rates (nearly three times as many children in care aged ten years or over were cautioned or convicted for an offence in that year); and unemployment at nineteen (with 30% of care leavers not involved in education, employment or training) (DfES, 2007).

While it may seem that the statistics speak for themselves, it would be wise to take a cautious approach to interpretation. One problem with analysis is that longitudinal studies looking at outcomes are often out of date, as policy changes very quickly. The effects of current policy will not be properly felt until those children the policies effect have reached adulthood, by which time it is likely that a different approach may have been adopted.

An example of the interpretive nature of data collection and statistical analysis about LAC in the past is available in the influential analysis of outcome indicators for children in care published by the Department of Health (DoH, 2003). To begin with, results will have been affected by the researchers' decisions about how to define a 'looked after' child. The researchers chose only to include young people who had been in continuous care for a year or more. They justified this decision because they claimed that this would ensure that only those young people that the local authority could have had a significant influence upon would be included. Subsequently, approximately 30% of LAC were omitted from the data (Jacklin et al, 2006). While this analysis may have been fit for purpose (to measure the effect of LA care) it does

not encapsulate the full complexity of the issues. The exclusion of young people on short term placements may have skewed the results.

The identification of the LAC population is further complicated by poor record keeping on a local level. Jacklin et al undertook a small-scale research project that aimed to identify and describe a group of young people in care (aged 15-16) and the 'key features of their cases as regards educational experience and attainment.' (Jacklin et al, 2006, pge. 1). They found that information from both the Social Services Department and the Local Authority, including lists of LAC and their school files, was missing, incomplete, or wrong in a significant number of cases.

A further consideration in the analysis of LAC data is the comparison group against whom the target group is being measured . The DfES statistics compare children in care with all children, when perhaps it would be more informative to compare children in care with young people who are matched with the group on other factors that are linked to low achievement. If this is the case, then current sampling is flawed.

Another problem with the data is that it is not clear what relationship is being measured. Does being in care lead to poor educational outcomes, or do other factors associated with being in care provide the causal link? Dent and Cameron (2003) state that being in Public Care is a risk factor in itself. They point out that this group of children exhibit most of the indicators of social exclusion. However, it is generally agreed that there may be a skew towards lower educational achievement in this group because of pre-care factors that are already linked to low achievement (Harker et al, 2004, Rutter, 2000). Berridge (2007) emphasises that a number of risk factors

linked to low educational achievement are also linked to admission into care, such as: poverty; the educational level of parents; family breakdown and socio-economic class. He warns against oversimplifying statistics to assume that being in care is a risk factor, but suggests a more complex picture that incorporates the wider outcomes for young people.

Nonetheless, there is a large body of evidence that supports the assertion that being in care has a strong link to poor educational outcomes and a higher risk of social exclusion (Fletcher-Campbell and Archer, 2003, Jackson, 2001) as well as research showing that positive experiences in school are linked to positive outcomes later in life, better psychological and physical well-being and resilience (see Thomson, 2007, Berridge, 2002, Jackson and Martin, 1998). Jackson and McParlin (2006) state that the negative skew of pre-care factors alone does not account for the large amount of low achievement. They claim that, as corporate parents, the education and health systems are failing to compensate for the early disadvantages that these young people have suffered (Jackson et al, 2002).

Methodological issues affect our ability to evaluate the effects of interventions aimed at tackling the low achievement of children in care. Often outcome studies are retrospective and may be subject to biases in recall. Two more issues are highlighted in a study by Harker et al (2003), a study that I will refer back to later in the report. Harker and colleagues interviewed a group of young people in care about their perceptions of educational support, and then followed this up three years later with a similar interview. Studies such as this, that take a longitudinal approach to LAC research, have tended to be subjected to a high level of sample attrition. Harker et al

(2003) found positive results regarding the sample of LAC's experience of the educational interventions they evaluated (the Taking Care of Education project), but acknowledged that as 24 out of 80 participants did not progress to the follow up sample, there may have been a positive skew. Those who were not available may have been subjected to more placement changes (a recognised factor of educational disadvantage for the group, DfES, 2007) and those who refused a follow up interview may have represented a more disaffected group, who may have had more negative educational experiences (Harker et al, 2003). The voice of those young people who are being let down by the system remains evasive too.

The qualitative bases of the methodology is also problematic. The interviewees perceptions of what has been most effective in supporting their education may not be reflective of actual causal links and may not remain stable over time (as shown to some extent in Harker's study, although there had been an intervention).

The smaller sample sizes of qualitative studies in general can exaggerate the effects of any biases. However, the perceptions of young people in care offer a quality of insight into our systems that cannot be gained from the more statistically based, quantitative methods, which we have seen are, in any case, subject to problems with achieving objectivity. Importantly, these types of studies also emphasise the importance of seeking to hear the voice of the young people themselves, particularly in this group where more often than not, they will have felt disempowered by the adult world and the systems within which they have been placed.

## **What underlies low achievement in children in care**

According to Jacklin et al (2006) there has been a gradual shift away from considering the within-child factors that influence poorer educational performance towards an examination of how systems can be altered in order to aid better outcomes for this group of young people. However, in order to address the systemic shortfalls, there first needs to be an understanding of what the underlying issues are for these young people and their educational disadvantage.

### **Resilience**

The concept of resilience recognises that there are a number of young people who do not suffer the same adverse effects as other children, despite having experienced what appear to be similar difficult circumstances (such as traumatic early relationships). Dent and Cameron describe resilience as not simply coping with adversity, but 'springing back' from major difficulties, and achieving 'normal development under the most difficult and challenging circumstances' (Dent and Cameron, 2003, pge. 5). Fonaghy et al (1994) long ago suggested that factors that predict resilience should be considered in a multi-level framework, including: within child factors; within-home factors and outside home factors.

Dent and Cameron suggested the following important protective factors for children in care:

- Secure attachment relationships
- Cognitive ability
- Social skills
- Positive self-image

- A supportive teacher
- Socio-economic status
- Level of education of family
- Parenting
- Wider community factors

While some of these factors are clearly not able to be manipulated or influenced through intervention, they should be taken into account when planning for service provision. If not, local authorities risk, as Jackson and McParlin (2006) have accused, failing to compensate for the disadvantages of young people without these protective factors.

A problem with resilience studies is that they are investigating the exceptions rather than the norm in a population. Consequently, such research tends to have a smaller population from which to sample, making it difficult to identify any causal factors from very individual accounts and experiences. In light of this, it could be argued that interventions should target those areas where they are most able to have an effect. From an educationalist's point of view, many of these protective factors are relevant to the educational setting. Attachment relationships (discussed below), sensitivity to cognitive ability, self-image, and support from the teacher and other contextual factors can all be considered when planning at all levels for young people in care (Dent and Cameron, 2003). This model of resilience supports the need for multi-agency, joined-up working. It is not being in care that is a risk factor so much as how the child or young person is treated or what systems are in place to help them. Williams et al (2001) found that young people in care were less likely to receive



treatment for mental health problems than peers, despite being far more likely to suffer poor mental health. This makes at least some of the protective and risk factors systemic rather than within child (Bloom, 1996).

Poor relationship histories and other pre-care factors may be a factor contributing to low attainment, but the failure to respond to that increased need is another contributory factor (Jackson and McParlin, 2006). Through taking an attachment perspective, the next section will discuss whether schools can act as a protective factor for young people in care.

### **Attachment**

In a piece of research funded by the National Society For the Prevention of Cruelty to Children, Mills suggested that 'much of the poor school performance of looked after children may be explained by histories of maltreatment' even when background factors such as social class were controlled for (Mills, 2004, pge. 4). Children in public care will generally have a known history of very troubled early relationships (Greig et al, 2008). 62% of looked after children in 2004 had parental maltreatment (neglect/abuse) recorded as the main reason for being in care, while in other cases, this may have been a secondary factor (Department for Education and Skills, 2005).

Early parental maltreatment may lead to the development of behaviour patterns that are described in attachment theory. In the following section, I will briefly describe some of the key posits of attachment theory before making an argument for its relevance for informing the way we educate children placed in care.

According to attachment theory, a child needs a warm and supportive relationship in the early years from receptive, caring adult figures in order to develop healthily (Bowlby, 1973). The primary caregiver acts as a secure base for exploration, thereby increasing the number of experiences that the child is exposed to. According to Bowlby, sensorimotor representations of secure base experiences are processed by the infant, leading to internalised constructs about self, relationships and the world (Bowlby 1973, 1980). The working models, or attachment representations guide behaviour in situations where the care giver is not present and increase resilience against negative relationship experiences. Insecure attachments will form the expectations and beliefs that guide behaviour in a range of situations and relationship scenarios (Bowlby, 1985) and can be: avoidant (restricted, flat and defensive learning behaviour (Greig et al, 2008) that seeks to avoid developing dependent relationships and risking failure through a task (Geddes, 2007)); ambivalent (attention-seeking and coercive, focussing on the teacher-pupil relationship at the expense of the task (Geddes, 2007)); or where the young person has suffered particularly poor relationship histories, disorganised (these are the group most likely to have mental health problems and be LAC (Kennedy and Kennedy, 2004).

While the application of attachment theory to the classroom is relatively under-explored (Geddes, 2007), its relevance is supported by the general importance of relationships to a pupil's experience. Furrer and Skinner (2003) found that a child's experience of school was most closely linked to their relationship with their teacher, over and above their relationship to their parents and or peers. The study did not look at children in care specifically, but if we assume that this broad generalisation also applies to this specific group and that many LAC are likely to have developed

negative working models of relationships with adults, this relationship is more likely to be problematic. In addition, Rey et al (2007) found that teachers tend to find it easier to form relationships with children who have had positive past experiences of the maternal relationship, heightening the disadvantage for most young people in care.

Kennedy and Kennedy (2004) summarised the literature which links secure attachment style in children to better scores on measures that could be regarded as relevant to educational performance. They extrapolated that securely attached children are more likely to:

- have socially appropriate responses;
- be more focussed and participate more in class;
- conduct better functioning goal-corrected partnerships;
- develop satisfying interpersonal relationships;
- have a positive view of self, and;
- cope adaptively with stressful situations.

The importance of relationships and social skills is likely to put children with poor relationship histories at a disadvantage in school, where access to learning is through the social dynamics of the classroom. There is evidence to support the notion of reading skills acquisition as a social process (Greig et al, 2008), which should therefore be susceptible to the influences of attachment style as summarised above. Although the authors do not make a clear assertion about whether or not this is the only way to learn how to read, they do present the theory that poor relationship histories will disadvantage young readers in a number of ways. They are more likely to:

- be insecure;
- have had unhappy experiences of reading, through a lack of sensitivity to the child's ability level and needs;
- have had less exposure to books;
- have interruptions to reading for other interactions such as discipline (Bus and van Ijzendoorn, 1995)

The importance of reading experiences at home highlights the need for a joined-up way of working that should include foster carers, children's home workers and/or parents.

Some of the conclusions from Greig et al's (2008) research needs to be treated with an element of caution. The researchers noted that the literacy items they used to assess the children's reaction to reading were loaded with difficult story themes that the authors had predicted would be emotionally significant to children with attachment difficulties. It is not clear whether more neutral testing materials would produce the same level of effect. In addition, the researcher did not actually assess for attachment style, but made an assumption based upon the care status of the young people. The limitations of a small sample size and the necessarily subjective nature of qualitative research should also be considered, alongside the theoretical assumptions that are made in adopting an attachment approach.

As well as the number of factors relating to social elements of learning, Kennedy and Kennedy's model (above) refers to securely attached young people's ability to cope with stressful situations. This would underlie the observation that insecure

attachments seem to lead to greater risk at times of change (Dent and Cameron, 2003), such as starting new schools (which children in care tend to do more often), changing year groups and other major and minor transitions that occur throughout an ordinary school career .

In addition, learning itself could be described as a stress inducing situation.

Educational tasks involve exploring ideas previously unknown and the risk of failure is ingrained. As such, Greig et al (2008) suggest that learning demands the same skills as a stressful situation, and so may trigger a child's attachment pattern of behaviour. It follows that a securely attached child will be likely to cope better with a poor teaching environment because of their increased resilience when faced with stressful situations. However, a well-targeted task will challenge a pupil, exciting their curiosity without making them overly anxious, leading to increased resilience in future tasks (Geddes, 2003).

Attachment theory can appear to be a deterministic, within-child approach to understanding children's behaviour. Criticisms that it is pessimistic and deterministic (Slater, 2007) do not account for the possibility for change (Water and Cummins, 2000). While there is evidence to suggest attachment styles remain stable over time (Waters and Cummins, 2000), the evidence does not provide conclusive proof to show whether it is within-person characteristics or the stability of environmental factors that maintain negative working models. Kennedy and Kennedy's model (2004) suggests that there is a more complex interaction of factors influencing a young person's behaviour in the classroom and so implies that there is a potential for change to be effected by the systems within which they are placed.

Relationships with emotionally significant others may also have the power to change internal working models (Grossman and Grossman, 1991). Rey et al (2007) argue that the teacher is well placed to adopt the role of an attachment figure outside of the family unit, in order to provide a safe base from which the child can develop a sense of belonging and security, leading to more exploration and learning. Geddes (2003) suggests that the classroom can create opportunities for the young person to have experiences that challenge patterns of interaction experienced in early life that may have informed the expectations that the young person holds about the way in which the social world functions. In Harker et al (2003), teachers were the most frequently mentioned person giving a supportive role by the young people in care they interviewed, for both academic and emotional support.

Even if in some cases it is not ultimately possible to change the effects of traumatic early relationships upon a young person's attachment style, systems can be put in place to try to support young people who have been disadvantaged by early and/or ongoing experiences. School can offer resilience building opportunities by: acting as a safe base; developing self esteem and self-efficacy; providing the opportunity to have constructive interactions with peers and supportive adults (Gilligan, 1998). In addition, a better understanding of psychological theory, such as attachment and resilience, may help develop teacher empathy. The teacher-pupil relationship is reciprocal, and some of the disadvantage that young people face may be related to the adults' reaction to their problematic behaviour patterns. Teachers may be helped to develop effective strategies to support young people in care if they can increase their understanding of the types of difficulties such children face in socially complex

situations such as the classroom (Rey et al, 2007).

### **Critique of attachment theory in the classroom**

One of the advantages of applying attachment theory in the classroom is that it allows a preventative rather than a reactive stance to the challenges linked to being a looked after child. The emphasis upon dynamic relationships in the theory supports a shift from within-child descriptions of behaviour towards an interactionist approach that implies the potential for intervention to improve educational outcomes for these young people.

According to Granot and Mayseless (2001), early attachment relationships have been found to be almost as good a predictor of educational outcomes as Intelligence Quotient scores, suggesting that intervention aimed at reducing the affects of insecure attachment should support attempts to improve achievement levels in the cohort.

However, there is a lack of evidence yet collected that directly addresses the effectiveness of attachment theory based interventions in the classroom and this is certainly an area for further study. Barth et al (2005), while recognising that the theory 'articulates' some of the difficulties that young people in care may experience in future relationships (the paper discusses foster care and adoption in particular, rather than education), questions the scientific basis of attachment theory. He highlights the danger of theory being taken as a scientific explanation of disturbed behaviour by foster carers and adoptive parents.

## **The role of the EP in providing services for children in care**

As I have argued already in the report, school has the potential to be one of the most influential protective factors in a looked after child's life (Dent and Cameron, 2003). Given the position of Educational Psychologists in terms of their application of theories such as attachment theory to educational and other settings and knowledge and experience on a systemic level, it would seem likely that the EP would be an important professional in the cross services corporate parenting team. However, there has been little research undertaken to provide evidence regarding the effectiveness of EP work with children in care (Jackson and McParlin, 2006).

One relevant study comes from Sinclair et al (2005), who investigated the impact of support other than social work for young people in care. Educational Psychologists were involved in 23% of the cases, and were associated with fewer placement breakdowns, if the foster carer had a positive attitude towards education. Their input was rated very highly by carers and they were also rated highly as consultants to residential care providers. Whilst this is clearly encouraging, the conclusions drawn are all based upon the perceptions of participants rather than measures of actual outcomes for young people following interventions. The perceived benefits of EP involvement are important to consider, particularly in light of the depth of data that personal accounts can provide and the potential to uncover important positive outcomes that statistical analysis might be insensitive to. However outcomes measures for young people would provide more robust evidence for actual rather than perceived impact. Barth et al (2005) purport that foster carers and residential workers may have a predisposition to value input from an attachment theory based perspective, as the theory may offer reasons for difficult behaviour in young people in



care that deflect responsibility from them, to previous carers. If EPs tend to take an attachment perspective, this may influence how they are rated in such opinion-based studies.

It is also unclear at what level the EP's involvement is considered to have impact.

Educational Psychologists can effect change for children in care on a number of levels (Dent and Cameron, 2003). This may include:

- 'Improving curriculum access' (Dent and Cameron, 2003, pge. 14), for example, by targeting support for early reading and supporting the social elements of reading skill acquisition.
- 'Making classrooms more supportive' (Dent and Cameron, 2003, pge. 14), developing strategies for the application of theoretical knowledge regarding the subtle difficulties of attachment difficulties that may impede access to education in terms of assessment and intervention (Greig et al, 2008).  
Teachers and support staff may need training about consequences of early traumatic relationship histories for many young people and how to intervene, as well as a greater understanding of the care system and how this might effect a young person's behaviour in the confines of a classroom (Comfort, 2004).
- 'Recognising the potential of schools for positive change' (Dent and Cameron, 2003, pge. 14) by helping schools to examine their practices on a systemic level in light of a deeper understanding of the challenges faced by vulnerable young people. The Who Cares? Trust (2004) found some young people with reading ages of 16 plus allocated to low ability classes. EPs may play a role in

facilitating changes in how schools manage young people with behaviour difficulties and in advocating on their behalf. EPs might provide guidance for systemic changes based on the evidence base for creating nurturing, warm environments (such as nurture groups, (Boxall, 2002).

- By being part of the multi-agency teams that are involved in individual and strategic planning for children in care and putting educational issues at the centre of decision making. As education seems to be closely linked to future success and social inclusion, it should be made a planning priority (Thompson, 2007). This is one of the areas where educational psychologists can initiate and support positive change, as educationalists, child and community psychologists and applying knowledge of systems and processes.

The development of a specialist LAC EP role has been recommended by influential researchers such as Sonia Jackson and Peter McParlin (2006) and incorporated into government guidance in the Care Matters agenda (DfES, 2007). At the LA where I undertook my training, the Educational Psychology Service deployed the equivalent of a full-time Educational Psychologist to work with Children's Social Services in a specialist LAC role. Two psychologists shared this post and it was whilst working with one of these specialist EPs that the consultation that this report is based on was requested. I will now describe and critique the consultation and then, finally, consider the role of specialist EP and the particular contribution that they can make, in addition to that of a generic school psychologist.

## **The consultation**

The young person at the heart of this case was a girl in Year 2 who will be referred to

as Alice (not her real name). She was described as looked after, in that she was under a voluntary care order and was living with a foster carer, along with her younger sibling. A baby brother was living in with a different foster family. This arrangement had been in place for nearly a year.

The school called a multi-agency meeting that would take the form of a consultation in order to share information and undertake in some joined-up thinking towards planning to meet the young person's educational needs in the broadest sense. It was decided that Alice would not attend the meeting, as she would have found it quite difficult to concentrate and may have found the content confusing.

It was anticipated that her current and future teachers would be the most important attendees, as transition into Key Stage 2 was a potential source of stress. However, the school was unable to release them from their classroom commitments. This highlights a fundamental shortfall in the execution of a multi-agency approach where commitment levels differ, both in terms of the relative resource implications and the value placed on the process. As discussed earlier, research indicates that teachers are highly influential in young people's school experience (Harker et al, 2003) and may be best placed to apply attachment-based interventions (see Geddes, 2007) and to modify management and teaching strategies according to a better understanding of psychological theory. In addition, the teacher is an expert in the young person's classroom behaviour and needs. They can provide detailed information about which strategies have worked well and which do not work for a particular child within a particular classroom dynamic that could be crucial to effective planning at this school level. Not releasing teachers to attend consultations may be a false economy for

schools. Part of the EP role could be to raise awareness of this argument in schools.

In this case, the SENCO was charged with relaying Alice's teacher's views and giving feedback. It was strongly advised that a meeting would be called between the current and future teacher so that both could discuss the feedback and share information. This would be supported by a further visit from the specialist LAC EP in September.

Other people invited included myself, acting as a specialist LAC EP, the Clinical Psychologist, Social Worker, SENCO, Learning Mentor, Foster Carer and Mother. Unfortunately, both of the latter were also unable to attend, but were represented by the Social Worker. She reassured the group that the foster carer was very interested in Alice's education and had asked for a question to be raised at the consultation asking for suggestions about how to best spend some money they had received to provide educational resources in the home.

The following is a brief summary of some of the main points discussed in the consultation:

### **Purpose**

The group agreed that the focus of the consultation was how Alice could be supported through transition into Key Stage 2, building upon the progress already made in Year 2. In addition, the consultation would afford an opportunity for information to be shared between school and other services (which the school felt had not happened to an adequate extent previously).

**Description of current situation**

The clinical psychologist and social worker were able to provide background information regarding the high level of adversity Alice had experienced in her life so far. In addition, the social worker gave important information about the current status of Alice's case. The Social Worker described how Alice had made good progress since being placed into foster care and had bonded well with her carer. This had been reflected in her improved (though still poor) concentration levels in school. However, the Social Worker brought to light the fact that Alice would be undergoing some big changes in her care status in the next school term, that were to some extent unpredictable. The implications of this would be change for Alice (possibly moving to different care status, resulting in a change of Social Worker and perhaps carer). With this information, the school would be able to plan support and recognise that some of Alice's behaviour might be a normal reaction to difficult circumstances when and if problems arise. The specialist EP would be able to consult further at this time about how to provide support.

It was noted that Alice experienced increased social difficulties when contact visits occurred and the implications for her ability to learn at these times were discussed.

**Strategies**

Briefly, the main actions agreed by the group were:

- A transition plan would be put into place. This would include an interactive booklet based upon one that the school were already using with young people who had difficulties coping with change and were on the Autistic Spectrum.

The psychologists were able to reassure the school that this would be appropriate, despite Alice not being on the autistic spectrum herself, and the Social Worker could concur that they use similar, social story based techniques to support vulnerable young people through various care transitions.

- Alice would be familiarised with her new classroom, aided by the need to take photographs of key elements for the completion of her transition booklet.
- The transition book would be used over the summer holidays at home to prepare for the first day of school.
- Alice would be able to meet with her new teacher.
- Alice had formed a close bond with her current teacher. It was felt that she would benefit from continued contact with this adult at designated times. This could be used for talking or playing as she may be an important attachment figure for Alice at a difficult time.
- There would be a meeting between the SENCO and the two teachers and support staff to discuss this meeting and further strategies. In particular, the new teacher would be advised about the special importance of:
  - consistency
  - positive feedback
  - time out
  - home school
  - visual timetable (for home and school)
- Training for school staff addressing attachment difficulties, the link to low achievement and classroom strategies would be provided by the EP, to

improve the school's capacity to provide a secure base for learning for children in care.

- Strategies for supporting Alice emotionally in the classroom were discussed, and a whole class approach was preferred as a first stage (the introduction of a form of time out, such as headphones, a quiet corner with a book or simply heads on the desk). Support would be provided to help Alice to regulate her emotional responses, but recognising the appropriateness of some of her reactions and allowing space for her to express these safely. Again, the EP would be available for ongoing support.
- The nature of educational support at home was discussed, with the importance of social reading being emphasised. However, we suggested that education for Alice needed to incorporate the development of social skills through play opportunities that she had apparently not had access to as a younger child. As previously discussed, social skills are integral to many aspects of learning and are an area of disadvantage to children with poor relationship histories (Rey et al, 2007). Toys that would help creative and imaginative play were suggested, that would allow Alice and her carer to interact socially. This would help her to develop the skills she needs to meet the demands of the social learning environment of the classroom.

Initially, the SENCO had thought that part of the EPs contribution would be to facilitate a cognitive assessment of Alice. It was decided that this might be considered for a time when Alice was settled into her next school year and care status. Transition, supporting Alice emotionally and developing her social skills were

considered the most important foci at this stage. Referring to the attachment literature, an argument was made that cognitive assessment at this time might be affected by any difficulties Alice might experience during stressful periods of change. Greig et al (2008) discussed the possible effects of attachment style upon the ability to cope with assessment itself. In their research they hypothesised that: materials might triggering difficult memories; young people may experience diversion of attention; and that it may be anxiety levels rather than cognitive ability being measured, particularly in language based assessment. As previously stated, attachment has been found to be nearly as good a predictor as IQ for academic success, meaning that cognitive testing may actually be assessing social advantage rather than ability (Berridge, 2006). This is an important contribution, as assessment under unfair conditions could lead to the perpetuation of low expectations from teachers for children in care.

While the main focus of this particular meeting was to develop a transition strategy, it also served as an opportunity for professionals to share information and to initiate joined-up working. Much important information regarding Alice's background, particularly regarding important, potentially stressful events likely to occur in the next school year were shared that will enable the school to better support her at this time.

The Clinical and Educational Psychologists both offered a psychological perspective that was predominantly from an attachment theory grounded formulation. The Clinical Psychologist had more in depth knowledge of Alice from working on a one-to-one basis with the child and her mother. The EP offered an educational perspective in terms of learning, classroom practices and the wider school, education and LA



systems.

Another important element of specialist EP involvement was consistency. Because of the way services are structured, a generic school EP would no longer have any involvement with the case once Alice had made the transition into Year 3. With Alice's imminent change in care status and therefore change in Social Worker, the specialist EP would be the only professional outside of the school context with ongoing involvement.

In the final section of the report, I will attempt to link the particular contribution of the EP in such cases to the research discussed earlier and consider the specific role of the specialist LAC EP.

### **Analysis of Specialist versus Generic role**

The school Special Educational Needs Coordinator (SENCO) had recognised the need to act preventively on this young girl's behalf in order to anticipate some potential difficulties in the future that might be linked to the traumatic experiences she had already had and the ongoing uncertainty about her future care placements.

Some of the SENCO's special attention to this case, which was not the school's most urgent in terms of immediate behaviour difficulties, was based upon earlier discussions as the school's generic EP concerning young people with difficult early and ongoing circumstances at home, how this might affect behaviour in the classroom, disadvantage children and the potential for schools to provide supportive interventions.

While the initial request for involvement was received in the role of generic EP for the school, I suggested that a specialist involvement would be more appropriate for a number of reasons:

- This was a complex case with ongoing legal matters regarding placement, which the specialist EP would have more information about.
- It would require an ongoing commitment, which the time allocation of the EP Service would find difficult to accommodate without reducing the amount of time available to other work in the school.
- Should Alice and her siblings need to change placement, the specialist EP would remain involved, where a school EP may lose contact.
- A specialist EP may have more relevant and up-to-date theoretical knowledge and experience of the processes relevant to the case.

In terms of theoretical knowledge in the LAC area, where there is a specialist LAC EP, they would tend to take priority in terms of access to training on the subject of attachment and other pertinent issues. While it may be argued that this is of benefit to a vulnerable group of young people (children in care), many of these issues are also relevant to young people living in difficult circumstances, who are not looked after, but are 'disadvantaged by our society', such as the children of travelling communities, single parents, adults with mental health etc. (Dent and Cameron, 2003). In addition, there are many young people who are not in care because they fall beneath the criteria used by Social Services, or because they have not been brought to the attention of Social Services. In some ways, this cohort could be described as equally or possibly more vulnerable to the effects of early maltreatment, if the situation is ongoing. Yet this group would have no access to a specialist EP. This raises a

question of equal access to resources if there is a possible deskilling of generic EPs through the accommodation of a specialist LAC role.

The sampling problems identified in LAC data analysis earlier in this report referred to the faultiness in comparing the low achievement of children in care to all other children. A more solid basis for important resource decisions would be to compare the achievement levels of children in care to other children who are not in care, but have similar risk factors, including poor relationship histories. It may be important not to over emphasise the link between attachment difficulties and being in care, but to bear in mind other vulnerable populations.

This being said, children in care do have a very specific set of circumstances that benefit from specialist knowledge of the care system in terms of negotiating the processes involved. The specialist role affords opportunities for the EP to develop working relationships across agencies by working regularly with each other. This allows the LAC EP to advocate for the school and young person on systemic levels, and to ensure that the importance of education is understood in multi-agency decision making forums. Jackson and McParlin describe EPs as well placed to bridge the gap between the care/education divide (Jackson and McParlin, 2006).

Perhaps one of the most important advantages of having a specialist LAC EP relates to the reported statistic that on average, a statemented child in care will move school six or seven times and see five to six psychologists over their school career (McParlin, 2001). A specialised Educational Psychologist role allows the EP to be attached to the child rather than the more usual arrangement of workload being

attached to schools. In addition, children in the care system will have a number of different social workers, depending on the stage of the system that they are at. This means that the specialist EP may be only person at a meeting who has seen the case from its beginnings. As Jackson and McParlin (2006) recommend, the EP in an excellent position to have complete knowledge of child's history, so that when they do change school, there is a professional who can explain to teachers and other professionals what the particular circumstances and needs are that are relevant to their education.

Finally, I would suggest that while there are clearly very important benefits to the role of Specialised LAC Educational Psychologist, these need to be considered alongside the potential costs. The role of specialist should be managed to minimise the deskilling of generic EPs through sharing of training opportunities and information sharing about cases within schools. Educational Psychologists in general have an important role to play in supporting the achievement of children in care, through their theoretical knowledge, applied experience and systemic knowledge, but the application of attachment theory to tackle low achievement should be part of a universal service, with a commitment to further research into the effectiveness of attachment based classroom intervention.

## References

Barth, R., Crea, T., John, K., Thoburn, J. & Quinton, D. (2005) Beyond attachment theory and therapy. **Child and Family Social Work**, 10: 257-268

Berridge, D. (2002). "Residential care." In McNeish, D., Newman, T. & Roberts, H. (Eds.), **What works for children: Effective services for children and families**. Buckingham: Oxford University Press.

Berridge, D. (2007) Theory and explanation in child welfare: education and looked-after children. **Child and Family Social Work**, 12: 1-10

Bloom, M. (1996). **Primary Prevention Practice**. Thousand Oaks, CA: Sage.

Boxall, M. (2002). **Nurture Groups in Schools: Principles and Practice**. London: Sage

Bowlby, J. (1973). **Attachment and loss: Vol. 2. Separation**. New York: Basic Books.

Bowlby, J. (1980). **Attachment and loss: Vol. 3. Loss**. New York: Basic Books.

Bowlby, J. (1985). "The role of childhood experience in cognitive disturbance." In Mahoney, M., J. & Freeman, A. (eds.), **Cognition and Psychotherapy**. New York & London: Plenum Publishing Corporation. pp. 181-200

Bus, A.G., & van Ijzendoorn, M.H. (1995). Mothers reading to their 3-year-olds: The role of mother-child attachment security in becoming literate. **Reading Research Quarterly**, 30 (4): 998–1015.

Comfort, R. (2004) **Meeting the Educational Needs of Looked After and Adopted Children**. Bristol: Our Place

Dent, R. J. & Cameron, R. J. S. (2003) Developing resilience in children who are in public care: the educational psychology perspective. **Educational Psychology in Practice**, 19 (1): 3-19

Department for Education and Employment and Department of Health (2000) **Guidance on the education of children and young people in public care**, London: DfEE/DoH.

Department for Education and Skills (DfES) (2007) **Care Matters: Time for Change**, Nottingham: DfES

Department for Education and Skills (DfES) (2005) **Outcome Indicators for Looked After Children: Twelve Months to 30 September 2004, England**, London: DfES

Department of Health (2003) **Outcome indicators for looked after children: year ending 30 September 2002**, London:DoH.

Fletcher-Campbell, F. & Archer, T. (2003) **The achievement at key stage 4 of young**

**people in public care** (Research Report 434) Slough:NFER.

Fonagy, P., Steele, M., Steele, H., Higgett, A. & Target, M. (1994). The Emanuel Miller Memorial Lecture, 1992: the theory and practice of resilience. **Journal of Child Psychology and Psychiatry**, 35(2): 231–257.

Furrer, C. & Skinner, E. (2003). Sense of relatedness as a factor in children's academic engagement and performance. **Journal of Educational Psychology**. 95: 148-162

- Granot, D. & Mayseless, O. (2001) Attachment security and adjustment to school in middle childhood. **International Journal of Behavioral Development**, 25 (6): 530-541

Geddes, H. (2007). **Attachment in the classroom: The links between children's early experience, emotional well-being and performance in school**. London: Worthing Publishing.

Gilligan, R. (1998) The importance of schools and teachers in child welfare. **Child and Family Social Work**, 3(1): 13–26.

Greig, A., Minnis, H., Millward, R. *et al.* (2008) Relationships and learning: a review and investigation of narrative coherence in looked-after children in primary school. **Educational Psychology in Practice**, 24 (1): 13-27

Grossman, K. E. & Grossman, K. (1991). " Attachment quality as an organiser of emotional and behavioural responses in a longitudinal perspective." In Parkes, C.M.,

Stevenson-Hinde, J. & Marris, P. (eds) **Attachment Across the Life Cycle**. London: Routledge.

Harker, R. M., Dobel-Ober, D., Akhurst, S., Berridge, D. & Sinclair, R. (2004) Who takes care of education 18 months on? A follow-up study of looked after children's perceptions of support for educational progress. **Child and Family Social Work**, 9: 273-284

Jacklin, A., Robinson, C. & Torrance, H. (2006) When lack of data is data: do we really know who our looked-after children are? **European Journal of Special Needs Education**, 21 (1): 1-20

Jackson, S. (Ed.) (2001) **Nobody ever told us school mattered**, London:BAAF.

Jackson, S., Feinstein, L., Levacic, R., Owen, C., Simon, A. & Brassett-Grundy, A. (2002) **The Costs and Benefits of Educating Children in Care**, Institute of Education Cohort Studies Working Paper 4

Jackson, S. & Martin, P. Y. (1998) Surviving the care system: Education and resilience. **Journal of Adolescence**, 21: 569–583.

Jackson, S. & McParlin, P. (2006) The education of children in care. **The Psychologist**, 19 (2): 90-93

Kennedy, J., H. & Kennedy, C., E. ( 2004). Attachment Theory: Implications for school



psychology. **Psychology in the Schools**. 41 (2): 247 – 259

McParlin, P. (2001). **Perceptions of Educational Motives, Expectations and Behaviours Within Long-term Fostering**. PhD Thesis, University of Leeds

Rey, R. B., Smith A. L., Yoon J., Somers C. & Barnett D. (2007). Relationships between teachers and urban African American children: The role of informant. **School Psychology International**. 28 (3): 346-364

Rutter, M. (2000) Children in substitute care: some conceptual considerations and research implications. **Children and Youth Services Review**, 22: 685-703

Sinclair, I., Wilson, K. & Gibbs, I. (2005) **Foster Placements: Why They Succeed and Why They Fail**. London: Jessica Kingsley

Slater, R. (2007). Attachment: theoretical development and critique. **Educational Psychology in Practice**. 23 (3): 205-219

Social Exclusion Unit (2003) **A better education for children in care**, London: Social Exclusion Unit.

Thomson, A. I. (2007) Looked After Children: Non-local authority placements and meeting educational needs. **Educational Psychology in Practice**. 23 (3): 273-282

Waters, E., & Cummings, E. M. (2000). A secure base from which to explore close

relationships. **Child Development**, 71: 164-172.

Who Cares? Trust (2004) **Measuring Progress: The Role of the Educational Psychologist**. London: Author

Williams, J., Jackson, S., Maddocks, A. *et al* (2001) Case-control study of the health of those looked after by local authorities. **Archives of Disease in Childhood**, 85: 280-285