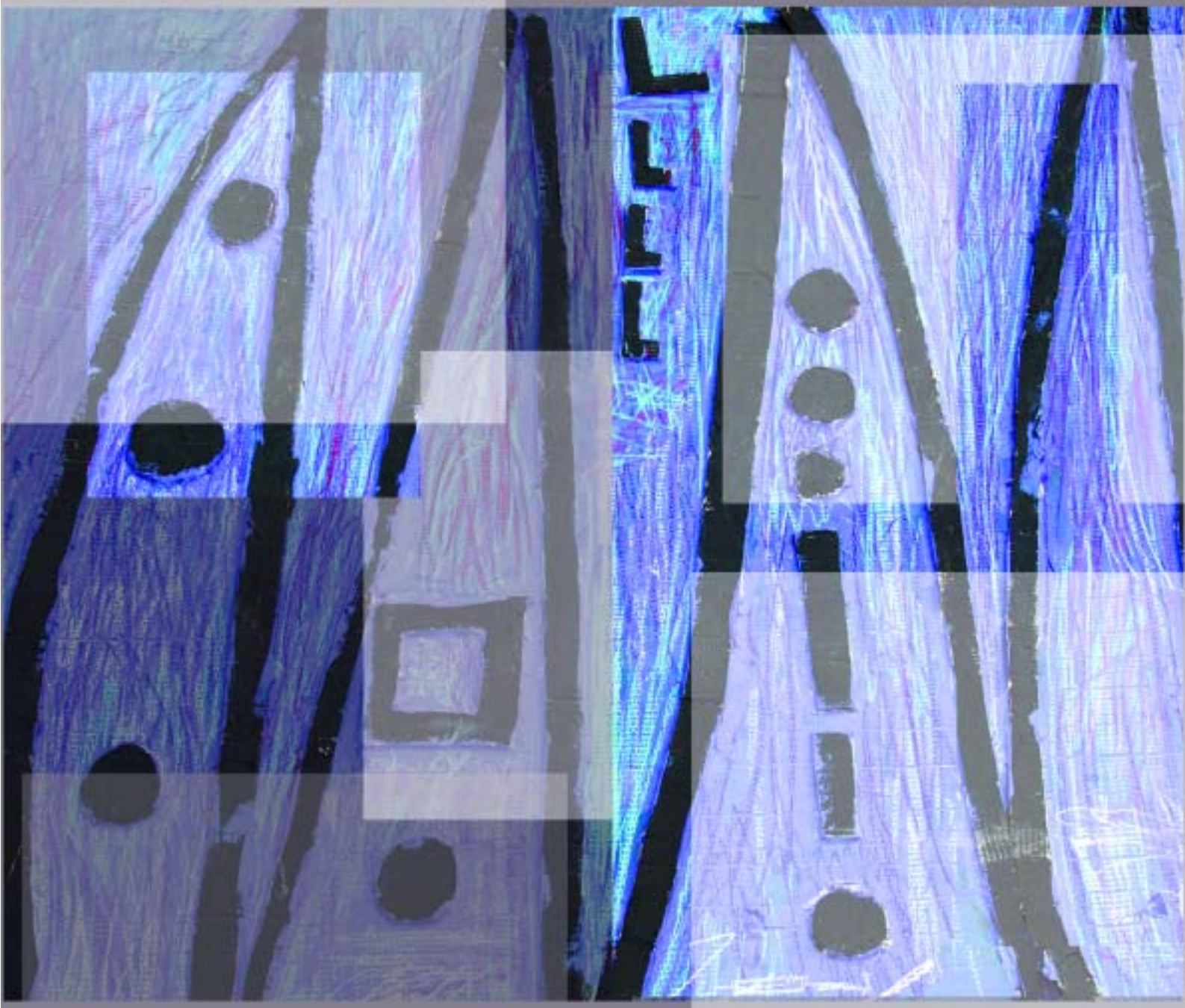
Improving Behaviour Through Therapeutic Approaches

Research into Practice in Nottingham City Learning Support Units



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The Structure of the report

This report is the culmination of a pioneering two-year research and development project funded by Excellence in Cities Nottingham. It is concerned with the use and effectiveness of therapeutic approaches and interventions for pupils who show challenging behaviour in Nottingham City secondary schools. The project is described more fully in Chapter 1.

As part of the research-side to the project, a mapping exercise was conducted in all Nottingham City secondary schools to establish what therapeutic services and approaches were being used as part of Learning Support Unit interventions with pupils who showed signs of challenging behaviour or who had social, emotional and behavioural difficulties (SEBD). This was followed up by two further stages of fieldwork: in-depth interviews with pupils, parents and professionals; and the establishment and assessment of nine pilot therapeutic projects. The findings of the mapping exercise can be found in Chapter 2; the results of the qualitative interviews with pupils, parents and professionals can be found in Chapter 3; the assessment of the pilot therapeutic projects can be found in Chapter 4. Chapter 5 discusses some of the key messages from this research for both policy and practice and the importance of evaluating therapeutic interventions so that the lessons can be learnt. These chapters will be of interest to readers outside Nottingham as well as to those who work in the City. They provide a unique source of research evidence on therapeutic interventions for pupils with challenging behaviour and SEBD.

Another major research dimension of the project was a review of the published research evidence on the effectiveness of therapeutic approaches for pupils in secondary schools. Computerised and other searches identified 1,500 texts that were scanned, with around 140 of these being relevant and specific to our current focus. Resource 3 provides a unique review and ordering of this research evidence, presented as an A - Z of therapeutic approaches. It brings together in one place the available research publications and will be an invaluable resource for policy makers and practitioners working in this field and who need to know the current state of knowledge and evidence on these therapeutic interventions. There are other Resources in this report that are also intended to be relevant and useful to practitioners, including guidance on what is meant by 'social, emotional and behavioural difficulties' (Resource 1); a commentary on the research criteria to be used when making judgements about the 'effectiveness' of therapeutic interventions (Resource 2); a Bibliography of relevant publications (Resource 4); and contact details of relevant organisations (Resource 5).

The report is in two major parts. The first part contains the five Chapters that report the research and development work conducted in Nottingham City. The second part contains the five Resources. Throughout the report we have also included 'signposts' to other relevant sections of the text, to help readers move between Chapters and Resources.

Professor Saul Becker

1
Learning Support Units and the Therapeutic Approaches Project in Nottingham

Saul Becker, Viv McCrossen and Carolyn Waterstone

The Therapeutic Approaches Project

The *Therapeutic Approaches Project* is the name of the research and development work funded through the Excellence in Cities programme between September 2002 and August 2004. It had five primary aims:

- To identify and map the diversity of therapeutic service provisions and approaches used with young people with challenging behaviour and social, emotional and behavioural difficulties (SEBD) attending Learning Support Units (LSUs) in Nottingham City secondary schools.
- To review systematically the available research evidence on the effectiveness of therapeutic approaches with this group of pupils, to determine whether there already exists a robust and reliable research evidence-base for 'what works'.
- To seek the views of a sample of pupils, their parents, LSU managers and other professionals, about their experiences, and their views of the therapeutic approaches that are used by secondary schools.
- To initiate a number of pilot therapeutic approaches and make some general assessment of their value for pupils with SEBD.
- To use the research and development that forms the basis of the Therapeutic Approaches Project to inform future therapeutic interventions and approaches used in Nottingham City secondary schools, and to inform thinking and developments at a national level.

The Project was managed by Viv McCrossen, Nottingham Excellence in Cities. The research was managed and coordinated by Professor Saul Becker. Two interim reports have been produced and disseminated as part of the Project:

1. An analysis of the mapping exercise and some preliminary evidence on what LSU managers in Nottingham City secondary schools see as effective therapeutic service provision and approaches (Becker, Sempik and McCrossen, 2003).

See Chapter 2 for a summary of the mapping exercise in Nottingham

2. The findings from in-depth qualitative interviews conducted with 44 respondents, including 12 pupils attending LSUs in Nottingham, their parents, LSU managers and other professionals (Becker and McCrossen, 2004).

See Chapter 3 for a summary of the findings from the qualitative interviews with pupils, parents and professionals in Nottingham

This report is the culmination of the Therapeutic Approaches Project and provides the main findings and conclusions of the research conduced in Nottingham and a full review of the research evidence on 'what works' in therapeutic interventions.

See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches

Learning Support Units, inclusion and therapeutic approaches

Many pupils with 'challenging behaviour' should be able to learn effectively in the mainstream classroom if there is good classroom management and a supportive environment. Other pupils will require extra and more specialist support and services. Depending on the extent and causes of their social, emotional and behavioural difficulties (SEBD), they may also require therapeutic interventions that are designed to ameliorate some of the negative aspects of their behaviour, as well as contributing to helping them make the most of their learning opportunities.

See Resource 1 for guidance on what is meant by 'challenging behaviour' and 'emotional and behavioural difficulties'

These therapeutic approaches include, for example, art therapy, music therapy, family therapy, counselling, social skills training and parent management training. The review of the published research literature on therapeutic approaches and the 'mapping exercise' conducted in Nottingham identified around 30 different therapeutic approaches used in secondary schools (see Chapter 2).

Therapeutic approaches can be delivered in mainstream classrooms (to all pupils) as part of a classroom management approach, however, these interventions are more likely to occur outside the mainstream classroom, in specialist Learning Support Units or other specialist provision, or in specifically designated sessions/events when used for pupils with SEBD.

Some pupils with SEBD attend LSUs within their (mainstream) school. Although LSUs vary in their approaches from school to school, they all provide separate short-term teaching and support programmes to disengaged pupils with difficult or challenging behaviour (Hayward, 2002, p. 6):

> *The Learning Support Unit exists to keep disaffected pupils in school and working while they are addressing their behavioural problems, facilitating their re-integration into mainstream classes as quickly as possible. Learning Support Units devise and support individual curriculum and behaviour packages so that pupils re-engage in the learning process, either in schools or elsewhere…. (Hayward, 2002, p. 6)*

Good practice guidelines for LSUs state that:

> *Equally important is for the curriculum to reflect strategies to improve behaviour, self-esteem, social skills, peer, family and school relationships… The curriculum should be tailored to individuals with an appropriate balance of personal and social education, circle time, anger management, behaviour strategies such as solution-focused brief therapy, handling conflict and counselling through one-to-one and group work sessions. Access to and use of Information Communication Technology is important…. (Hayward, 2002, p. 31)*

Thus, one key aim of LSUs is to provide therapeutic interventions designed to address pupils' challenging behaviour, in the context of reintegrating these pupils back into mainstream education wherever and as quickly as possible.

An inspection of LSUs conduced by Ofsted as part of a review of Excellence in Cities found that most LSUs are successful in promoting inclusion, tackling disaffection and reducing exclusions and provide good personal support for pupils, helping them in tangible ways to improve their behaviour. Ofsted identified that in LSUs where pupils were making the greatest progress the common features of good practice were:

- A well-organised working environment where there was good access to resources, particularly ICT, to support learning.
- Thorough assessment of pupils' attainment to inform lesson planning and regular review of progress recorded on individual plans.
- A varied programme of activities designed to develop each pupil's academic and social skills, including specific programmes to help pupils manage their behaviour.
- Clear criteria for entry to and exit from a placement, including the opportunity to attend mainstream lessons in subjects where pupils were successful.
- Liaison between the unit manager, form tutor, year head and parents, and with external agencies as necessary (Ofsted, 2003, p. 59).

Ofsted recognised that while a programme of therapeutic-related activities, geared towards helping pupils manage their behaviour, was a necessary component for good practice, this by itself was not enough: "In a quarter of the units [LSUs] staff focused heavily on discussion about improving behaviour, at the expense of work on improving pupils' learning. Much of this discussion

lacked focus and failed to follow basic counselling and support principles" (Ofsted, 2003, p. 60).

Thus, it is important that any therapeutic interventions are focused and applied according to appropriate therapeutic criteria. Wilson and Ryan (2002, p. 179) argue that it "is important to offer effective therapeutic interventions to emotionally damaged young people, so that they may receive help at a time when they are developmentally receptive to it."

A broad, systemic approach, drawing on a number of therapeutic interventions and their underlying principles and theories, is often advocated. Dwivedi, for example, argues that "Psychiatric disorders in children are invariably of multifactorial origin and are produced by the interplay between the child's constitution, child's past experiences and the child's living context (family, school, peer group, and so on)… It is, therefore, very important to keep the Interactional model in mind whilst managing such problems, that is the interaction of three Ps: the Precipitating factors impinging upon the Predisposing elements and Perpetuated by situational factors" (Dwivedi, 1993, p. 295). Thus, responding to children's social, emotional and behavioural difficulties requires interventions on a number of interrelated levels.

King and Schwabenlender (1994) suggest that many educators will be unaware of the "rich array of supportive therapies and thus do not use them" (p. 14). They go on to outline a range of therapies available. They also suggest that supportive therapies should not be seen as a 'magic pill', but rather as a useful repertoire of strategies to chart and respond to children's emotional and behavioural problems. They too suggest that a multi-strategy approach is needed: "Changing maladaptive and destructive behaviour is far too complex a task to rely on only one or a limited number of interventions. Various supportive strategies described herein offer great promise…" (p. 17). Kazdin (1997, p. 172) suggests that treatments which neglect the multiple domains and symptoms of child conduct disorder are likely to have only limited effects. The pupils who are most likely to benefit from therapeutic interventions are those with the least risk factors (such as age at onset of challenging behaviour, child-parent relationships, socio-economic disadvantage etc).

Learning Support Units in Nottingham

Learning Support Units were introduced into Nottingham schools in September 2000 as part of the Government's Excellence in Cities (EiC) initiative. The core strands of EiC included LSUs, Learning Mentors and Gifted and Talented with extra resources targeted at schools and pupils to enable them to achieve more.

See Resource 3, 'Mentoring (including Learning Mentors)', for the evidence on the effectiveness of learning mentors in secondary schools

The Nottingham EiC partnership of the Local Education Authority and secondary school headteachers decided to site a LSU in every secondary school using extra funding from the Pupil Retention Grant. This decision was made to reflect the fact that every school had concerns about the behaviour of a minority of pupils. However, each school is operating in a different context and therefore the nature of LSU provision varies across the city. What LSUs in Nottingham have in common with LSUs across Britain is that they were all established to respond particularly to the needs of severely disaffected and/or underachieving pupils in imminent danger of being excluded who would benefit from intensive support away from the classroom.

LSUs were not to be seen as a punishment but as a place where pupils could get support to overcome their difficulties. Most pupils receive support from the LSU on a part-time basis and attend mainstream lessons for the rest of the time. However, some pupils need more intensive full-time programmes.

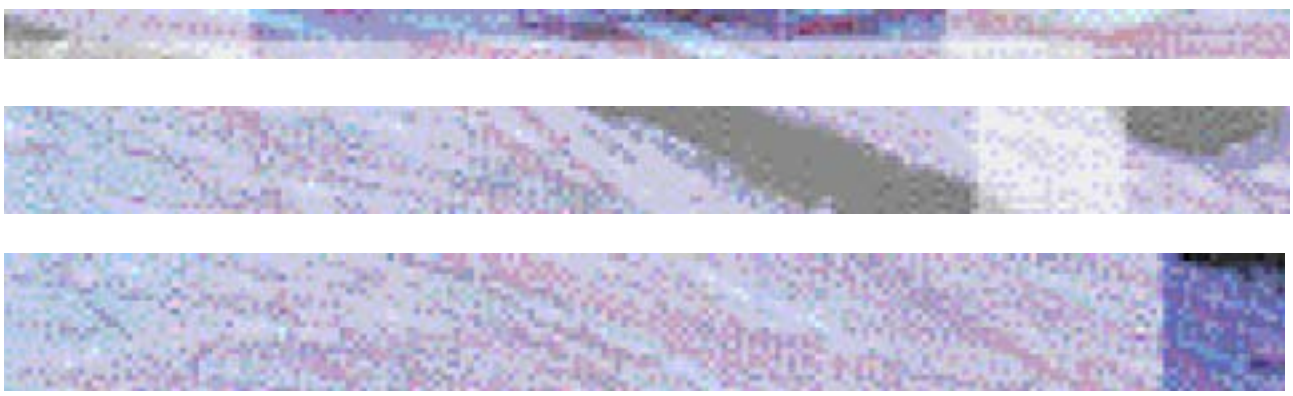
Between 2002-03, LSUs in Nottingham supported around 5 per cent of the school population, that is 779 pupils. Three quarters of LSU pupils are male (compared with 50% of male pupils in the City population); 47 per cent of LSU pupils are eligible for free school meals compared with 33 per cent across the City (Nottingham Excellence in Cities, 2003a, 2003b).

A snapshot survey of 13 Learning Support Units in Nottingham, conducted on 12th November 2003, found that:

- 163 pupils in 13 secondary schools were involved for some or all of the day in LSU curriculum or behaviour-based classroom activities.
- There were substantial variations in the number of pupils attending LSUs, ranging from 5 pupils attending one unit to 21 at another. The mean average was 12.5 pupils.
- 80% of the pupils were boys - which corresponds with the 2002-03 proportion for boys recorded in the Nottingham Excellence in Cities Information and Data report (Nottingham Excellence in Cities, 2003a). In three of the LSUs the intake on the snapshot day was exclusively of boys. In only one school was there a gender balance.
- Three quarters of the pupils in the LSUs were white.

Pupils in LSUs have an entitlement to a broad, balanced and relevant curriculum and, at the beginning of the initiative, there was an emphasis on ensuring that pupils were not disadvantaged on their return to mainstream classes. However, as LSUs in Nottingham developed, it became clear that pupils needed access to specific *therapeutic* programmes of support to address the issues that had led to their referral in the first place.

Various programmes were developed in the Nottingham LSUs and support was sought from outside school from statutory, voluntary and private agencies in order to address these needs. However, this was not being done in a systematic way and schools did not always have the knowledge and expertise to make informed choices. The LEA therefore put in a bid to the Department for Education and Skills to research what therapeutic provision was available to Nottingham schools and make recommendations concerning the most effective interventions. Funding was received for a two-year initiative - the *Therapeutic Approaches Project*. The remaining chapters in this report provide the findings from this project.



2
Mapping therapeutic services and approaches in Nottingham City secondary schools

Saul Becker, Viv McCrossen and Joe Sempik

In this and the next two chapters we focus on the use of therapeutic services and approaches in the City of Nottingham.

This chapter outlines the findings of an exercise to map the extent and use of therapeutic services and approaches by all the Learning Support Units in Nottingham's 18 secondary schools. This was the first aim of the *Therapeutic Approaches Project* described in Chapter 1. A detailed report of the methodology and findings of this exercise was published in June 2003 (Becker, Sempik and McCrossen, 2003). This report was disseminated widely to local Learning Support Unit workers and other relevant stakeholders. Here we present a review of the most relevant findings.

The first part of the chapter identifies the use of *therapeutic service provision* in Nottingham (in other words, it is concerned with mapping the providers of services and with providing information about these providers), while the second part of the chapter focuses on the use and perceived effectiveness of *therapeutic approaches* - such as anger management, social skills training, and so on.

See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches

See Chapter 4 for an assessment of the value of 9 pilot therapeutic projects in Nottingham

The therapeutic services used by Nottingham secondary schools

Each LSU manager in Nottingham provided details of their school and its overall experiences of using therapeutic services and approaches, and they also gave their assessment of the effectiveness of these services and approaches.

The mapping exercise identified 172 therapeutic service provisions used by the 18 LSUs within Nottingham City secondary schools in January 2003. All 172 of these provisions have been allocated to one of the 20 classes shown in Table 2.1. This classification groups together therapeutic service provisions of a similar nature and allows data to be presented in an understandable and useful format.

Table 2.1: Classification of therapeutic services provided in Nottingham City secondary schools

	Classification	Description
1	Social Services	All departments and provisions
2	Youth Offending Team	
3	Medical	Paediatrician, doctor, nurse (other than CAMHS)
4	CAMHS	Child and Adolescent Mental Health Service
5	Learning Support Unit	School-based LSU specialist therapeutic provision
6	Behaviour Support Service	LEA-based BSS (excluding LSUs and mentors)
7	Learning Mentors	School-based learning mentors
8	School projects	School-based projects other than LSUs or mentors
9	LEA Provisions	e.g. EWS, education achievement team
10	Counsellors	e.g. School and private counsellors
11	Government Initiatives	Education Action Zone and Surestart
12	Art	Art, music, theatre groups (external)
13	Sporting organisations/outdoor	e.g. Nottingham Climbing Centre,
14	National Organisations	e.g. NACRO
15	Youth Provisions	Youth schemes, projects, services & provisions
16	Training Support Agencies	Training agencies and college departments
17	Community Education Psychology Service	LEA
18	Voluntary Agencies	e.g. NSPCC
19	Substance Misuse Services	Specialist substance misuse services
20	Connexions	Government Initiative

Types and extent of therapeutic service provision used in schools

Table 2.2 summarises the use of different types of service provision using the classification shown in Table 2.1. So, for example, the Community Education Psychology Service delivers 15 therapeutic service provisions to the 18 schools. Art-related services are used in 4 schools, and so on. Table 2.2 also ranks the use of these service provisions so that the most used services are at the top of the list, with the least used services at the bottom. The most used service is thus Youth Provisions - 16 of Nottingham's 18 secondary schools used youth schemes, youth projects, etc. The next 'most used' types of service provision are Behaviour Support Services, Community Education Psychology Services and Learning Support Units' own therapeutic provision - all used in 15 schools. The least used type of service provision are Substance Misuse Services - a highly specialist service used in just 2 secondary schools in Nottingham City, and Connexions - used in just one school at the time of the mapping exercise.

Table 2.2: Use of types of service provision in Nottingham secondary schools, ranked by frequency

Classification	Use
Youth Provisions	16
Behaviour Support Service	15
Community Education Psychology Service	15
Learning Support Unit	15
Social Services	14
Learning Mentors	14
Child and Adolescent Mental Health Services	14
Local Education Authority Provisions	11
Youth Offending Team	10
Voluntary Agencies	10
Training Support Agencies	6
Medical	6
Counsellors	5
School Projects	5
Sporting Organisations/outdoor	4
Art	4
National Organisations	3
Government Initiatives	2
Substance Misuse Services	2
Connexions	1

The 'mixed economy' of therapeutic services

The largest provider of therapeutic service provision in Nottingham is the *statutory sector,* while the smallest provider is the *private sector.* Sixty (35%) of all service provision are based in the statutory sector; 45 (26%) are from the *education department* itself; 41 (24%) are from *'in house'* providers; 13 (8%) are from *voluntary bodies;* and 11 (7%) are based in the *private sector.* However, the private sector is the largest single provider of Counselling services to LSUs.

Waiting period for a service
There is no waiting time for 56 out of 171 service provisions. Put another way, there is immediate access to one third of the service provisions used by Nottingham schools.

- There is a one-week wait for 22 service provisions (13%)
- There is a 2-4 week wait for 38 service provisions (22%)
- There is a 4-8 week wait for 14 service provisions (8%)
- There is a more than an 8-week wait for 30 provisions (18%)

Specialist mental health and psychological services such as Child and Adolescent Mental Health Services (CAHMS) and the Community Education Psychology Service (CEPS) have the longest waiting time for a service. CAMHS is the single largest source of waiting for more than 8 weeks (accounting for 9 incidences out of the 30 where people have had to wait for longer than 8 weeks before they can receive a service). CEPS is the second largest source of waiting for more than 8 weeks (accounting for 6 incidences out of the 30 where people have had to wait for longer than 8 weeks).

Involvement of parents/carers in service provision
One in five (32 out of 172) of the therapeutic service provisions in Nottingham *did not involve parents/carers at all in discussions*. Thirty-six service provisions (21% of the total) *gave information to parents* but didn't involve them any further. One hundred and four service provisions (61%) *did involve parents* in more depth. Statutory providers - particularly Social Services, Youth Offending and CAMHS provision are among the few services that *always* involve parents.

Information given by service providers about pupils' progress
The services which are seen to be the *best* in providing progress information to LSU managers about the pupils referred to services are: school-based projects other than LSUs, national organisations, local education authority provision, art therapies, Government initiatives, Connexions and substance misuse services (even though the latter two were rarely used, they were good at providing progress information).

In total, 27 (17%) of providers were seen as *poor,* with another 10 (6%) seen as *very poor* in providing information about pupil progress. Well over half the LSU managers thought that the Child and Adolescent Mental Health Service (CAMHS) and Social Services (SS) were poor/very poor in providing progress information.

How do LSU managers choose a particular therapeutic service?
When the LSU managers were asked to identify the 'evidence base' on which they chose to use a particular therapeutic service provision, the majority (15 out of 18) said they had no specific evidence that they could cite. The comments made by LSU managers suggest that there are four primary reasons why a specific therapeutic service is chosen for a particular pupil with challenging behaviour:

- The service is seen as having *specialist expertise.*
- It is *established practice* to make use of the service.
- It is the *defined procedure* to use the service for specific behaviours or concerns (e.g. social services for child protection/welfare cases).
- All other *options* have been *exhausted.*

In no case was any service chosen explicitly on the basis of available evidence that showed the service to be the best available for a particular type of behaviour or child's needs.

See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches

Perceived effectiveness of service provisions
LSU managers were asked to judge the effectiveness of therapeutic service provisions based on their experience of using these services for pupils with challenging behaviour.

Art-related provisions and substance misuse services were seen as *very effective* by all LSU managers who had made use of them. Other services ranked as very effective/effective by most of those who had used them are (in order): Medical services, counsellors, school-based projects (other than LSU or mentors), local education authority provision, national organisations, youth provision, sporting organisations/outdoor activities, training support agencies and Government initiatives. Box 2.2 provides comments from LSU managers to illustrate why they view these services as *effective.*

Box 2.2: The most effective services in Nottingham: LSU managers' comments

Art Therapies
"A great opportunity to experience something different. All young people received a video of their work at the end".
"Available on campus. Fast response. Good activity that prompts positive behaviour".
"In-house provision - positive response - excellent resources and well thought out with positive outcomes".
"It encourages young people to talk about social issues that are affecting them".

Medical
"The medical team [nurse/doctor] had a good response time. Excellent feedback. Very approachable".
"Available via school. Fast response. Build good relationships".
"Excellent service. Response rate very good - developed good working relationships".

School Projects
"Improved young person's outlook and access to school, friendships and confidence. Very responsive service - evidence suggests early intervention with non-school attenders is most effective".
"In-house and prevents exclusion. Reduces stress for other members of staff. Young people achieve".

Youth Provision
"Accessible. Good with kids - skills based. Language very empowering for young people".
"The organisation knows young people on the estate and have developed effective relationships in the community - this is carried over to work in school".

The types of challenging behaviour referred to services
What kinds of social, emotional and behavioural difficulties are referred to services? Table 2.3 shows the types of behaviour that were referred to the different service provisions used by LSUs in Nottingham. They are ranked in order of frequency so that the most frequently referred behaviours are at the top of the list, and the least referred behaviours are lower in the list. So, for example, aggression among Nottingham secondary school pupils is the behaviour most frequently referred to a therapeutic service. Almost a quarter of all services in Nottingham involved aggression as the most referred behaviour.

Table 2.3: Most frequently referred behaviours to therapeutic service providers in Nottingham

	Percent
Aggression	23.0
Low self esteem	15.2
General emotional problems	11.9
Relationship difficulties	8.2
Parenting issues	4.9
Offending/potential offending behaviour	4.5
Learning needs	4.5
Poor attendance	4.1
Welfare/child protection	4.1
Attention disorder/hyperactivity	2.5
Complex behavioural problems/autism	2.5
Self harm	2.0
Health/sexual health/pregnancy	2.0
Substance misuse	1.6
Sexualised behaviour	1.6
Disaffection/non-cooperation	1.6
Bullying	1.2
Statementing	.4
Other	4.1
Total	100

See Resource 1 for guidance on what is meant by challenging behaviour and emotional and behavioural difficulties

The use of therapeutic approaches in Nottingham

We now turn to the *therapeutic approaches* that are used by services in Nottingham. Table 2.4 shows the therapeutic approaches that are used by the 172 service providers. It can be seen that *counselling* is used in 51 of the 172 service provisions. Put another way, just less than 30 per cent of all service provision in Nottingham provides some form of counselling. Additionally:

- one quarter of all service provision provides some group work;
- one in five provide consultation;
- 17 per cent provide social skills training;
- 11 per cent provide anger management, and so on.
- At the lower end of the Table, it can be seen that just fewer than 2 per cent of service provision contains some form of play therapy.

The frequencies and percentages in Table 2.4 exceed 172 and 100 per cent because each service provision can provide a range of therapeutic approaches.

Table 2.4: The therapeutic approaches available through the 172 service provisions in Nottingham

	Frequency	As Percentage of Number of Service Provisions (total = 172)
counselling	51	29.7
group work	43	25.0
consultation	34	19.8
social skills training	30	17.4
activity based	26	15.1
anger management	19	11.0
family therapy	19	11.0
psychological/ psychiatric assessment	14	8.1
parent training	12	7.0
family resource workers	10	5.8
brief solution focused	9	5.2
learning support	9	5.2
art/music/drama	6	3.5
assessment/ observation	6	3.5
medical/medication	4	2.3
play therapy	3	1.7
other	23	13.4

Location

Over two thirds (68 per cent) of all therapeutic sessions take place within a *school location,* another 12 per cent take place at the *young person's home,* 7 per cent at a *clinic* and 10 per cent at some *other educational location.*

Perceived effectiveness of the therapeutic approaches

Table 2.5 shows how each of the therapeutic approaches are judged by Nottingham's LSU managers in terms of their *effectiveness*. It must be emphasised that this ranking is of *perceived* effectiveness based on 'experience' rather than any systematic evaluation by LSU managers. The Table splits the overall ranking into a number of groups, with the first group being those therapeutic approaches that are ranked as *very effective/effective* by *all* LSU managers, while the fifth group lists those approaches that are ranked as very effective/effective by around *sixty percent* of respondents. There are 5 therapeutic approaches ranked as effective by all LSU managers in Nottingham: anger management, learning support/mentoring, assessment/observation, medical/medication and play therapy.

Table 2.5: Ranking of therapeutic approaches by their perceived effectiveness

Group one *(therapeutic approaches ranked as very effective/effective by all LSU managers)*
Anger management
Learning support/mentoring
Assessment/observation
Medical/medication
Play therapy
Group two *(therapeutic approaches ranked as very effective/effective by at least 90% of LSU managers)*
Activity based
Group work
Social skills training
Group three *(therapeutic approaches ranked as very effective/effective by at least 80% of LSU managers)*
Brief solution focused
Counselling
Art/music/drama
Group four *(therapeutic approaches ranked as very effective/effective by at least 70% of LSU managers)*
Consultation
Family therapy
Child protection
Group five *(therapeutic approaches ranked as very effective/effective by at least 60% of LSU managers)*
Parent training
Psychological/psychiatric assessment

- See Resource 2 for a discussion of how to judge the 'effectiveness' of therapeutic interventions
- See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches
- See Chapter 3 for what pupils, parents and professionals in Nottingham have to say about therapeutic approaches
- See Chapter 4 for an assessment of the value of 9 pilot therapeutic projects in Nottingham

Final comment

The mapping exercise reported in this chapter shows the use of therapeutic services and therapeutic approaches by all the Learning Support Units in Nottingham secondary schools in January 2003. It identifies the services and approaches that are seen by LSU managers to be most effective and least effective, and shows why LSU managers hold these views.

It is clear from the exercise that a wide range of service providers, from different sectors, deliver therapeutic services and approaches to nearly two hundred Nottingham pupils with challenging behaviour each school day (see Chapter 1). However, it appears that *how* these services are chosen rests not on a foundation of evidence on 'what works', but rather on existing practice, custom and on what is available locally - 'supply-led' services rather than 'needs-led' or 'evidence-based'. These are themes developed throughout this report.

3

"Pick and Mix"? What pupils, parents, LSU managers and other professionals say about LSUs and therapeutic approaches in Nottingham

Fiona Becker and Viv McCrossen

"I think with therapeutic approaches you have to use a different bit, it's like pick and mix, a bit of this and a bit of that helps. I don't think it's ever one whole thing and I don't think we've got time because these are real living children, we haven't got the time just to try one thing, we have to try a little bit of everything."
(Head of Year)

In the previous chapter we outlined the findings of an exercise to map the extent and use of therapeutic services and approaches by all the 18 Learning Support Units in Nottingham's secondary schools. In this chapter we present the results of forty-four in depth qualitative interviews with four groups of respondents: twelve pupils who were attending Nottingham LSUs because of their challenging behaviour; their parents; LSU managers; and other professionals. Providing the perspectives of 'users' of therapeutic approaches (be they pupils or any of these other stakeholders) was the third aim of the *Therapeutic Approaches Project* described in Chapter 1. A detailed report of the methodology and findings of this part of the study was published in May 2004 (Becker and McCrossen, 2004).

The chapter is in six sections:

- a profile of the twelve pupils who attended LSUs and who received therapeutic interventions;
- a review of the range of challenging behaviours that these pupils exhibited, from the perspectives of the different groups of respondents;
- the perspectives of our respondents on the issue of whether pupils have a 'choice' about attending a LSU;
- the perspectives of our respondents on the use and benefits of therapeutic approaches;
- the perspectives of our respondents on the outcomes of attending LSUs and of receiving therapeutic interventions, with a focus on the positive outcomes and problematic aspects;
- some final concluding comments.

The respondents

In-depth interviews were conducted with 44 respondents, including 12 pupils who, at the time of interview in 2003, were attending LSU support in seven of Nottingham City's secondary school. Half the pupils were girls and half were boys. The pupils came from years 8, 9 and 10 and were aged 13 to 15 years. All of the pupils were white except one who was African-Caribbean/white. Two thirds of the pupils lived in households headed by a single carer, one sixth lived with both parents and one sixth lived with a parent and step-parent. A brief profile of the twelve pupils can be found below.

The parents of nine of the twelve pupils in our sample were also interviewed (ten parents interviewed in total). Ten LSU managers were also interviewed. They had contact with ten of the pupils in this sample. In addition, twelve other relevant professionals were interviewed: heads of year (7), deputy heads of year (2), SENCO (1), form tutor (1), learning mentor (1), a staff member from the Multi Agency Support Team (MAST) and a youth worker.

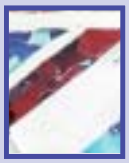
The pupils

Here we provide brief profiles of the twelve pupils with social, emotional and behavioural difficulties who were interviewed. All names have been changed to protect the identities of individual pupils and parents.

Anna

Anna is a 14-year-old, year 10 pupil. She lives with her mother and siblings. Anna was targeted for LSU support because of concerns about her behaviour and attitude. She was not fulfilling her potential and she was disengaged from the school curriculum. She was described as 'very manipulative' and she could be very offensive towards staff.

Anna attended a LSU full-time for all of year 10. The principal therapeutic approach used with her was a groupwork programme, which involved teamwork, outward-bound activities and community development work.



Krystal

Krystal is a 15-year-old, year 10 pupil. She lives with her mother, step dad and older sister. School were concerned about Krystal's low self-esteem and lack of confidence. They thought that Krystal was not achieving her full potential. She was identified as a very withdrawn and insecure young person who had difficulty making friends.

Krystal attended a LSU for the whole of year 10. She attended a LSU for 2 hours per day twice a week. The main approach used was groupwork, which involved team building, community development work and outward-bound activities, including a five-day residential trip on a boat.

Rachel

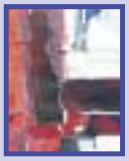
Rachel is a 14-year-old, year 9 pupil who lives with her mother and siblings. The family experienced a high degree of social problems and consequently there was a range of agencies involved including social services, CAMHS, youth services and MAST. Rachel was described as vulnerable by staff. Poor concentration and leaning difficulties meant that Rachel struggled with the curriculum and she could be very disruptive in class. She had periods of exclusion from school and was excluded from school at the time of interview for this study.

Rachel attended a LSU for a year, on a part-time basis. She received support for five hours per week from a teaching assistant in the LSU. The LSU sought additional support for Rachel from MAST, which she attended three mornings per week. Whilst at MAST Rachel was involved in a drama group, social skills group, and outward bound activities. She formed a close working relationship with one staff member who used cookery as a focus for re-engaging Rachel and building her self-confidence and skills.

Sophie

Sophie is a 14-year-old, year 9 pupil. She lives with her mother. She was referred for LSU support because she was missing lessons, truanting and being confrontational with teachers. Sophie was described as 'bright' but was underachieving and had become disengaged from school.

Sophie was the subject of a School Action Plus programme. The Behaviour Support Service worked with the LSU to assess Sophie's behaviour. Sophie attended a LSU for a year part-time. The main therapeutic approaches were anger management, counselling and support from a Connexions personal advisor. She also had a learning mentor. When Sophie was not in the LSU she attended mainstream classes with a monitoring card in order to keep track of her behaviour and attendance.

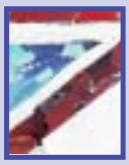


Claire

Claire is a 13-year-old pupil in year 8. She lives with her mother who is a single carer. Claire was referred to a LSU because of her disruptive behaviour in class, her low self-esteem and her sexually inappropriate behaviour towards male staff. Claire was already receiving additional classroom support at the time of the LSU referral.

Claire attended a LSU for a year part-time. A variety of therapeutic approaches were used with her during that time. She had a learning mentor, took part in group activities and attended a behaviour modification group, which included work on anger management. Claire also used the LSU on a drop-in basis when she felt she needed some time out of mainstream classes.

Claire's mother attended a parenting programme run by the LSU and consequently became more involved with the LSU and her daughter's progress.

Natasha

Natasha is a 14-year-old pupil in Year 9. She lives with her mother who is a single parent. Natasha was referred for LSU support due to her internal and external truanting, her disengagement from school, conflict with teaching staff, difficulties relating to other pupils and her outbursts of temper. As a consequence of Natasha's behaviour the school agreed she could attend school on a part-time basis.

Natasha attended a LSU for a half a day, every day. Natasha used her time in the LSU to catch up with basic literacy and numeracy work. The main approach used with Natasha consisted of support from Youth Services. A youth worker, with whom Natasha had formed a close working relationship, came into school to support Natasha with her schoolwork and additionally she worked with Natasha on an activity basis at a local youth project. As part of this off-site provision Natasha took part in organising a horse riding weekend trip.

Sam

Sam is a 13-year-old pupil in year 9. He lives with his mother and stepfather. He was referred for LSU support because he was having relationships problems with other pupils and getting into fights due to his outbursts of anger. He was already identified as a child with ADHD, managed by Ritalin.

Sam attended the LSU for most of his school day during year 8. However, in Year 9, this was altered to part-time due to changes in the operation of the LSU. He spent his time in the LSU on schoolwork. In addition, he attended a Youth Action Project one day a week at the local youth and community centre. Here he completed a social skills-based programme that explored self-awareness, self-assessment and behaviour management. A reward system involving sport and ICT was used to reinforce his progress.

Kieron

Kieron is a 13-year-old pupil in year 8. He lives with his mother. His behaviour in school was described as 'challenging' and efforts to manage it had previously failed. Kieron was frequently missing lessons, he had difficulty controlling his temper and making relationships with adults.

Kieron attended the LSU on a part-time basis, every day. He had support from a learning mentor. The LSU used a behaviour modification approach with Kieron as a means of reinforcing appropriate behaviour, particularly with respect to anger management. As Kieron tended to reject adults, a lot of time was focused on relationship building and social skills. He was paired with a teaching assistant in the LSU and together they completed a programme centred on football skills.

Max

Max is a 14-year-old pupil in year 9. Transition between primary and secondary school had been a major problem for Max. He was originally referred to a LSU due to his temper outbursts, swearing, and his disruptive behaviour both in and out of the classroom. There was concern that Max was putting himself in danger as he climbed out of windows and up walls in order to 'escape' from the classroom.

Max lives with his mum and siblings. A number of social problems, including neglect, were a feature within Max's family and consequently the family were receiving help from social services.

Max spent two years full-time in the LSU and at the time of interview was starting a reintegration package. He received lessons within the LSU provided by mainstream teachers. Additionally, the unit delivered a range of therapeutic approaches that Max benefited from which included anger management, social skills, drama and a ‘positive plays’ approach. He also attended a Trailblazer project, involving outward-bound activities, which was organised by the local youth services.

Josh

Josh is a 14-year-old, year 9 pupil. He lives with his parents. Josh previously had difficulties in his primary school. He was referred to a LSU because he was often missing lessons. When he attended lessons he was often verbally abusive to staff and he walked out of the classroom when challenged by them. He had temper outbursts that resulted in him throwing furniture. Some years earlier Josh had been a child protection concern. School considered that Josh's behaviour fell within the autistic spectrum, although this was not a formal diagnosis.

On entry to the LSU, Josh was timid and withdrawn. Josh was educated within the LSU where a behaviour modification approach was integrated throughout and this included regular feedback to parents. Because of the time Josh spent in the LSU he received a number of therapeutic approaches. He saw an individual counsellor from CAMHs on a weekly basis. He received a four-week programme from the Behaviour Support Service preparing him for the transition to key stage 4. Connexions also came into the LSU on a weekly basis. Josh attended a Trailblazer programme, which involved a range of outward-bound activities. Josh also used a soft play area within the LSU for relaxation and tension release.

Michael

Michael is a 14-year-old, year 9 pupil. He lives with both his parents and brother although his dad is often working away from home. A number of events led to Michael's referral to a LSU: minor petty stealing, getting upset in lessons and conflict with teachers. He was viewed as an unhappy young man and there was concern about his attitude towards school.

Michael spent two terms in a LSU where the main therapeutic approach was regular support from a learning mentor.

Curtis

Curtis is a 15-year-old pupil in year 10. He lives with his mum and siblings. He was referred to the LSU because he was an angry young man who had a violent temper. He was isolated in school and it was thought that he was being bullied. He had low self-confidence, low self esteem and he struggled with his schoolwork, which his mother attributed to his dyslexia. Curtis also skipped lessons.

Curtis received a combination of therapeutic approaches on and off site following a referral to the LSU. He attended a Youth Provisions project at a local community centre for four hours per week. This project involved groupwork, team building and focused work on health and life skills. In addition, Curtis received help with anger management. A behaviour modification approach was integrated throughout this work. He also went on regular trips out with the youth project. Within the LSU Curtis was part of an Excel group, which focused on developing social skills. The Attendance Team were also involved with Curtis.

What kinds of challenging behaviour did the pupils exhibit?

In the majority of cases reported here, the type of social, emotional and behavioural difficulty (SEBD) that led to a referral to a LSU can be described as 'acting out'. However, in one case a young person was referred because she was very withdrawn. The behaviours most often mentioned as a cause for referral were: being disruptive and misbehaving; pupil/teacher difficulties; internal truancy; low achievement; violent or dangerous behaviour; and difficulties with other pupils, including bullying and emotional problems. For example, pupils told us about their behaviour:

> *"I was sent out of the classroom a lot and I was shouting, shouting at the teachers and just doing my own thing". (Claire)*

> *"…because I was just disrupting classes and not being co-operative and just being a*

nuisance to the teachers and disrupting lessons". (Michael)

"...I was jumping off roofs, out of windows, dashing [throwing] knives, scissors, paper…". (Max)

"I was walking out of lessons, not listening to any teachers, swearing, running, not going in my lessons at all". (Natasha)

Parents also recognised the seriousness of their children's behaviour:

"If he hadn't gone there [to the LSU] it would've been an exclusion and he would've been permanently excluded, and they've helped him no end".

"He was playing truant from school, couldn't keep him in school. He was having a lot of problems with other children…he was being picked on".

"[She was] running round school, wouldn't go into school, wouldn't do as the teachers tell her".

"Well he was being bullied, quite a lot, virtually three or four times a day he'd come home crying his eyes out wanting to get knives out and things to go and attack somebody that had just picked on him. Which didn't help so I had to restrain him and keep him at home. Basically he had problems with understanding the questions that the teachers were asking him in lessons because he suffers with dyslexia".

LSU managers also talked about the behaviours that had led to a referral:

" …because of poor behaviour, failing to attend lessons and truancy. There were learning issues, it was all behaviour, emotional and attendance". (about Sophie)

"…because he was a high profile pupil in mainstream because his response to challenge is to walk out, to be abusive, verbally abusive to teachers". (about Josh)

"He was presenting, he's been quite an angry young man, quite isolated and on his own, a temper on him that often got violent". (about Curtis)

"Violent behaviour, temper outbursts, not coping in lessons at all". (about Max)

"The main reason was sexually inappropriate behaviour. There were concerns about male staff being in classrooms with her on their own and some general misbehaviour". (about Claire)

All of the other education professionals agreed that the pupils required support from a LSU due to challenging behaviour. For example, the head of year commented that Michael needed LSU support because:

"…there was a number of incidents which led up to this. Minor petty stealing, getting very upset in lessons, generally getting himself into all sorts of problems and difficulties which resulted in staff, you know, sending him to see me or the deputy".

In relation to Josh, his head of year said:

"…he wasn't coping in the lessons, he wasn't attending the lessons and it was becoming a problem where he was actually internally getting onto the brink of externally truanting in school. And this appeared to be some emotional reason why he wasn't going to lessons".

In contrast, Anna's difficulties concerned her behaviour towards staff. The head of year said of Anna:

"She was very manipulative…a crafty little girl. She could be very offensive to staff but in a very controlled way, she wasn't, she's not a pupil that's angry or this, you know she just lets it go. She's been very controlled, she knows what she is doing".

Max's behaviour caused concern for his head of year:

> *"He's a tiny little boy, swinging from banisters, climbing on windows, climbing on the tables, jumping across the chairs you know it was basically that sort of bizarre behaviour, it was very attention seeking behaviour".*

Rachel, like Max, presented similar concerns to her support worker at MAST:

> *"Rachel finds it very difficult to be in large groups. So her behaviour in the classroom situation was sort of very bizarre, she'd perform funny little dances, wouldn't listen to the teacher and she finds it very hard to do work unless somebody is sitting with her one-to-one. And a lot of time, because she struggles so much in the classroom, she decides she can't do the work so she just walks out the classroom".*

In a few cases the school had already been alerted to a child's behavioural difficulties by their previous primary school; for example, the deputy head at Clare's school said:

> *"Her behaviour on entry and previous information about her behaviour at primary school had given us, had alerted us to her needs. The behaviour over the first term and a half actually put that in perspective and she was an extremely difficult youngster to manage within a classroom or to allow to achieve any form of success".*

See Resource 1 for guidance on what is meant by 'challenging behaviour' and 'social, emotional and behavioural difficulties'

Do pupils have a 'choice' about going to a LSU?

It was apparent from the interviews that LSUs across Nottingham have different practices as regards to referral. In some cases there is a policy of self-referral as well as formal referral through the school. There was a wide variation across the LSUs in terms of how they are used, how much time pupils spend within them, what activities they undertake whilst there, which therapeutic approaches are used and whether pupils were involved in any additional off-site provision. Consequently, direct comparisons between pupils are difficult.

As far as pupils were concerned, however, seven thought they had 'no choice' at all about attending the LSU. They said either their parent(s) had wanted them to go to the LSU, or they believed that had they not gone then they would have been excluded from school. For example:

> *"Well I had no choice because my mum wanted me to go and I did want to go but then I didn't want to go. So it was just scary going back into school after that long being excluded". (Rachel)*

> *"I think I didn't have any choice because I think they would've excluded me or chucked me out of school". (Claire)*

The remaining pupils perceived that the LSU referral was appropriate given their behaviour; indeed many pupils said that they had wanted to be in the LSU and they did not perceive it as a 'punishment'.

All of the parents had been in agreement with their child being supported by a LSU. In six cases the parents thought that their child wanted to go into a LSU because their child wanted the chance to be involved in the activities offered by the LSU, or because their child realised they needed extra support:

> *"He looks forward to it, he literally loves going there and he says they actually talk to him one to one, they treat him as an adult and they*


respect him, which isn't what he was getting in full-time classrooms".

"…I think he saw it as a way to help him, I don't think he sees it as a punishment".

The majority of LSU managers said that the pupils started off with reservations about attending a LSU but became more positive about it once they had engaged with the staff and activities. For example, Josh's LSU manager commented:

"He [Josh] saw it as compulsory certainly but settled very quickly to this different environment, to not having the challenges of being on corridors, the things that really wind him up and having clear expectations and clear instructions that sometimes he was not accessing in the mainstream. Not to say the instructions weren't clear in mainstream classrooms but he needs to be in a much smaller classroom environment".

As far as all our respondents were concerned, the issue of choice or compulsion to attend a LSU did not seem to affect the eventual outcome for the pupils (see the section on Outcomes later in this chapter).

Other education professionals confirmed that in the majority of cases pupils did not have a real choice about whether or not they attended the LSU, in that the schools in conjunction with parents made the decision. Other professionals confirmed that most of the pupils were either negative or ambivalent about attending a LSU but that this attitude soon changed once they had become engaged with their LSU. This ambivalence was attributed to pupils fearing the unknown, being away from friends or feelings of being punished.

Perspectives on the therapeutic approaches

LSU managers reported that they identified the appropriate interventions for each pupil based on his or her specific needs. To meet these needs LSU managers drew on a range of approaches that were available within the school, for example learning mentors, behaviour management, group work, and anger management programmes (see Chapter 2 for a listing of all the therapeutic approaches used in Nottingham schools). Additionally, they linked pupils to a range of activities provided by external agencies such as Connexions, the local CAMHS team, Youth Services, MAST and the Princes Trust initiative. In some cases these external agencies were providing the main therapeutic approach for pupils in LSUs.

For some pupils a range of therapeutic approaches was needed to address different behavioural and developmental problems. For example, Kieron attended the LSU for much of the time he was in school and the LSU manager thought this pupil saw the LSU as a safe retreat. The programme for Keiron consisted of anger management work, support from a learning mentor who primarily built a relationship through using football as a shared activity, and a behaviour management approach involving target-setting and rewards. The LSU manager thought that each element of this package helped Keiron in different ways: the anger management helped him to reflect on his experience and behaviour; playing football provided him with a one-to-one relationship; and target setting helped him to focus on his behaviour. As a consequence of these interventions the LSU manger said about Keiron:

"… he's much more confident and able to talk to people…He's able to listen, his time that he needs to calm down does reduce…he smiles now, probably for the first 3 months of our intervention I'd never seen his teeth."

Anna attended an Excel programme (Princes Trust initiative) which involved spending four hours per week engaged in activities such as group work, citizenship, outward-bound activities and individual work aimed at raising self-esteem. Behavioural approaches are used to encourage positive behaviour. The LSU manager considers that these activities helped Anna to better relate to others and to improve her behaviour in school.

Josh had weekly input from the behavioural support service and Connexions. Josh has had behaviour modification running through and all his lessons were delivered with a focus on emotional literacy, behaviour management and self-awareness. Staff in the LSU had helped as they had "provided [Josh] with an unconditional supportive relationship". As a consequence Josh settled quickly to clear expectations and instructions.

The LSU manager for Claire described the range of approaches that were used: a learning mentor helped Claire to establish a trusting relationship; in addition she received in-class support, attended a behaviour modification group and took part in group work activities.

None of the LSU managers cited published research evidence as the basis for their choice of approach, rather they gave other reasons for choosing a particular therapeutic intervention, namely: the nature of the pupil's problem; prior knowledge of the approach working with similar children in the past; there being no evidence base as it was a pilot programme; or that the therapeutic approach was an available resource in school:

> *"It's one of the approaches [anger management] that we had available at the time, it's proven to work with various other youngsters and it's one that if it wasn't working or was inappropriate we could have taken Curtis off and found something else for him".*

> *"It was an option [Youth Action Project] that was made available to us at the beginning of the year and he seemed like a suitable candidate". (about Sam)*

> *"…we've heard of a similar programme ['play programme' includes behaviour management and social skills] that has worked and also you know it's been a big team effort and everybody has worked all over the place. And you know we thought this approach would be really, really beneficial to the pupils". (about Max)*

> *"Well I think his mum was quite keen to have one [learning mentor] and I think it was talked about by the heads of year and my line manager and it was just decided that was the way we would go now with him". (about Michael)*

None of the other professionals referred to any published research that might have been used to inform the choice of therapeutic approach. In a third of cases these professionals thought the approach was chosen because of previous experience of this intervention being successful in school with other pupils and/or because the resource was already available in school. This use of 'professional wisdom' - knowledge based on practice experience - can be an important source of evidence, particularly in the absence of formal research evidence.

The pupils themselves identified the therapeutic approaches that they found most helpful. Half of the pupils said that they thought that working on anger management had been particularly helpful. For example:

> *"…it used to calm me down a lot and it helped me from getting angry. But counselling…hasn't helped me as much as anger management has, that's why I like it more". (Sophie)*

> *"Losing your temper doesn't actually do anything… it just gets you in more trouble, it's not proving anything at all". (Max)*

Two pupils mentioned that their learning mentor was very helpful. For example:

> *"she's just very good at understanding how to deal with problems and how to stop problems occurring before they get too big…". (Michael)*

Three pupils said they were seeing a counsellor regularly. However, only one of them said this was helpful whereas the other two described this as 'boring'.

For some pupils it was the activity itself that they found beneficial, be it football, playing computer games, cookery, art, outward bound activities, positive play or project work on drugs, relationships or sex education. This suggests that what is important is identifying an activity which engages the individual pupil's needs and interests and which motivates them to take part.

All of the pupils, except one, said they found the staff helpful. Many pupils appreciated the relationships they had developed with the staff in the LSU, citing that they were easy to talk to, helpful with schoolwork and supportive. Having a meaningful relationship with one person, be it a learning mentor, teacher, youth worker etc., was valued highly by these pupils. Girls in particular mentioned this in the interviews:

> *"…they [teachers] help us with our work and they speak to us". (Anna)*

> *"[teachers] help me with my work and help me with my classes, like timetables and sometimes they help me with my behaviour". (Rachel)*

> *"…they're nice to you but they're strict like they don't let you talk and stuff which is probably good because otherwise people are going to take advantage of it". (Michael)*

> *"They have to take a lot of naughty kids on and they have to try and stay calm with them and explain to them, keep them in control and that". (Sophie)*

Parents confirmed the importance of activities and relationships. In two thirds of cases the parents had a good understanding of what activities their children were undertaking in the LSU. They identified that the approaches were effective either because of the activity itself, which enabled their child to gain a new skill or insight, and/or because of the relationship that their child formed with an adult (teacher, learning mentor or youth worker). Several parents said that it was the individual attention and time provided either by the LSU staff, learning mentor or youth worker that made the real difference to their child and that this was the most helpful aspect of the LSU:

> *"They [LSU staff] communicate better, they seem to understand the child's problem and be able to bring it out of them and they seem to have more time. Whereas the ordinary teacher who's got forty kids in the room cannot spend that much time with one child".*

> *" I think they've just got a bit more time for 'em. Do you know instead of like if they did something wrong it's not a major catastrophe for them; they can spend more time with each kid. And the groups aren't that big are they so there's more hands on".*

> *"…she gave him time, she showed him that she respected his feelings, you know all the things I desperately needed someone to do…but that type of relationship isn't possible within the normal teaching classroom setting…".*

Some parents could not identify any single aspect that helped their children the most; rather they thought it was the combination of the staff, activity and environment together.

Some parents could not identify one individual approach that had been helpful either because their child was involved in a package of activities and they could not separate out one in particular, or because they did not understand enough about what approaches were being used, and why.

Over half the parents did not identify any problems in relation to the therapeutic approaches in the LSU. However, two aspects caused concern for a minority of parents:

- Their child was attending school part-time by arrangement with the school.
- They did not consider they were sufficiently knowledgeable about the activities that their children were doing and/or their children's overall progress in the LSUs.

All of the LSU managers and other professionals who were interviewed were able to identify approaches that had been particularly beneficial to individual pupils. They also reported that the intensity of LSU involvement varied enormously between the pupils. Some pupils had more individualised programmes and one-to-one work whereas others were primarily undertaking a group work programme. Improvements were noticed in pupil behaviour even where the approach was less intensive. Two LSU managers, for example, reported:

"She actually felt for the first time that she could be part of the solution of her own behaviour and actually started to make herself step back as opposed to us stepping her back when we see situations come in". (about Claire)

"…she has matured, I think this is the word, and she does not fly off the handle anymore, she now stops and thinks and controls her emotions. Even if there's been a big problem out of school she won't now fly off the handle she'll come to the base [LSU] first". (about Sophie)

A third of pupils in our sample received support from a learning mentor as either the only intervention or as part of a package of interventions from the LSU. In all cases the other professionals were positive about the impact of learning mentors:

"I think because we recognised that somebody like Michael needed to develop a relationship with someone he could talk to. He finds it difficult to talk to me and he needed that regular contact of someone who would see him every week and develop that relationship. So we've had to try and tease out what his problems were and get him to verbalise the sort of things that were causing problems".

The only downside of having a learning mentor, mentioned by one professional, was the disruption it caused, as the pupil was withdrawn from class for his session.

Several professionals spoke of the effectiveness of target-setting with pupils, either in the LSU or once they were back in mainstream class.

Several professionals said they could not identify one single approach that had been effective because these could not be disaggregated from the whole experience in the LSU.

See Chapter 2 for details of the therapeutic approaches used in Nottingham schools and what LSU managers have to say about them

See Chapter 4 for an assessment of the value of 9 pilot therapeutic projects in Nottingham

Outcomes of attending LSUs and receiving therapeutic support

Broadly speaking, pupils had a positive perception of LSUs. When asked about the best aspects of the LSU the most common responses were: the helpfulness of staff; better able to get on with schoolwork; and the activities/trips. For example:

"The best thing is that I don't really have teachers shouting at me to tell me to do stuff. Because sometimes the teachers really have a go at you for basically no reason". (Curtis)

"Probably you get a lot of work done because you haven't got everybody around you, you can just work". (Michael)

Most pupils thought that the LSU had prevented then from being suspended or excluded:

"because my temper is too bad, I would've been excluded straight away". (Max)

"I would've got kicked out of school straight away if I was in mainstream". (Rachel)

Pupils thought that the worst aspects of attending a LSU were: doing a particular activity; bullying by other pupils in the LSU; or being away from friends.

All of the pupils identified that their behaviour had improved significantly as a result of LSU attendance. The majority of them said it was their behaviour in school that had changed the most. Over half the pupils thought that it had also helped them to improve relationships and behaviour at home.

All the parents also thought that going to a LSU had helped their son or daughter and, in the majority of cases, they observed that there had been a significant improvement in their child's behaviour. Many realised that without the additional support their child may well have been excluded from school. Several parents said their child had made progress in their general education as a result of LSU attendance, which in turn enhanced their child's confidence and self-esteem.
For example:

"…at school and family it's [the LSU] helped quite a lot. It's calmed him down a lot at home, it's kept him in school where he's not walking the streets and not getting into any bother. And it's also helping him to make friends as well…".

"She's a lot more outgoing now... she started mixing with other people a bit more".

"Well he actually now stays in all his lessons at school instead of wandering the corridor where he used to wander round school all day and not learn anything. Now he's actually learning something which it's really helped him there. He's better with me and his sister. He's very good with his nephew".

"It's done him the world of good through being in there [LSU]. He seems to learn more as well in there whereas if he was in mainstream school he wouldn't have learned nothing".

It was very rare, however, for any of the parents to talk about how the LSU had helped themselves. Parenting programmes had been identified as one of the approaches used in two cases although none of the parents involved spoke about the impact of these.

In all cases the LSU managers thought that it was better that the pupils had attended the LSU than remaining in mainstream classes. In half of these cases the managers thought that without LSU support the pupils would have either had more fixed term exclusions or would have been permanently excluded. In the remaining half of cases the managers thought that pupils would have been in further trouble, hurt themselves or would not have made any improvements in their behaviour had they not received LSU support.

In several cases managers described how the relationship between the LSU and parents was initially poor either because of previous relationship difficulties between school and home or because parents were ambivalent about LSU support. In several instances the LSUs were successful in changing this relationship to a more co-operative one where parents felt involved.

All the LSU managers and other professionals identified positive outcomes for the pupils as a consequence of attendance at a LSU and receiving therapeutic support, echoing the interview findings from pupils themselves and their parents.

The deputy head of year at Kieron's school, for example, thought that the most helpful aspect of the therapeutic approaches had been the focus on building Kieron's emotional literacy so that "he could understand that actually emotions are okay". The provision of support for his mother was also an extremely important component of the work with Kieron. Similarly in relation to Josh, the head of year spoke of providing Josh with an emotional curriculum because "he didn't have a way of actually explaining to anybody how he felt. His way of explaining it was his actions". In response to this the LSU approach was that in "Every curriculum area there is the use of words for anger and feelings. Anything to do with emotion is put right across History, English, Maths, everything because that actually gives a child the language in order to be able to express themselves".

Claire was described by the deputy head of year as "extremely difficult to manage within a classroom or to allow to achieve any form of success". The deputy head of year considered that the LSU had been very beneficial for Claire: "It's changed rather than managed her behaviour". She thought that two approaches had been particularly helpful to Claire: anger management and cookery:

"The anger management gave her the tools to look at herself and to address her particular needs and the cooking because it's given her a huge personal boost…I mean the cookery works because it's not seen as cookery in its own, you know there's much more under there".

Positive outcomes

LSU managers and other professionals identified a number of major positive outcomes of pupils' attendance at a LSU and receiving therapeutic interventions.

The development of friendships both within the LSU and outside of it; for example:

> *"… he's become a lot more amenable to everybody and a lot more tolerant of everybody as well". (LSU manager about Max)*

> *"It helped him with friendships, it's helped him with accessing the curriculum because before he was spending a lot of time out of the class room on the corridor or in confrontations with peers and with staff whereas now that's certainly improved so that he's accessing the curriculum more. He's making friends and he's learning some, raising his self esteem". (LSU manager about Josh)*

Progress with schoolwork due to the LSU environment and the individual attention:

> *"I think when they're down here it's excellent because it's a very quiet place, they've got time to think about what they've done, think about their behaviour, they've got time to catch up with the work that they're behind with. They actually do a lot more work in there than they would do in class because there's nobody to distract them and they work quietly. And I think the majority of them when they go out are quite surprised at how much they've actually done". (LSU manager about Michael)*

The development of a trusting relationship between pupils and staff (be they a teacher, mentor, youth worker). This was frequently identified as an important factor in helping pupils to change and to feel supported. The qualities that appeared to make the relationships between staff and pupils particularly effective were: time, patience, unconditional regard and respect that staff gave to pupils attending a LSU. For example:

> *"The staff take a lot of time, a lot of patience, build up, you know try really hard to build up a positive relationship with her which is quite difficult with Krystal because she tends to be very, very, very quiet, very insecure and can be quite difficult to draw out of her shell some days". (Professional about Krystal)*

Improvement in pupils' behaviour. In line with all the other interviews in this study managers and professionals saw changes in pupil behaviour in school as a consequence of LSU attendance. While the extent of change was variable amongst the pupils the vast majority of managers and professionals thought that without the LSU intervention these pupils would not have remained in school. Some common themes emerged about the types of improvement. Several of the sample mentioned that pupil self-esteem was markedly improved. There were also remarks about pupils being more sociable, pleasant and less confrontational.

Maintaining a working relationship with parents.

Some of the professionals appreciated the importance of working with parents in order to enable them to have a positive view of school as well as helping to support the interventions of the LSU. For example, Claire's mother initially had a poor relationship with school but this changed as a consequence of Claire's attendance at the LSU and the relationship that staff developed with her - to the extent that Claire's mother is doing voluntary work in school and she is better able to manage her other children too. Kieron's deputy head of year also observed:

> *"I think that the most significant thing for me was when mum came to the graduation and met Mrs L and met the parents of other students and she felt relieved and supported that her son was not on his own. As a result of that what we're doing is we're having a surgery for any parent to come in and sit and talk to other parents or me or the EWO. Because when they came and sat in this space to look at what their kids had done it's probably the first positive experience they'd had about their kids in educational terms".*


The head of year in Josh's school explained how useful it had been to meet with Josh's mother as part of understanding his past experiences. He thought that the support given to Josh's mum enhanced her confidence too.

Problematic aspects

The problematic aspects identified by LSU managers and other professionals included:

Attitudes of other staff or pupils who thought it unfair that pupils who were perceived as 'naughty' or 'difficult' were being 'rewarded' by way of extra attention or 'treats'. One professional said that other pupils were envious of the types of activities on offer in the LSU. One had noted that some pupils misbehave in order to be sent to a LSU and that well-behaved pupils questioned why they were not being rewarded with LSU-type activities.

Stigma. LSU managers described the stigma that was attached to LSU attendance, presumably because LSUs are regarded as a place to contain pupils with 'problems'. This stigma affected the pupils' initial reaction to LSU attendance, making them wary about attending the unit. Some LSUs have tried to overcome this by renaming the LSU, for example calling it 'Base' or 'Space'.

Dependency. Several professionals said that it could be very hard for pupils to leave the LSU especially where they were settled within the environment and secure in the relationships they had made with staff. Developing an exit plan for each child was therefore seen as crucial for pupils. In some cases an 'open door policy' was used to ease the transition between LSU and mainstream school:

> *"LSU-wise Natasha has become institutionalised herself by not wanting to come back out into school and that's been, that's the main problem. Her exit plan has not worked because she's not wanted to be part of that". (LSU manager about Natasha)*

> *"The main problem that Sophie is going to face is with the closure of the school and moving to another one. She is again now at this particular point starting to exhibit behavioural problems that we had twelve months ago and that's because of insecurity. What will happen when she goes to another school where she's not going to know the staff and everything is new is what I fear". (LSU manager about Sophie)*

Managing relationships between pupils within the LSU and managing a range of challenging behaviours. Many of the LSU managers and other professionals reported how difficult it was to manage relationships and behaviour in the LSU. Despite having more time for working with pupils, their behaviour could often still be difficult.

Missing out on schoolwork. Some professionals were concerned that pupils attending LSUs were missing out on completing the core curriculum but they appreciated that in some ways this was a sacrifice to be made if difficult pupils were to be held in schools and enabled to work on their other needs.

See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches

Final words

It is evident from the in-depth interviews with our forty-four respondents that attending a LSU and receiving therapeutic support as part of a package of interventions can have many positive (as well as some problematic) outcomes. Many of the positive aspects were recognised by all our respondent groups: pupils, parents, LSU managers and other professionals.

It also seems clear that the selection of a therapeutic approach for a particular pupil has far more to do with what is available ('supply') and what has already been tried before ('custom' and 'experience'), than it has to do with any appreciation of what works ('evidence-informed practice'). This was also a finding of the mapping exercise reported in Chapter 2. However, as the A - Z of therapeutic approaches in Resource 3 shows, most therapeutic interventions for pupils with SEBD have simply not been evaluated formally, so there is little

reliable research evidence on what is or isn't effective, and why. In the absence of this research evidence-base, making a judgement about what approach to use based on custom, experience or supply becomes a necessity.

Thus, "Pick and mix" can be both sensible and deliver good results, as the interviews reported in this chapter show clearly. From all perspectives (pupils, parents, LSU managers and professionals), therapeutic interventions as part of a LSU package of support can have real beneficial outcomes including improvements in pupils' behaviour and relationships. There is no doubt that certain factors contribute greatly to any beneficial outcomes, not least the time and space that pupils have in LSUs; the relationships and trust that they are able to build with staff who care; and the activities that pupils undertake - which interest, motivate and engage them. These seem to be at the core of the therapeutic experience for these pupils. Separating the effects of these core characteristics of trust, time, environment, relationships and activities from the specific or unique nature of any particular therapeutic intervention (such as anger-management, social skills training etc) is complex. We cannot be sure whether there is something else about 'anger management' or any other therapeutic approach (over and above the focus on relationships, the activities that are done, the trust that develops etc) that has a key impact on outcomes for pupils with challenging behaviour in secondary schools.

See Resource 2 for a discussion of the research criteria that is used to judge whether or not a therapeutic approach is effective

See Resource 3 for the published research evidence on the effectiveness of 31 therapeutic approaches

4
“The trend is right”: Piloting therapeutic projects in Nottingham - a preliminary assessment

Richard Silburn, Pat Silburn and Viv McCrossen

> *"The first person to notice any change in behaviour is the parent. It takes a bit longer to filter through at school. All the parents have come back to say there have been positive improvements, every single one. It goes up and down, of course, but the trend is right". (Homeopathy Project Worker)*

One of the principal objectives of the Therapeutic Approaches Project was to "establish, run and monitor a limited number of pilot therapeutic projects in a few Nottingham schools to identify models of good practice and effectiveness" (see Chapter 1). Schools were invited to put forward costed proposals and in the end nine were chosen and the necessary funding was granted. In most cases the projects were relatively short-term, typically to last for one term, although one was from the outset intended to last for a year; another project has now been extended for a further period. Given the short duration of many of the projects, it was evident that it would not be appropriate to attempt a thorough, formal project evaluation. Nonetheless it is possible to make a preliminary assessment, drawing upon the experiences of the providers and participants while their memories are fresh.

It was in this spirit that in February 2004 a letter was sent from the research team to each LSU manager to say that towards the end of the pilot project a meeting would be arranged with members of the research team "for an informal discussion…(to) focus on the following themes:

- how and why did you choose your particular project,
- aims and objectives, especially any special or unusual ones,
- is it directed at any particular group of young people,
- how has the project gone (so far),
- any particular problems encountered,
- have you noticed any changes in pupil-behaviour or attitude,
- are there any lessons or advice for other LSU practitioners who might wish to replicate the project,
- if you have been evaluating the project as it has evolved we would like to hear what conclusions you may be reaching.

In addition, there may be other points that you would like us to stress, and if so we would be interested to hear them."

These meetings duly took place in each school between March and May 2004, and over the same period Viv McCrossen, the Project Manager, met with small groups of pupils to get some feedback from them about their experiences. The tape-recorded discussions with the managers, and in one case the service-provider, and with the groups of pupils form the basis of this chapter. Each project will be briefly described, and the more important and revealing of the themes listed above will be reviewed. The chapter will conclude with some observations and recommendations about good practice that could be of use to other LSU managers contemplating similar programmes of activity.

The Projects

We are concerned with nine projects, located in six different secondary schools in Nottingham. Some of the projects were organised and run entirely in-house; others used external providers and consultants, either working on their own or in partnership with LSU colleagues. Figure 4.1 gives a brief summary outline of each project and is followed by some more detailed comment.

Figure 4.1: The 9 pilot projects

School	Project name/type	Description	Target group
Bigwood	Art	A rolling programme of workshops to focus on the use of acrylics to express mood and feelings through colour and texture.	Pupils demonstrating aggressive behaviour and/or low self-esteem.
Top Valley	Art/Sculpture	To develop a collective large-scale art display.	Pupils demonstrating aggressive behaviour and/or low self-esteem.
Elliot Durham	Film-making	To explore issues of identity,self-esteem, behaviours,emotional literacy and relationships through drama, art, photography and film-making.	Pupils who had difficulty co-operating with teachers or other pupils; inability to work in groups.
Fairham	Dramatherapy	To use a creative and expressive medium to enhance the ability to express emotion, and to accept and manage feelings, to increase self-understanding and to encourage more positive relationships with adults and peers.	Pupils with serious emotional and/or behavioural problems.
Henry Mellish	Teambuilding	To encourage teamwork, to enhance self-esteem and motivation, and to build up trust through team-games, climbing, abseiling, caving, biking and canoeing.	Pupils with low self-esteem and low motivation.
Henry Mellish, Top Valley and Bigwood Schools	Swimming	To enhance swimming skills, and to develop self-esteem.	Pupils with low self-esteem and low motivation.

School	Project name/type	Description	Target group
Bluecoat	Counselling	Professional counselling using techniques such as art-therapy, drama, sand-modelling, games etc.	Pupils with emotional and/or behavioural difficulties.
Henry Mellish	Homeopathy	Homeopathic medication recommended by a professional homeopathic consultant.	Pupils demonstrating aggressive behaviour and/or low self-esteem.
Top Valley	H2O	Pupils are encouraged to drink water at regular intervals through the day, both at school and at home.	Pupils demonstrating aggressive behaviour and/or low self-esteem.

Art-based projects

The first four in the table were conceived as Arts-based projects, and initially each of them was designed to include some external support. In one case, however, the plan to include an Artist-in-Residence foundered, and the project at Bigwood School went ahead entirely on internal staffing.

These projects were in part inspired by the observation that some of the most difficult pupils showed greater interest and enthusiasm for their art lessons than for other parts of the curriculum, and the projects hoped to build on this. As one LSU manager put it:

> *"Teachers were coming back to us and saying 'One thing they will do for England is to colour'. They are quite happy to do art-work, drawing, colouring, and they will do that for ever, and they are quiet and they are settled when they are doing that sort of work".*

It was observed moreover that Art, whether pictorial or expressive, creates an opportunity to explore the inner world of feelings and emotions to a greater extent than other subjects in the school curriculum. The two Art projects at Bigwood and Top Valley both placed emphasis on wanting to encourage students to use the medium of Art as a means of expressing their moods and feelings. But there was also the aim of improving pupils' social skills.

- The *Art project* at Bigwood School owed a great deal to the exceptional dedication of the teachers in the Art Department, one of whom gave up what would have been two free periods to run the project. The proposal envisaged a rolling programme of workshops on Friday afternoons, to "focus on the use of Acrylics and real canvas painting. Pupils will be encouraged to express mood and feelings through colour and texture". In the event the 12 week-programme extended to film-making, photography, art-based play and incorporated some music as well. A video-diary chronicling all stages of the project has been developed.

- The Top Valley *Art project,* run in collaboration with providers from City Arts, planned to develop a collective, large-scale art display (a sort of sculpture) of the pupils' own design. The final product is to be prominently displayed on the outside of the LSU premises. At all stages of the planning, design and execution of the project a video-record was kept, providing each pupil with a permanent record they could include in their portfolio of accomplishment. Still photographs were also taken every week, and these were used as a prompt at the start of each weekly session. The aims of the project were to help pupils to learn how to control their own feelings, and to give them a positive experience that would help them to change their own self-image, and in turn enable the school to change their image of them.

The *Film-making project* at Elliot Durham was aimed at pupils in Year 7, their first year at secondary school. The chosen group had very weak self-esteem, and very limited capacity to cooperate with others. They could be described as 'internal truants', physically present in the school, but only marginally engaged in any school activity:

> *"Some pupils find it very difficult to cooperate with one another in either small or larger groups. It was easier for them to withdraw into themselves and do nothing, than to risk getting involved. So we wanted a project where pupils would have to work together, and in the process raise their own and each other's self-esteem. The group that we assembled were not used to working together at all".*

The Elliot Durham project was run in collaboration with the Nottingham City Museums and Galleries Department, and two-freelance co-workers, one a drama specialist and the other a film-maker. The introductory sessions involved games and role-play, to build trust and cooperation. This led to an art-work project that explored pupils' ideas and feeling about themselves, by them drawing round their own body and then pasting onto the outline positive things that were important to them. They then practised being another character, going to the Castle to use masks, and they were asked to describe their new character in a single word (chosen words included confident, strong and empty). They then went round the gallery to find portraits, and were invited to speculate about what those people might have been like. This led to the collective development of a story-line for a short film, which they then scripted, and filmed. The film was shot over a period of six weeks, and was then edited and assembled by the co-workers. The finished product was later shown at the Castle before an invited audience (including pupils and their families), and certificates were presented to each of the pupils.

The *Dramatherapy project* at Fairham was aimed at pupils with serious emotional needs. It employed a professional Dramatherapist who could draw on a range of techniques such as improvisation, role-play, mime, games, story-telling etc. The original plan was for there to be two groups of four pupils each working together, one group of year 9 pupils, and year 7 and 8 in the other. However when it became clear that the therapist needed to be able to work with the children on her own (without the support of a teaching assistant) it was decided that she would work with groups of 2. In one extreme case the work was one-to-one.

Team-building and physical activity projects

Two Projects aimed to develop practical and social skills and to encourage team-building through physical activity:

- One of three projects at Henry Mellish School, the *Teambuilding project* picked up on some Outward Bound work that the school has done before. The project programme included team-games, climbing, abseiling, caving, biking and canoeing. The group of pupils included both boys and girls, and the aim of the project was to encourage teamwork, to enhance self-esteem and motivation, and to build up trust.

- Henry Mellish also collaborated with two other nearby schools, Top Valley and Bigwood, in a *swimming programme.* Pupils, all of them boys, were collected by bus from each school and taken to a nearby swimming pool for a series of swimming lessons. In the case of the Top Valley school, the swimming was one element in a wider therapeutic project about water (H2O).

Pupils from the three schools on the swimming project, and the team-building project at Henry Mellish

> *"…were all suffering from low-self-esteem, low motivation. They were not interested in school. Some couldn't follow instructions, others couldn't work with other people".*
>
> *"They were a real mixed bag, some with self-esteem problems, some who got bullied and then there were some kids who are bullies. It was a real mix. In fact, our kids were much worse than the ones from the other schools. They were much more lively!".*

Explicitly-Therapeutic projects

The final three projects were more directly therapeutic in their approaches. The *Counselling project* was built on and extended similar work already undertaken at Bluecoat School. But whereas counselling had previously been confined to pupils with emotional difficulties, but who did not also display behavioural problems, the counsellng project extended counselling to those who displayed both emotional and behavioural difficulties, and who needed more support than their class-room teachers could offer. They were not otherwise in contact with the LSU, although of course they were at risk of becoming involved if their behaviour persisted or deteriorated. Professionals working for an outside agency provided the counselling. The intervention they made was tailored to the needs of individual pupils. The ultimate aim of both the project and of the LSU is to reintegrate pupils into mainstream as rapidly as possible.

The *Homeopathy project* at Henry Mellish focussed on two groups of pupils; those showing aggressive and angry behaviour, and those with low self-esteem at risk of bullying:

- Henry Mellish School collaborated with a qualified practitioner of Homeopathic medicine, in a year-long project, to explore the contribution that a homeopathic intervention might make to help pupils with behavioural and emotional difficulties. If successful, the school would have another resource to help pupils within the LSU, or to use to prevent pupils from being referred to the LSU. This project relied on an especially close and cooperative relationship with parents.

The *H2O project* at Top Valley was aimed especially at hyper-active boys, with serious behavioural difficulties:

- Top Valley School's H2O project included participation in the swimming programme mentioned above, but went beyond this to emphasise the critical, but often overlooked importance of water in daily life. It was based on the concern that dehydration or the consumption of less healthy liquids have adverse effects on health and mood, and the routine of drinking water at regular intervals might also encourage a greater awareness of the importance of good eating and drinking habits.

See Resource 3 for the published research evidence on these and other therapeutic approaches

Who were the projects aimed at?

The pupils most likely to be referred to a LSU are those displaying emotional and/or behavioural difficulties of a kind that disrupt normal classroom learning. This phrase covers an extremely wide range of feelings and behaviours, of varying persistence and intensity. While it clearly includes outbursts of verbal or physical aggression or uncontrollable anger, that is to say challenging and confrontational behaviour, it also extends to the

inability to relate to or cooperate with others. Thus it applies to the seriously withdrawn pupil, unable to cope with the slightest of confrontations, and very vulnerable to bullying, or to the child with low self-esteem.

The LSU pilot projects described above addressed difficulties of this kind across the entire spectrum. Each project was targeted at pupils who were displaying particular behaviours and difficulties, the two most common being pupils with a pattern of aggressive and anti-social behaviour and those with low self-esteem. In some cases the chosen pupils were already attached to the LSU and so taking part in the project was built into the wider programme of LSU activities they experienced. But in others there were pupils who were a cause for concern within the school, but who had not been referred to the LSU, and were still in mainstream classes; the hope was that successful participation in the project might be a preventive measure, making a referral to the LSU unnecessary or inappropriate.

Many of the pupils chosen to join the projects had some awareness of why they had been chosen, although they often used different terms to describe their own behaviour:

> *"I was naughty all the time, walking out and kicking doors and that".*
>
> *"Skiving, being naughty, swearing at the teachers and stuff like that".*
>
> *"I'm always shouting, I can't do my work and I'm always shouting…and bullying people".*
>
> *"The teacher never used to like me so I used to swear at her…and then I got excluded for calling a teacher Ginger".*
>
> *"I get upset when people pick on me…I normally get picked on every day".*
>
> *"I didn't have no confidence in me…I would be crying a lot".*

Parents too were very aware of their children's difficulties, more than most, although they may not be able to explain them, nor may they be able easily to cope with them:

> *"His behaviour was disgusting, bad, bad, bad. At school he gets into trouble for swearing at teachers, running across tables, slamming doors. When he's at home, if he can't get his own way he's got to tap or slam doors or kick things. It's awful, terrible behaviour. I say to him 'You're going to give me a nervous breakdown, you're going to give me a heart attack', because that's how you feel".*
>
> *"He's got a very low self-confidence, it's nil. He tended just to sit in the corner of the room, you know not putting his hand up, he probably knew the answer but he's just not confident enough to do it…everything was took personal, if anybody says anything nasty he'd be in tears, you know everything was his fault".*
>
> *"She'd be coming home from school all moody, rude, bad-tempered…everyone was in the firing line, it didn't matter who the person was".*

See Resource 1 for guidance on what is meant by challenging behaviour and emotional and behavioural difficulties

Changes in behaviour or attitude

At the time the assessment interviews took place most of the projects were still on-going, and most of them had only been in operation for a relatively short period of weeks and months, so it would be premature to expect too much by way of measurable improvements in behaviour or attitude. But in fact every project was able to offer examples of real and sometimes remarkable progress. The evidence, though anecdotal, is vivid, and in many cases the observations of the LSU staff are corroborated by other people both in the school and beyond it. Most projects also include more formal evaluations and tests of their own, which will be brought together as each project draws to a close.

Some observations refer to the behaviour of the *group as a whole, while working together as a group:*

"When we started the project, if you sat six of them round a table, within minutes they would be grabbing hold of each other, and wanting to take each others' things. It still happens occasionally, but not often. It is a most noticeable difference".

"With things like climbing or abseiling, pupils saw the need to obey instructions and to work together. Then they would start to correct one another if necessary. They became more supportive and protective of one another, and the relationships with LSU staff who were part of the team became stronger and more open". (Henry Mellish Team-Building Project)

"The pupils have developed a considerably more positive attitude, relationships with teachers are more open, and concentration is greatly improved. Some pupils are now working together in a way they couldn't have done before". (Top Valley Art Project)

"We can see that some of the children are more open, they smile more, they are interacting more". (Fairham Dramatherapy Project)

"What you find is they come back and say 'well, so and so tried to bully me again the other day and I told him where to get off' which is something they haven't done before. They find in themselves that they can stand up for themselves".
(Henry Mellish Homeopathy Project)

"They have taken a project through to completion, and they have done it collectively, and it's going to be a solid tangible end product. When they were first chosen, and there was the idea that they might make a film, they didn't believe it, thought it was just a big joke, that they were being teased. Now it's done, and they can compare how they felt then and how they feel now. It will have made a real difference to them internally, which hopefully will last throughout their secondary schooling".
(Elliot Durham Filmmaking Project)

Other comments are more about *individual* reactions:

> *"Increased self-awareness and self-confidence, fewer negative responses and more positive ones. All the things we hoped would happen…".* (Elliot Durham Filmmaking Project)

> *"We have used questionnaires on self-confidence and self-esteem and slowly their scores are increasing. With only one exception they have crossed the threshold where reintegration into the mainstream starts to become appropriate".* (Bigwood Art Project)

> *"J. had very limited self-esteem. She was very quiet and wouldn't get involved. She really excelled at some of the more dangerous activities such as climbing and abseiling, and she seems to be much more confident than she was before. She is now a prefect in the school; I doubt if she could have taken that on before".*

> *"K. didn't go to lessons, she was distracted and wandered about the corridors. When she was in class she could be totally disruptive…she has come on in leaps and bounds, it's been fantastic…".*
> (Henry Mellish Team-building Project)

Sometimes positive changes were noticed not only by the staff of the LSU but by *mainstream teachers:*

> *"…her English teacher commented on how much her behaviour has improved. The head teacher said he couldn't believe it was the same person".*
> (Henry Mellish Team-building Project)

> *"They are now coming back from mainstream classes with report cards that say 'excellent' every single lesson, which is a huge turn-around".*

There has also been positive feedback to the school from *parents:*

> *"The first person to notice any change in behaviour is the parent. It takes a bit longer to*

filter through at school. All the parents have come back to say there have been positive improvements, every single one. It goes up and down, of course, but the trend is right".
(Henry Mellish Homeopathy Project)

"About four of the parents in the past few weeks have talked about how their children's behaviour at home is getting better".
(Fairham Dramatherapy Project)

And *parents* themselves told us that:

"It's worked tremendously well…her confidence is boosted to the top, and we know about it because she speaks her mind now, and that's what I wanted for her to be confident and to speak her mind. Now she's just a happy go lucky girl, she's a bubbly personality and I'm very proud of her".

"He's got the confidence just to be himself a little more…he'll go out and play now whereas before he just sat in the house and didn't do anything".

"He's much calmer, he's calmed down a lot. He's stopped having nightmares, he's stopped sleep-walking, he's stopped slamming doors, he's stopped swearing at teachers".

"When he used to get nasty he just used to fly off the handle, but now I think he sits back and he thinks about what he's going to do before he does it, and he calms down a lot…he knows he can sort things out without the violence…he used to go in fists first and ask questions later, but now he stops and thinks first".

Do the *pupils* themselves feel that they have benefited from the projects? In many cases it is clear that they do:

"My temper has calmed down a bit".

"It's helped me to find out why I'm angry, and it helps me to stop getting angry with people".

"My attitude's changed…I've stopped being cheeky to people so I'm not getting into trouble either, not much anyway".

"I'm a lot healthier".

"I concentrate more".

"I think it's helped me with willpower…I can control myself…I've quit smoking as well".

"If I didn't get my way I used to shout and start kicking chairs and all, but now I don't do that. Like if they say 'No, you can't go on the computer' I say 'Alright, but if I'm good for the next lesson, then can I go on the computer?'".

Problems encountered (and overcome)

Most of the projects chosen for support were, for the LSUs concerned, innovative. In most cases projects of the kind described had not been attempted in that LSU before. Where they were building on previous experience, they were extending it to different groups of pupils. Inevitably most projects encountered some problems and difficulties, some of which were anticipated, but some which came as more of a shock.

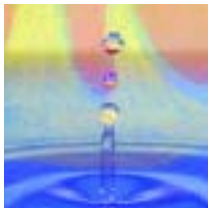
Not all those pupils chosen at the start stayed with their project through to the end. In most cases there was some *fall-out* and some pupils who *withdrew* from the project:

"Two students started and then withdrew, which is about the normal attrition rate. One further student withdrew after five sessions at her mother's request, although we felt that she was getting a lot out it".
(Bluecoat Counselling Project)

"One boy withdrew from the project at an early stage".(Fairham Dramatherapy Project)

"One pupil had severe behavioural problems and he withdrew from the group".
(Henry Mellish Team-building Project)

Apart from those students who withdrew entirely from their project, there were others whose participation was erratic. A number of project managers referred to attendance problems:

"We started off with quite a large group and it ended up with about four or five. Attendance from all three schools dropped off towards the end. The younger ones were the keenest and seemed to enjoy it most. Sometimes sessions were missed, not because they didn't want to come, but because they had forgotten to bring their swimming kit with them".
(Swimming Project)

"Attendance has been an issue, very often because of chaotic life styles at home".
(Henry Mellish Team-building Project)

Usually the most severe difficulties were encountered at the *start of the project,* during the first two or three sessions. Wherever the project was run by or involved an outside provider, there appeared to have been a pattern of early problems. It seemed that many of these LSU pupils required more time to get used to people they had not met or worked with before. It was necessary to allow sufficient time to build up the levels of self-confidence and trust that was needed for everyone to be able to work together effectively:

"It takes a long time for some of the pupils to get to know you and to trust you, and to rely on what you say. So the first session was a bit difficult…I think it's fair to say that the first time we met the co-workers began to wonder what they had taken on…I don't think any of us were quite prepared for how negative the kids would be at the outset".
(Elliot Durham Filmmaking Project)

"The first session was very difficult indeed, difficult for everybody. And after the session was over we had a lot of incidents one after another throughout the day. It was a very problematic day…it took about three sessions for the groups to settle in".
(Fairham Dramatherapy Project)

"The first week was tough. When the group of eight met together for the first time, there was a lot of goading, not so much one person attacking another as one person goading another to verbally abuse a third. There was quite a bit of that in the first week, but later it all came together".
(Henry Mellish Team-Building Project)

Some of the pupils made very similar comments:

"I hated the first session, because we didn't know anyone".

"We didn't know each other and we weren't getting along, but then it started to get alright".

The swimming project involved pupils from three separate schools who didn't know one another beforehand, but who had to share a bus to take them from their schools to the swimming pool and back again. To start with there was considerable mistrust and rivalry between the three groups, and in consequence provocative behaviour. One teacher commented:

"The worst part was the bus journey…I thought they were all going to have a fight".

The pupils reported the same thing:

"We didn't know each other and we didn't get along".

"I didn't like the boys what are there…they're hard like, like telling you to shut up and everything. I felt like punching them".

It is not just getting used to new people that requires time and patience. Being asked to *do new things,* or being exposed to *unfamiliar situations* can arouse anxieties that in turn may provoke challenging behaviour:

"If you ask them to do something new, their initial reaction is often to say 'No', and if they say 'No' you have to just leave it, and hope that as time passes they will start to join in".
(Elliot Durham Filmmaking Project)

The acute difficulties at the opening session of the Dramatherapy project were occasioned in part because of the novelty of the process itself. But a most striking illustration of the shock of the new comes from the Filmmaking project, on the

occasion when the group visited the Castle Museum and Art Gallery:

> *"…it was different, it was new, it was some thing out of their experience…the idea was to go there to explore wearing masks from the Castle collection and to make an entrance like the character in the mask. They just lost it in a big way…I think it was to do with the fact that we were on different territory there…'we don't know what is expected of us, so the only behaviour we can be sure of is to behave in the way that will get us into a lot of trouble'. And that's what they did! It was very difficult to manage. Because it was different, because it wasn't here in school, because we had gone on a bus, because there were other people around, (there were the public in the gallery), because they had never been in an art gallery before, it was just too much for some of them to handle".*

Once these kind of early teething problems had been overcome, the projects settled down. From time to time, individual pupils might erupt, or there would be some kind of incident or situation that needed calming, but the more extreme, general turbulence experienced in the early weeks was soothed.

A minor problem that might arise was when one or more of the group *refuse to join* in some parts of the programme. This required patience, flexibility and tact, and sometimes the reluctant pupil could be persuaded or coaxed into joining in. The Film-making project gives several examples of this:

> *"The first session we played ball-games team-games to get them to work together as a group, and this one girl just wouldn't have anything to do with it, so eventually one of us went and played a ball-game on her own with her, and she was happy to do that. And eventually she came back and got involved. Every now and again she would walk off, and not be involved, especially when a new game came up, and she didn't feel confident enough to do it".*

> *"Young P. only really wanted to do the filming. There was no way he was going to take an acting part…but one day, we were waiting to start filming, the camera was running but we hadn't started, when he just came over to me and sat down and started to talk to me in character. He did a wonderful piece…and it wasn't that he was being filmed without him knowing, no he knew it was happening. He just felt confident because there was just the two of us. He was happy to do it, but it was on his terms".*

There were on occasion other more general difficulties that might hinder the work of the LSU staff. In some cases it stemmed from *mistrust* or *misunderstandings* about the role of the LSU itself among mainstream teachers within the school. In others the mistrust or misunderstanding focused more on the aims or methods of a particular project. The Homeopathy provider for example encountered what she described as

> *"a credibility issue, a certain wariness…many of the staff don't understand what homeopathy is about, and what I am trying to do. There are also problems of confidentiality; I have to liase with teachers but there are things that I can't tell them because of the need for confidentiality. They don't always understand this. If you like, there is a different culture in a school".*

At another school, it was suggested that

> *"some mainstream teachers resent the fact that what they see as disruptive pupils are rewarded for their behaviour by the privileged treatment they get in the LSU. Meanwhile they are expected to cope with the demands of a large class, where there are other pupils whose behaviour is hard to control".*

An illustration of a simple misunderstanding is the case of the LSU where

> *"pupils are encouraged to play chess. This is not always understood by others who think of it simply as a game. But it is also a good exercise in the need to think before you act".*

Sometimes a mainstream teacher can undermine the good work of the LSU by a thoughtless comment, such as greeting the return to class of a pupil from the LSU with the words "Here comes trouble!".

Clearly the work of the LSU needs to be carefully explained to all staff in a school, and the LSU personnel need to liase closely with their mainstream colleagues.

Involvement of parents

All LSU and project managers were agreed on the importance of securing the maximum parental involvement, and in many cases quite elaborate systems had been put in place to make this easier.

In some instances, parental agreement was required before a child could start on a project. This was most clearly the case for the projects that provided some sort of directly therapeutic help. In the case of the Homeopathy project, parental involvement was essential not only to sign their agreement, but also because the therapist needed detailed information from the parent about the child, background information that covered their entire life-course, as well as a medical history. Indeed there was a 30-minute private consultation with the parent before the child was involved at all, with regular consultations thereafter. Likewise the Counselling project arranged a meeting between each parent and the therapist beforehand, so that the parents were fully informed of what was being proposed. Even where such a formal approach is not a requirement, most LSU managers try to maintain close contact with parents.

Many children in the LSUs come from lone parent families, and in these cases it is almost invariably the mother who is the responsible parent. Several managers were at pains to stress that very often the parent is confused and bewildered (and exhausted) by their children's behaviour which can be even more difficult in the home environment than it is at school:

> *"Behaviour is often worse at home than it is in school. At home they may actually smash things, they run off and no one knows where they are, they fight with siblings, you know, not just quarrels but fist-fights. It's similar kinds of behaviour but it can be more exaggerated at home".*

> *"Many of the parents we deal with have lost hope themselves with their children. They don't believe that they can ever do anything good in school. Sometimes it is hard to get them to reward their children, to say 'well-done, I'm proud of you'".*

To start with it could be quite difficult to get parents involved:

> *"I sent parents a letter explaining what we were going to do, and invited them to come in to talk about it…it was difficult at first persuading them to come but now they come in fortnightly. We talk about targets, about what's gone on in the week before, show them the work and so on".*
> (Bigwood Art Project)

Some parents can also be unreliable:

> *"Appointments are made and then missed, children don't make it, they arrive late, appointments are missed, they don't reply to letters or other requests".*
> (Fairham Dramatherapy)

A lot of contact with parents is made by telephone. This too can present problems at first:

> *"Where it has been the case that all contacts from the school have been negative ones, there may be a great reluctance to answer the phone. You get into a cycle where parents look at their watch and when three-o-clock is approaching they think 'Right, if the phone rings in the next half-hour I'm not answering it because I know it's school'".*

> *"Mostly it's mobiles, and around three, they'll turn them off, because they know it will only mean trouble".*

This was confirmed by some of the parents we spoke with:

"I used to be at home and I used to dread the phone ringing. I used to want to switch it off, but suppose there's been an accident so I can't. As soon as the phone went I knew it was the school. I was having calls nearly every day".

The importance of *reinforcing the positive* was emphasised time and again:

"We are keen to get the parents on board, so to begin with we would make a phone-call every other day to accentuate the positives all the time, to give the parents something to celebrate".
(Bigwood Art Project)

"We contact parents by phone at least once a week, and always try to give a balanced report, so that even if there have been some incidents there are hopefully some positive things to report as well".
(Top Valley H2O Project)

"We have daily feedback to parents; we phone them to say how their kid has got on, so we phone them with positives as well as negatives".
(Fairham Dramatherapy Project)

This sort of positive contact is greatly appreciated by parents:

"I got a phone call on Friday from a teacher saying what a fantastic lesson he'd had, and I said 'Are you sure you've got the right child?', and she goes 'Yes, it's your boy, and it was a fantastic lesson, absolutely brilliant'. I've never heard that before, never, they've never done that. It's always been them phoning and saying 'He's jumping on tables, he's doing this, he's doing that', but now we had one saying he's really good. Now they are sending him a well done card through the post. He's really pleased with that".

But in addition to telephone contact, there are a range of other face-to-face meetings:

"The LSU maintains an open-door policy for parents, including taking part in LSU activities (such as anger awareness) if they wish".
(Top Valley H2O Project)

"We have award ceremonies and invite the parents in. A lot of parents come, and take photographs of their kids because for the first time they were getting positive praise".
(Bigwood Art Project)

"We have fortnightly reviews with parents…our parents work in the centre with us".
(Fairham Dramatherapy Project)

In some cases there are positive benefits for the parents themselves:

"When you have got the parent and child together, and one has to listen to the other one, quite often the parent is learning things about their child that they didn't know, they didn't know how they felt about things".
(Henry Mellish Homeopathy Project)

"They are actually learning better parenting skills by working with us and seeing how we work with the children. A lot of our parents have said to us 'I wish I could do this' or 'I don't know how to put in boundaries' or 'I overreact' so we do a lot of work with parents. Some of the parents have emotional or mental health needs of their own".
(Fairham Dramatherapy Project)

"So much of their contact with school has been negative, so we hope that this project will have done something to help with their relationship with their child, and they can glimpse something good that they have done, and hang onto that achievement".
(Elliot Durham Film-making Project)

Some lessons from experience

There are a number of points that everyone we spoke with wanted to emphasise, based upon their own particular experience, and which should be taken seriously by other LSU managers who are trying to develop their work.

1. *The aims and objectives of any project need to be thought through very carefully,* so that the providers can explain themselves and their plans very clearly to everyone who might be involved. This is especially important with projects of an avowedly therapeutic nature:

> *"A lot of time and effort needs to be spent with pupils and parents at the outset, explaining exactly what is to be provided. Consent is essential. Therapy only works with pupils who want it to work, and this of course excludes many who might in fact benefit".*
> (Bluecoat Counselling Project)

2. *The particular needs and characteristics of the pupil group need to be acknowledged and the programme designed in detail accordingly.* For example, the very difficult opening session experienced by one project may have been made more difficult

> "*…because I don't think they had got enough ready, so that right bang we were going to do things straightaway. The kids didn't want to talk about it, they wanted to have activities straight away".*
> (Elliot Durham Filmmaking Project)

3. If a project is likely to expose children to situations or people that they haven't encountered before, then again careful explanation and preparation will be needed to minimize the danger of a disruptive or challenging reaction.

4. Where outside providers are to be used, then they should be carefully briefed about the particular needs of each child they will encounter. There are in each case likely to be sensitive issues that should be avoided or if not handled with extreme care and skill:

> *"There is potential for huge problems if they happened to hit on the wrong subject-matter, or pushed the wrong buttons".*

> *"Sometimes an outside provider may prefer not to know about the background and needs of pupils in advance, or suggest that it is not necessary. It is absolutely essential. They must be aware".*

5. Sharing information can of course be controversial, due to the confidential nature of much of the information that may need to be exchanged. Procedures and arrangements will need to be devised that allow for sharing of personal sensitive information in line with data protection principles.

6. The nature of the intervention may determine the size of the group who will take part. The view of the LSU manager where the Dramatherapy project ran, was that

> *"This sort of work is especially suitable for emotionally damaged and traumatised children, but care must be taken to determine whether they should have individual contact or work in a small group. It is not usually appropriate for large groups. Perhaps three is the maximum".*

7. Some projects may operate to ground-rules, or set boundaries to acceptable behaviour, that are different from those in force elsewhere within the LSU. Where this is so, it is inappropriate for other LSU personnel to attend these sessions. It may also be the case that following a session,

> *"…the children should be given the choice about whether to return to normal class, or to take some free time. They may need some private time".*

8. The 'danger-points' are at the start of the week, on Monday when pupils return after the week-end, and at the end of the week, with a free week-end in view. At one school

> *"…the last period on these two days is a game of football, not just as a game, but as a reward, on Monday for developing a commitment for the week ahead, and on Friday for fulfilling it".*

Some Points of Good Practice to guide those setting up a project

- Be as clear and specific as possible about the project's aims and objectives.
- Establish formal and appropriate referral systems.
- Gain consent and as far as possible active cooperation from parents, carers and the pupils themselves for participation in the project.
- Establish clear guidelines to govern the sharing of sensitive or confidential information, with outside providers (if these are to be used) and with mainstream classroom teachers and others.
- Establish monitoring and evaluation systems of a kind that will yield the most robust evidence.
- Collect baseline data (and update as necessary).
- Explain very carefully to all pupils taking part what the project is about, and what is expected from those who take part.
- Be flexible and tactful with those pupils who find it especially difficult to work with people they don't know, or engage in activities that are unfamiliar to them.
- Accentuate the positive wherever and whenever possible. Praise the child and inform the parent.

Conclusion

Although there will be many more lessons to be learned, it is clear that these pilot projects have accomplished a great deal. Comments from the providers, the LSU managers, mainstream teachers, parents and in many cases from the pupils themselves all attest to the benefits that have accrued. Many pupils feel better about themselves, and are somewhat more confident in facing what is for many a threatening secondary school environment. Some interesting questions remain. Some projects focussed on pupils near the start of their secondary education, in the hope that any benefits achieved will be sustained throughout their years of schooling and beyond:

> *"K. has become more self-aware, more confident; N. instead of being anti-everything and negative about everything has positive ideas…what will happen for the rest of their school lives is very hard to tell at this stage".*

Time will tell whether and to what extent this hope is realised, or whether the benefits are shortlived unless constantly reinforced and topped up by additional interventions whether within an LSU or in the classroom.

It is striking that although the projects described have been very different one from another in their approach, in their methods and have encouraged many different kinds of activity, they all report success with some of those taking part. Do the different projects all have some common characteristic which has contributed to their success, perhaps as much as or even more than any particular benefit that flowed from the specific intervention?

There are some features that are common to all the projects, and indeed to all the LSUs:

First, the work is intensive; there is a very high staff-pupil ratio so that each pupil gets a considerable amount of personal attention, far

more than would be the common experience in the mainstream classroom situation:

> *"It is them talking and somebody listening which helps".*

It is also more likely that *small improvements in behaviour or attitude will be noticed* and responded to:

> *"very often the biggest achievements come about through some very small thing, easily missed or taken for granted".*

Second, all the LSUs we visited occupied a dedicated space, often in a detached building or annex of some kind. If some pupils find the environment of a large secondary school to be threatening, then maybe the LSU can become for them a place of safety:

> *"All we do in a LSU is to replicate the primary setting. Kids don't move about from one class to another, we move to them. Their space is consistent, their environment is consistent, they belong to a particular space and feel safe in that space".*

Third, everyone we spoke with accentuated the positive; pupils who in general are seen as disruptive and problem-causing, are now praised whenever some praise is merited; any strengths they possess are recognized and encouraged. It may be that for some pupils this is their first experience of this kind either in the home environment or in their school experiences to date:

> *"What is probably the biggest factor is that you are giving them positive attention for the first time ever perhaps. You are non-judgmental about whatever they say to you, they can say whatever they like without being criticised. That's a very positive thing, and that's why a lot of them want to come to the LSU, because they don't often get it".*

Fourth, the direct involvement of parents, again in a positive way:

"Where parents are much more actively involved in schooling it will be very normal for parents to be around".

Fifth, establishing and assessing these pilot therapeutic projects highlights the importance of ongoing monitoring and formal evaluations. To develop a body of convincing research evidence on the effectiveness of therapeutic approaches requires those who are commissioning and providing such schemes to develop the necessary evaluation systems to allow us to determine what works and why. This theme is pursued in Chapter 5.

5
Therapeutic approaches in LSUs: From research to practice

Saul Becker, Viv McCrossen and Carolyn Waterstone

> *"Systematic monitoring and evaluation were the weakest feature of most learning support units. Few schools could demonstrate objectively the effectiveness of their unit or identify the most successful approaches for pupils of different age groups" (Ofsted, 2003, para 209, p. 60).*

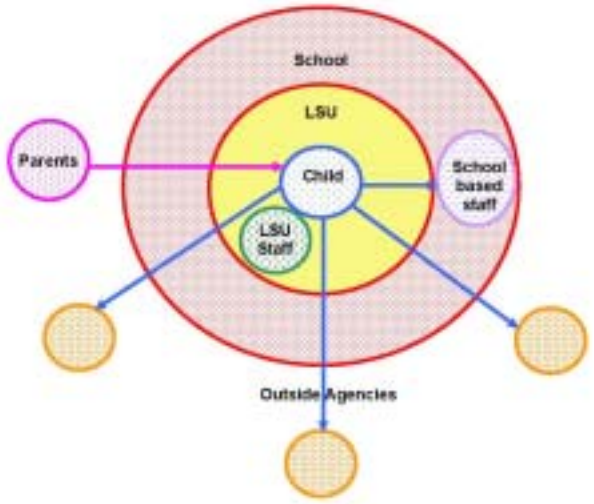
In this Chapter we first identify some of the key messages for policy and practice from the Therapeutic Approaches Project. We then go on to present a discussion of the challenges to good practice posed by an inadequate evidence-base on the effectiveness of therapeutic interventions and by the continuing lack of monitoring and evaluation of what works, and why.

Key Messages for Policy and Practice

It is clear from this research that Nottingham City LSUs are all providing a therapeutic environment to some extent. The key elements of this are the relationships that pupils make with LSU staff, the safe, positive and supportive environment that is established and the time available for pupils' needs to be addressed through individual and small group work. The pilot projects were aimed at meeting the emotional needs of the pupils rather than focusing on their behaviour yet all the projects reported improvements in pupils' behaviour. This would seem to evidence that unmet emotional needs can often present as challenging behaviour and are an essential component of the package of support that is offered to LSU pupils.

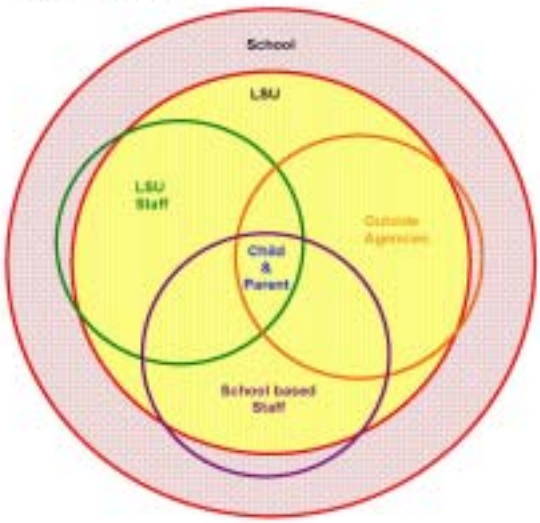
The research presented in Chapters 2 and 3 showed that LSU staff are working therapeutically with pupils (for example, providing anger management groups, social skills groups and so on) and they have often been trained and supported to do this by LEA support services. However, the tendency is to refer on to outside agencies for more specialist support for a pupil. From the research it is not clear that this is always the most effective way of delivering services because communication between the agencies and the LSU can be problematic. Where off-site provision is perceived as effective, LSU managers report close involvement and good communication. LSU managers work hard to involve parents positively in their child's progress but many parents still said that they were not really aware of the therapeutic work that their child was engaged in. School staff can also vary in their involvement in supporting LSU pupils. Figure 5.1 shows how all this can lead to fragmented support for the pupil.

Figure 5.1: Model 1 - Fragmented



Most LSU managers aspire to a model where LSU support for the child and parent/carer is integrated (Figure 5.2). The pilot projects (reported in Chapter 4) show that there is potential for more specialised direct work with pupils and their families to be provided within the LSU environment by staff from elsewhere in the school or from outside agencies. This more integrated way of working is also that recommended as the way forward in the new Children Bill. Many of the projects were able to engage parents positively either as an integral part of the approach or in celebrating the achievements of their children at a special event.

Figure 5.2: Model 2 - Integrated



The major advantages of an integrated approach to addressing pupils' emotional needs within the LSU are:

- There is a defined space within the school where pupils feel safe and can access support to help them address their behaviour and its underlying emotional need.
- The support of a trusted adult is easily available to a pupil even when they have left the LSU.
- LSUs support the school to be an inclusive environment where pupils' emotions can be expressed and addressed.
- LSU staff have very detailed knowledge of their pupils and are able to tailor individualised packages of support to meet their particular stage of emotional development.
- Outside agencies can build on this knowledge more easily if working within the LSU rather than having to reassess and start from scratch.
- Work can be provided more quickly through the LSU than through referral to outside agencies where there is often a long waiting list.
- It is easier for pupils to be introduced to another adult to work with them within the safe and trusted environment of the LSU.
- LSUs develop strong, positive relationships with parents and therefore parents can be more easily included in supporting their child.
- All the professionals working with LSU pupils become part of the LSU team which helps to promote better understanding and communication.

However, as we have already observed in Chapter 4, work within the LSU needs to be negotiated carefully as school rules and therapeutic approaches don't always go together! Misunderstandings can lead to confusion for the pupils and adults involved.

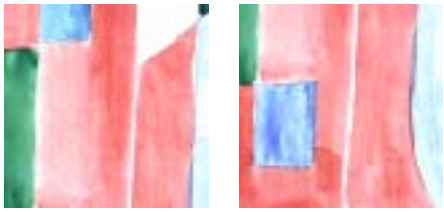
What helps to make an integrated model work?

- A positive whole school ethos and approach.
- A well resourced LSU - staff and space.
- Collective responsibility for meeting the needs of pupils with SEBD.
- Specialist agencies providing training for school-based staff.
- Flexible, creative and responsive LEA support services and partner agencies working within the school environment.
- Building layers of support around the child rather than 'referring on'.

From this research it is clear that building emotional capacity for young people through creative and sustained means can reduce levels of aggression, improve self-esteem and raise educational attainment.

The lack of reliable research: some challenges to better practice

The lack of scientific evidence for most treatments and therapeutic approaches for pupils with challenging behaviour (see Resource 3), and the danger that existing research evidence may not always be applicable to 'real world' settings (see Resource 2), poses a number of challenges for



LSU managers, teachers and other practitioners working with this group of pupils. Three of the main challenges are outlined below.

First, do we have evidence on effectiveness?
Because most approaches have not been evaluated at all, and certainly not to levels of high scientific rigour, we do not know (a) whether most therapeutic approaches are effective and (b) whether they are more or less effective than other treatments or no treatment at all. Deffenbacher, Oetting and DiGiuseppe argue that to inform practice, research must address two fundamental questions:

> First, is the intervention more effective than doing nothing (absolute effectiveness)? If the intervention provides no benefit, does not prevent client deterioration, or actually harms, then there is little to recommend it. Second, if an intervention is effective, then is it more effective than other interventions for the same problem (relative effectiveness)? (2002, p. 268)

Empirical support for any therapeutic approach should include information on absolute effectiveness and, where available, relative effectiveness. However, this level of evidence is rarely found in most published studies.

See Resource 2 for a discussion of the research criteria that can be used to judge whether or not a therapeutic approach is effective

See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches

Second, should we carry on using therapeutic interventions in the absence of reliable evidence, or should we stop using them until we have the evidence?
Ollendick and King question whether we should use therapeutic treatments in the absence of supporting evidence. They conclude that we should probably continue 'treatment as usual' until such support is available - but that alternative treatments and approaches "need to be submitted to systematic inquiry in randomized controlled trials before their routine use can be fully endorsed" (1991, p. 406). At the same time, treatments and approaches should not be offered without reasonable evidence that they will help to ameliorate any impairment and symptoms. Ollendick and King show that 'treatment as usual' can have no more beneficial effects for some children than no treatment at all, or a placebo. Ollendick and King present a conundrum:

> On the one hand, it might seem unethical to use a treatment that has not been empirically supported; on the other, inasmuch as few empirically supported treatments have been developed, it might be unethical to delimit or restrict practice to those problem areas and disorders for which treatment efficacy has been established. What, after all, should we do in instances when children and their families present with problems for which empirically supported treatments have not yet been developed? (Ollendick and King, 1991, p. 408).

They suggest that after an assessment of the case and a consideration of alternatives the best approach should be chosen, and that practitioners must keep informed of new developments in theory and practice, and the supporting research evidence.

Kazdin suggest that: "At present, perhaps the best strategy is to select the treatment that appears to be promising based on the evidence and applying that as the initial treatment of choice" (1997, p. 173). In most cases, as we can see in Resource 3, the current knowledge base doesn't allow for any greater precision in allocating a particular therapeutic approach to a particular pupil. As we saw from the qualitative interviews conducted with pupils, parents and professionals in Nottingham (Chapter 3), in practice - and in the absence of empirical evidence on effectiveness - a 'pick and mix' approach exists where therapeutic interventions are largely chosen with reference to availability (supply), and to custom and experience. But as we also saw in Chapters 3 and 4, *this*

approach can lead to very real and beneficial outcomes for pupils and their families.

See Chapter 3 for what pupils, parents and professionals have to say about therapeutic approaches in Nottingham

See Chapter 4 for an assessment of the value of 9 pilot therapeutic projects in Nottingham

Mindes and Murphy (1982) suggest that despite the lack of hard research evidence on effectiveness, there is often practitioner knowledge and experience that points to the value of a particular therapeutic approach. Writing specifically about play therapy, they suggest that "no concrete or hard fast evidence can be offered for this approach in operation, but clinical judgement which occurs daily, weekly, and annually in the multidisciplinary interchange among staff indicates that play and games are effectively utilized by program participants and that change or learning occurs: cognitively, physically, and in the social/emotional sphere" (p. 138). As we saw in our qualitative study in Nottingham (Chapter 3), this practitioner or craft knowledge, based on experience of working with particular approaches for particular children, can be an important source of 'evidence', especially where there is an absence of rigorous research evidence. The preliminary assessment of 9 pilot therapeutic approaches presented in Chapter 4 also provides further evidence that can help inform practitioner knowledge of what works.

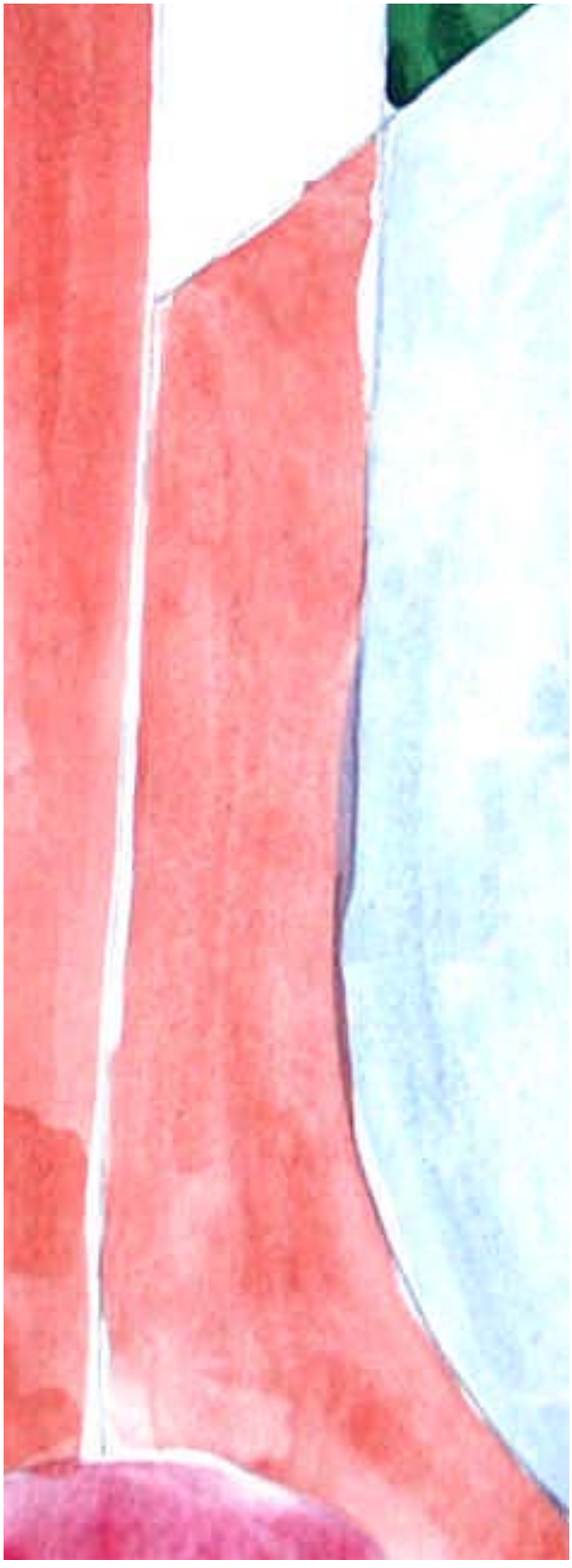
Third, even if there is research evidence, will the therapeutic approach make a real difference?

Kazdin (1997) suggests that while there is robust evidence (especially generated from randomised controlled trials) that certain therapeutic approaches (referred to above) do lead to positive outcomes, we still need to know "is the change enough to make a difference in the lives of the youths who are treated?" He argues that "clinical significance" is important here: "Clinical significance refers to the practical value or importance of the effect of an intervention, that is, whether it makes any 'real' difference to the patients or to others with whom they interact" (p. 169). One way of evaluating clinical significance is to assess whether pupils who have had a therapeutic intervention go on to function at normative levels at the end of the treatment - in other words, that their behaviour changes in ways that then places them within the normal range of child and adolescent behaviour. While there is some evidence to show that certain therapeutic approaches have an immediate or short-term impact on behaviour, few if any research studies have been conducted to demonstrate long-term beneficial outcomes or 'clinical significance'. The research in Nottingham (Chapters 3 and 4) suggests that pupils do gain from therapeutic interventions, but whether these gains are sustained in the long-term, or whether pupils go on to function within the 'normal range' of child and adolescent behaviour, have simply not been tested. Nor is it clear what causes these beneficial outcomes in the real world - whether, for example, it is something intrinsic to a particular therapeutic approach, or whether it is a product of time, space, small classes, relationships and trust - characteristics that are common to most therapeutic interventions (see Chapter 4).

Thus, evaluation of 'real' effectiveness of any therapeutic approach or intervention is key: "It is important that any new work done in a school setting is evaluated for its effectiveness… Evaluation needs to take place at various levels, involving the whole staff, the group leaders and the pupils. A variety of techniques can be employed" (Coppock and Dwivendi, 1993, p. 275). Kazdin (1997, p. 171) also argues forcefully for the need to evaluate therapeutic approaches and interventions, and that many therapeutic approaches (such as 'camps', care of horses, etc.) tend to avoid evaluation: "Evaluation is the key because well-intentioned and costly interventions can have little or no effect on the youths they treat and may actually increase antisocial behavior". There is a need to evaluate the use of therapeutic and other interventions not just in secondary schools, but also in primary schools (Evans et al, 2003; Harden et al, 2003). Ofsted (2003, p. 60) have argued that systematic monitoring and evaluation were the

weakest feature of most learning support units.

Evans et al (2003) recommend that researchers and practitioners work in partnership to carry out rigorous studies of the strategies currently used to support children with EBD. Such partnerships need to actively include children and take account of their views on the appropriateness of strategies. It is this partnership approach to research and development, and to 'hearing the voices' of children and other stakeholders, that have characterised the Nottingham Therapeutic Approaches Project and the work presented in this report.



Resources

In this section of the report we provide five Resources that will be of practical value to LSU managers, learning mentors, teachers and all those working with pupils who show challenging behaviour and social, emotional and behavioural difficulties (SEBD).

Resource 1

Guidance on what is meant by, and how to recognise, 'challenging behaviour' and 'emotional and behavioural difficulties'

This Resource provided definitions and gives practical advice on how to recognise social, emotional and behavioural difficulties in mainstream school settings.

Resource 2

What research criteria should we use to judge whether a therapeutic intervention is effective?

This Resource provides a discussion of the conceptual issues involved in determining whether or not a particular therapeutic approach is effective. This will be useful to LSU managers and practitioners because it provides guidance as to the kind of information that is required to make informed judgements about 'what works'. It will also help them to 'read' research and evaluation reports because it identifies the types of information (and data) that they need to be looking out for. This Resource provides essential context and background to Resource 3, and will help readers understand and interpret the research evidence reviewed in Resource 3.

Resource 3

An A - Z of therapeutic approaches for pupils with challenging behaviour: A review of the research evidence on 'what works' in secondary schools

This Resource is a review of the published research evidence on the effectiveness of therapeutic approaches for pupils with challenging behaviour. Over 1,500 texts were initially searched and around 140 of these were defined as being relevant and specific to our focus. This Resource, listing therapeutic approaches from A to Z, will be invaluable to local and national policy makers, LSU managers and practitioners, and reviews the current state of the research evidence-base on therapeutic interventions. The research evidence is reviewed for the following 31 therapeutic approaches:

1. Activity Therapy or Adventure Therapy
2. Anger Management
3. Art Therapy
4. Bibliotherapy (the use of stories for therapy)
5. Circle of Friends
6. Cognitive Behavioural Therapy (CBT)
7. Coping in Schools Programme
8. Counselling
9. Dance/Movement Therapy
10. Drama Group Therapy
11. Family Therapy
12. Group Therapies/Group Work
13. Homeopathy
14. Individual Therapies
15. Mentoring (Including Learning Mentors)
16. Multisystemic Therapy (MST)
17. Music therapy
18. Nurture Groups
19. Parent Management Training (PMT)
20. Peer Support Programmes
21. Pharmacotherapy (the use of medication)
22. Play Therapy and Non-directive Play Therapy
23. Psychotherapy
24. Quiet Place/Quiet Room
25. Relaxation Training
26. Social Skills Training
27. Social and Therapeutic Horticulture
28. Stress Management Education
29. Technology/Computer Mediated Education
30. Transition Groups
31. Water-related Therapy

Resource 4

Relevant Publications and Bibliography

This Resource is a listing of all the publications that are cited throughout the report. Readers who are interested in any of these publications or who may want to follow them up can get full publication details from this section. All publications can be ordered from any good bookshop. Alternatively, some of these publications may be available from the Education Department or other specialist libraries.

Resource 5

Useful Contacts

This Resource lists contact details for relevant organisations and individuals, including useful websites.

Resource 1

Guidance on what is meant by, and how to recognise, 'challenging behaviour' and 'emotional and behavioural difficulties'

Saul Becker

Challenging behaviour and emotional and behavioural difficulties

The 1989 Elton Committee of Enquiry into discipline in schools concluded that a "small minority of pupils have…severe and persistent behaviour problems as a result of emotional, psychological or neurological disturbance" (DES, 1989). This type of behaviour is often referred to formally as 'emotional and behavioural difficulties' (EBD), or in short-hand, as 'challenging behaviour'.

Pupils with emotional and behavioural difficulties were defined as children who:

> exhibit unusual problems of adaptation to a range of physical, social and personal situations. They may set up barriers between themselves and their learning environment through inappropriate, aggressive, bizarre or withdrawn behaviour. Some children will have difficulty making sense of their environment because they have a severe pervasive developmental disorder or more rarely an adult type psychosis…[They] have developed a range of strategies for dealing with day-to-day experiences that are inappropriate and impede normal personal and social development, and make it difficult for them to learn. (Quoted in Cooper, Smith and Upton, 1994, pp. 51-2)

The Department of Education's Circular 9/94 is the key document in defining the meaning and scope of EBD. It states that:

> Emotional and behavioural difficulties lie on the continuum between behaviour which challenges teachers but is within normal, albeit unacceptable, bounds and that which is indicative of serious mental illness. The distinction between normal but stressed behaviour, emotional and behavioural difficulties, and behaviour arising from mental illness is important because each needs to be treated differently. (Department of Education, 1994b, p. 7, para 2)

While all children will have emotional and behavioural difficulties of some kind at some point in their development, Circular 9/94 reminds us that this should be considered to be 'normal'. Thus, the pupil who is simply disruptive or naughty, or who is experiencing some emotional stress within normal and expected bounds, ought not to be defined as a child with EBD. Another Department of Education circular, 8/94, gives advice on the maintenance of order in the mainstream classroom, and how to manage pupil's behaviour within these normal bounds (Department of Education, 1994a). Careful classroom management will thus benefit all pupils, including those with EBD, because most pupils with EBD will be educated within the mainstream classroom.

Recognising emotional and behavioural difficulties in practice

As we have seen above, EBD lies on a continuum between challenging behaviour that is 'normal' (even if it is unacceptable), and serious mental illness, including conduct disorder. Circular 9/94 (Department of Education 1994b) outlines the kinds of behaviour that pupils with EBD may display. It states that emotional and behavioural difficulties range from social maladaption to abnormal emotional stresses. They are persistent (if not necessarily permanent) and constitute learning difficulties. The Code of Practice for Special Educational Needs (SEN) also provides useful descriptions of EBD (Department for Education and Skills, 2001). For example,

> Emotional behavioural difficulties may become apparent in a wide variety of forms - including withdrawal, depressive or suicidal attitudes; obsessional pre-occupations with eating habits, school phobia, substance misuse, disruptive, antisocial and uncooperative behaviour; and frustration, anger and threat of actual violence. (Department for Education and Skills, 2001, para 3.65)

Dwivedi reviews some of the main research findings which show that emotional and behavioural problems in children can also persist, and can be a pre-curser to, adult mental disorders - some of which can be very serious (Dwivedi, 1993, p. 291). Dwivedi outlines the contributory factors, including biological, cognitive and socio-economic determinants, as well as patterns of upbringing, that can lead to emotional and behavioural problems in children. The earlier that behavioural and conduct disorders start, the more resistant to treatment they are, and the more serious the outcome (Mental Health Foundation, 1999). Interventions need to be applied as early as possible. Research shows, for example, that where pupils are placed and educated in specialist EBD schools, they are only likely to return to mainstream classrooms if they are under 13 years old and if plans to reintegrate them are made within the first two or three years of their placement. Very few pupils ever return to mainstream schools following longer-term education in EBD schools (Farrell and Tsakalidou, 1999, p. 336).

Harden et al (2003, p. 1) argue that:

> The term EBD is a broad label which has been used to group a range of more specific difficulties such as behaviour which interferes with a child's own learning or the learning of their peers; signs of emotional turbulence (e.g. unusual tearfulness, withdrawal from social situations); and difficulties in forming and maintaining relationships. Definitions of EBD are contested and there is a need to consider the role that societal, family and school environments play in creating and ameliorating children's social, emotional and behavioural problems.

In Scotland, and increasingly in England too, the term *social, emotional and behavioural difficulties* (SEBD) is used, to emphasise the social aspects of EBD. The Association of Workers for Children with Emotional and Behavioural Difficulties (AWCEBD) changed its name in 2003 to the Social, Emotional and Behavioural Difficulties Association (SEBDA) in recognition of this change in emphasis. In this report we also use the term SEBD in recognition of this broader conceptualisation of emotional and behavioural difficulties.

Munn and Lloyd (1998) suggest that when the label 'SEBD' is professionally applied to pupils then one or more of the following are implied in the judgement that this person has SEBD:

- We believe this child is experiencing problems more severe than those experienced by most children.
- We are finding this child's behaviour in school extremely difficult to cope with.
- We find this child's behaviour strange and disturbing. We think that this child's social, emotional, psychological and/or educational development is at risk unless some help is provided.
- We consider that someone more expert than ourselves should become involved with this problem.
- This child has been assessed as having SEBD and therefore requires special support/resources. (Munn and Lloyd, 1998, cited in Lloyd and O'Regan, 1999, p. 38)

It has been suggested that "Up to 20 per cent of children experience emotional and behavioural difficulties requiring help and support. These problems are of a moderate to severe nature in nearly 7-10 per cent of the children and the prevalence of these difficulties tends to increase in proportion to the age of the child or adolescent. Those living in urban areas have a higher prevalence than those living in rural areas" (Coppock and Dwivedi, 1993, p. 265). Social, emotional and behavioural difficulties are also more common in boys.

Resource 2

What research criteria should we use to judge whether a therapeutic intervention is effective?

Saul Becker

This Resource discusses some conceptual issues about how we determine whether a particular therapeutic approach is effective or not. This discussion is important to LSU managers and other practitioners because it identifies the main research criteria that need to be addressed if we are to move to evidence-informed practice in therapeutic interventions. It also highlights the fundamental need for more and better evaluation of all therapeutic interventions so that a proper evidence-base of rigorous studies can be developed and applied in practice (see also Chapter 5).

Absolute and relative effectiveness

In making judgements about 'what works' or the effectiveness of different therapeutic approaches, we need to consider two measures:

1. *Absolute effectiveness* is proven where the therapeutic approach or intervention is shown to be more effective than doing nothing at all.
2. *Relative effectiveness* is proven where one therapeutic approach or intervention is shown to be more effective for the same problem than another intervention or approach (see Deffenbacher, Oetting and DiGiuseppe, 2002, p. 268).

Empirical support for any therapeutic approach should include information on absolute effectiveness and, where available, relative effectiveness.

How much evidence do we need, and of what quality?

What quality of evidence, and how much of it, do we need to show that a therapeutic approach used with pupils with SEBD in secondary schools is absolutely or relatively effective? Ollendick and King (1991) provide a useful discussion of what counts as 'empirically supported treatments for children and adolescents' - what we would refer to in the UK as 'evidence-based practice'. Three categories of treatment efficacy are proposed:

- *Well-established treatments,* where the treatment or therapeutic approach has been shown to be superior to a psychological placebo pill, or to another treatment, and this must have been demonstrated by at least two different investigations or investigatory teams, using clinical trials conducted with treatment manuals.
- *Probably efficacious treatments,* where the treatment must be shown to be superior to a waiting-list or to a 'no treatment control' only, and this must have been demonstrated in two studies from the same investigator or investigatory team, using clinical trials conducted with treatment manuals.
- *Experimental treatments,* where the treatment has not yet been shown to be at least probably efficacious. This category was intended to capture long-standing or traditional treatments that had not yet been fully evaluated, or newly developed ones that had not yet been put to the test of scientific scrutiny (Ollendick and King, 1991, pp. 337-8; see also King and Heyne, 2000, pp. 2-6).

Ollendick and King point out that the development of new interventions is to be encouraged and that treatments can move from one category to another over time, depending on the empirical (evidence-based) support for them. They conclude that there are very few treatments or therapeutic approaches for children with conduct disorders that have rigorous scientific evidence (conducted to the specifications required above) to support them. Only parent training programmes can be viewed as 'well-established' (supported empirically to the highest level), and only those parenting programmes based on Patterson and Gullion's work relate specifically to children with SEBD who are also of secondary school age. These parenting training programmes are designed to teach parents to monitor targeted deviant behaviours, observe and reward incompatible behaviour and ignore or

punish deviant behaviours. This approach has been shown to be more effective than psychodynamic and client-centred therapy interventions in addition to no treatment control groups. Boys and girls, varying in age from early childhood to adolescence, have benefited from this approach. In Nottingham, only 12 therapeutic services (out of 172) were directed specifically at parent training programmes (Chapter 2), and only two parents in our sample of respondents (Chapter 3) had any involvement in parent programmes.

Ollendick and King observe that ten other treatments have been identified which meet the criteria for 'probably efficacious' status: "Some of these were variants of parent training, whereas others included child-centred and context-relevant treatments such as anger-control training, anger-coping training, parent-child interactive therapy, problem-solving skills training, rational-emotive therapy, and multisystemic therapy. Most of these simply await replication by a second research team before advancing to 'well-established' status" (Ollendick and King, 1991, p. 403).

Kazdin (1997) also confirms the need for a body of evidence and argues that there are four 'promising' treatments for conduct disorder among children, each with a growing number of research studies confirming their effectiveness. The four 'promising' treatments are:

- cognitive problem-solving skills training
- anger management training
- functional family therapy and
- multisystemic therapy.

Each of these approaches is discussed in Resource 3 and some of these approaches are in use in Nottingham schools, as the 'mapping exercise' has shown.

See Chapter 2 for details of the therapeutic approaches used in Nottingham schools

See Chapter 3 for what pupils, parents and professionals have to say about therapeutic interventions in Nottingham

See Chapter 4 for an initial assessment of the value of 9 pilot therapeutic projects in Nottingham

See Resource 3 for a review of the published research evidence on the effectiveness of 31 therapeutic approaches

There are very few treatments for child behaviour disorders that have been scientifically proven to be 'effective' or 'well-established', although there are a number where the evidence is now growing slowly. We do not know what doesn't work until it's been empirically shown not to work. Nor, for that matter, do we know categorically what does work, in the absence of reliable evidence.

Efficacy and effectiveness

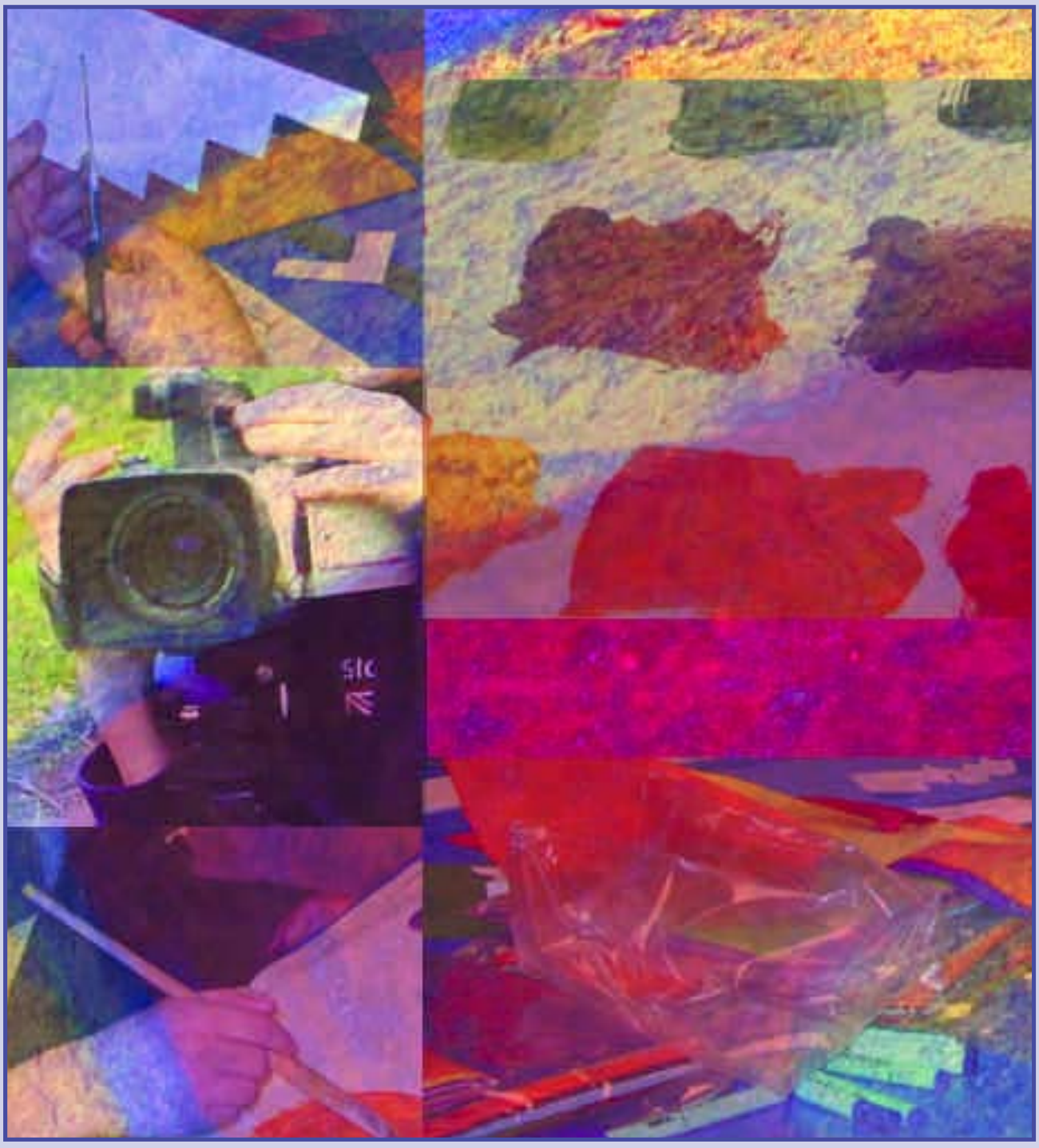
Even where there is research evidence about the *usefulness* of a therapeutic approach, this may not indicate that it is effective in the *real world.* King and Heyne (2000, p. 8) make a distinction between 'efficacy' and 'effectiveness'.

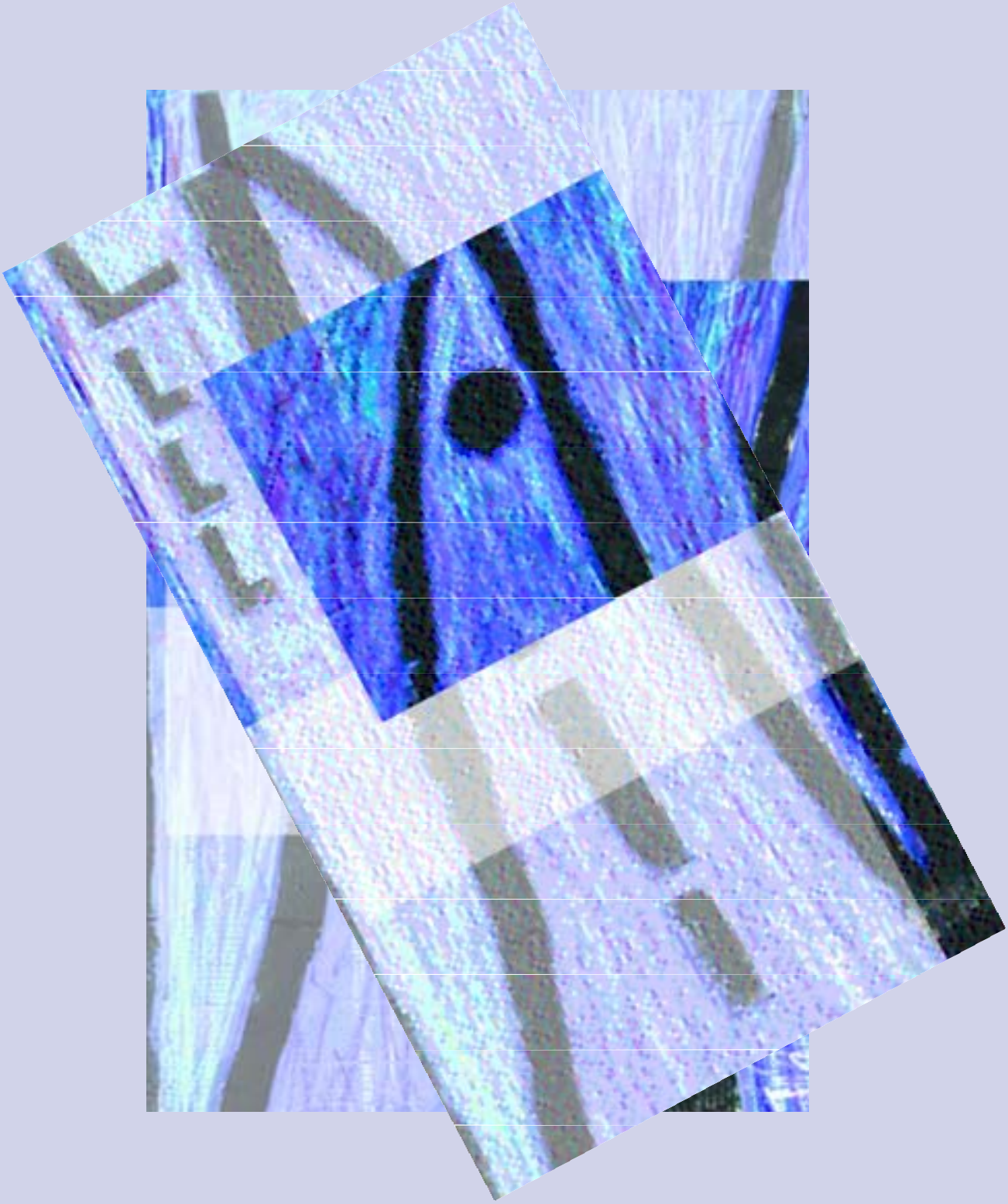
Efficacy refers to the empirical validation of an intervention based on well-controlled (often randomised) clinical trials involving time-limited and manual-based treatment - the so called 'gold standard' research design for this type of work.

However, there is more to determining whether a treatment is useful or valuable than demonstrating that it can produce change under *controlled* conditions. Hence, the empirical validation of therapeutic interventions needs to extend to a demonstration of *effectiveness* in real world clinical settings (what Kazdin refers to as 'clinical significance'). For example, in their meta-analysis of the effects of psychotherapy with children and adolescents, Weisz et al (1995) acknowledge that many of the 150 studies they review are laboratory-based interventions rather than psychotherapy as practiced in the real world - and that "the findings may thus reveal little about the effectiveness of most clinic-based interventions" (p. 463): "Clearly, research of the type reviewed here needs to be complemented by research on the impact of interventions with clinic-referred children in service-oriented treatment settings"

(p. 463). To take another example, while there are statistically significant differences between behavioural and non-behavioural treatments for adolescents, Weiss and Weisz (1995, p. 320) question whether they are clinically significant and are meaningful in terms of client functioning in the real world.

See Chapter 5 for discussion of the implications for practice of an under-developed research evidence-base on therapeutic approaches





Resource 3

An A - Z of therapeutic approaches for pupils with challenging behaviour: A review of the research evidence on 'what works' in secondary schools

Saul Becker with Sarah Lawrie

It is difficult for LSU managers, policy makers and practitioners to keep up to date with the research evidence on therapeutic approaches, and getting hold of the research can also be problematic and time-consuming. In this section over 140 pieces of research are reviewed (from an initial search of 1,500 texts[1]) and are ordered to help practitioners identify the rationale for a particular therapeutic approach and the evidence on its effectiveness.

The research evidence is reviewed for the following 31 therapeutic approaches:

1. Activity Therapy or Adventure Therapy
2. Anger Management
3. Art Therapy
4. Bibliotherapy (the use of stories for therapy)
5. Circle of Friends
6. Cognitive Behavioural Therapy (CBT)
7. Coping in Schools Programme
8. Counselling
9. Dance/Movement Therapy
10. Drama Group Therapy
11. Family Therapy
12. Group Therapies/Group Work
13. Homeopathy
14. Individual Therapies
15. Mentoring (including Learning Mentors)
16. Multisystemic Therapy (MST)
17. Music therapy
18. Nurture Groups
19. Parent Management Training (PMT)
20. Peer Support Programmes
21. Pharmacotherapy (the use of medication)
22. Play Therapy and Non-directive Play Therapy
23. Psychotherapy
24. Quiet Place/Quiet Room
25. Relaxation Training
26. Social Skills Training
27. Social and Therapeutic Horticulture
28. Stress Management Education
29. Technology/Computer Mediated Education
30. Transition Groups
31. Water-related Therapy

See Resource 2 for a discussion of the research criteria to be used to judge whether a therapeutic approach is effective or not

1. Activity Therapy or Adventure Therapy

What it is and rationale: Activity or adventure therapy includes a wide array of therapeutic experiences ranging from trust walks to mountain climbing (Wick, Wick and Peterson, 1997, p. 53). Learning objectives are achieved alongside enjoyable and challenging outdoor activities that cannot usually be performed in conventional settings (Fox and Avramidis, 2003, p. 268). The literature on adventure therapy suggests that it can help develop cooperation, trust, problem-solving skills, self-esteem, personal confidence, a positive perception of self, and opportunities to exercise and to evaluate choices. Participants are encouraged to support and accept assistance from their peers. Mastery of the experience strengthens the individual's sense of power and self-worth to help overcome frustration. Success enables children to deal more effectively with future problems (King and Schwabenlender, 1994, p. 17).

Research evidence: There is little robust research evidence that shows activity or adventure therapy has absolute or relative effectiveness when used with pupils with SEBD (see Resource 2). However, its use has been studied with various groups of children, including young offenders (Pommier and Witt, 1995; McRoberts, 1994) and has been shown to have beneficial outcomes. Farnam and Mutrie's (1997) study of 19 pupils of secondary school age attending an EBD school found positive outcomes

[1] Saul Becker acknowledges the assistance of Sarah Lawrie who conducted the preliminary electronic and manual searches for this literature review. The analysis presented here is based on Professor Becker's reading and critical assessment of this literature and of other texts generated from his additional searches. A written description of the search methodology used for this literature review is available from the author.

in group cohesion, self-perception and reduced anxiety levels after attending a short programme. Wick, Wick and Peterson (1997) evaluated an Adlerian adventure therapy approach with *primary* school pupils and found that a significant increase in the children's self-esteem was achieved through just six one-half hour sessions. Teachers interviewed also said that they felt the pupils had started to mediate their own problems. Fox and Avramidis (2003) conducted a small-scale evaluation of an outdoor education programme for secondary school-age pupils with EBD and found that the programme was successful in promoting positive behaviour and academic gains for most pupils. They concluded that while outdoor education may not offer a solution to dealing with EBD, it did represent a powerful tool for reducing disaffection and for promoting inclusive practice. However, Fox and Avramidis also admitted that the design and size of their study made generalisations difficult. They concluded that: "The limited number and scope of the above studies highlights the need for further research exploring the value of outdoor education of pupils deemed to be experiencing EBD. In particular, there is a need for an examination of the educational attainments of such pupils during their participation in outdoor education programmes (alongside behavioural outcomes), as well as the identification of the most effective way of designing and implementing such programmes" (2003, p. 269).

See Chapter 4 for an initial assessment of the value of a pilot Team-building project in Nottingham

2. Anger Management

What it is and rationale: Angry children may engage in anti-social behaviours, including acts of violence. Children that become aggressive at a young age also tend to respond violently to challenging situations in later life (Kellner and Bry, 1999, p. 645). Thus, "Anger management is intended to counteract aggressive behaviours that interfere with students' interpersonal relationships at school and at home and to teach students how to express anger in ways that are less destructive for themselves as well as others. Constructive management of anger means 'making changes in thoughts feelings and behavioural responses to provocations that stimulate an anger response'" (Carter, 1994, p. 3; Eggert, 1994).

Research evidence: While anger management has been popular in the United States for some time, anecdotal evidence shows that its use with a range of groups, including children, is now also increasing in the UK (Pati, 2003). Kellner and Bry's (1999) small-scale study of the effects of anger management groups in a day school for emotionally disturbed adolescents found that the seven pupils who took part in the programme showed positive improvements when rated by teachers and parents in post-intervention assessments. The pupils exhibited a trend towards fewer incidents of physical aggression. The anger management programme included psycho-education, anger discrimination training, logging incidents of anger, and training in pro-social responses to anger. Sessions were held weekly for 10 weeks. However, the study is far too small to generalise the findings to other groups and settings. Similarly, Deffenbacher, Oetting and DiGiuseppe's (2002) review of studies found that anger management interventions worked well with adults, but here too problems of generalisation to other groups apply. In a review of approaches that have focused on reducing aggressive behaviour among children, Powers and Neel (1997) found that highly structured programmes had more significant (i.e. beneficial) treatment effects than less structured ones, although none of the programmes produced significant long-term benefits. They suggest that this may be because children with emotional and behavioural problems may have very high levels of aggression that require very structured interventions, and the interventions themselves need to take into account the multiple factors that actually lead to aggression in the first place. Thus, there is no reliable or robust research evidence to date that suggests that anger management approaches are an effective long-term therapeutic intervention for pupils with SEBD, although there is some evidence to suggest that it may be a 'promising approach' (Ollendick and King, 1991, p. 403; see also Resource 2).

3. Art Therapy

What it is and rationale: The expressive arts encourage the development of divergent thinking, creative self-expression, and perceptual awareness. They can help develop children's critical thinking skills; provide children with pleasurable opportunities to experience success; provide them with a sense of empowerment; and can help teach children to re-channel negative energies in constructive ways (King and Schwabenlender, 1994, p. 16). They can support normative patterns of communication through artistic expression. It has also been claimed that they can promote a child's cognitive, emotional and social development, contributing to improved academic performance (Frostig and Essex, 1998, p. 63). Drawing and other forms of art are non-threatening activities in which feelings and emotions can be released on paper or in other mediums. "In the art therapy setting individuals work with art materials they can control. During the creative process they begin to understand and take command of their own lives" (Algozzine, 1992, p. 7:2, quoted in Carter, 1994, p. 5). Art activities promote self-esteem, self-confidence, and feelings of acceptance and success. Educators can better understand pupils by examining their artwork (King and Schwabenlender, 1994, p. 16). Brief, solution-focused art therapy allows pupils to represent their conflicts more readily than they can verbalise them: "The art can speak the unrest and confusion that is pervasive and simultaneously give focus to the session through an art product. The adolescent is attempting to find his or her identity" (Riley, 1999, p. 85).

Research evidence: Most claims for the effectiveness of art therapy are not supported by any reliable evidence, for example Riley's assertion that "Art therapy, *more than any other therapeutic approach,* has demonstrated it provides the creative opportunity to integrate a positive, active, nonthreatening therapy with the intrinsic talents and abilities of the adolescent stage of development" (Riley, 1999, p. 84, our emphasis). Despite the use for centuries of art as therapy, there is a profound lack of reliable and robust evaluation studies that have assessed its effectiveness with *any* client groups, including pupils with SEBD. Burleigh and Beutler's (1997) review of art therapy effectiveness studies found that there was no critical mass of well-controlled studies, and the authors concluded that at that time there was only suggestive support for the value of art therapy as a means of altering targeted problem behaviours among children. In a later review of published art therapy effectiveness studies (many of which relate to groups other than children), Reynolds, Nabors and Quinlan (2000) identified 17 studies that met their criteria for inclusion in the literature review. These authors also concluded that there is only suggestive (i.e. not proven) evidence of positive effects due to art therapy. They report one study, conducted by Tibbets and Stone (1990) which found that adolescents attending a short-term art therapy programme (once a week for 45 minutes, spread over 6 weeks) had a significantly greater reduction than a control group (doing weekly activities such as board games, taking walks) in the level of depression and an increased level of positive emotions and expressed pride in themselves (Reynolds, Nabors and Quinlan, 2000, p. 210). Olive (1991) found that art therapy could help pupils with emotional and behavioural difficulties develop their interpersonal skills even though other beneficial therapeutic and behavioural outcomes were less evident. Thus, with very few studies to commend the benefits of art therapy for pupils with SEBD, and a greater body of contra-evidence (that art therapy has little beneficial therapeutic outcomes over and above anything else), we must conclude that at this stage there is no robust or reliable research evidence to suggest that art therapy it is an effective therapeutic approach for pupils with SEBD. It is also unlikely that research evidence showing its effectiveness will be forthcoming in the absence of well-designed evaluation studies. This is not to say that art therapy should not be used - it appears to be able to offer creative opportunities for self-expression - but there is virtually no formal research evidence to support its use as a *therapeutic* intervention to help children with more deep-rooted social, emotional and behavioural problems.

See Chapter 4 for an initial assessment of the value of three Art-related therapies in Nottingham, including an Art, Photography and Filmmaking project

4. Bibliotherapy (the use of stories for therapy)

What it is and rationale: Bibliotherapy can be defined as treating problems through the use of books. Educators can sensitise children to themselves and to others through literature. Literary material can assist the reader to develop problem-solving strategies for future problems that they may encounter, or help solve existing problems. Readers must first *identify* with a character in the book, then they must *interact* with that character (necessary to release emotions), and then they must develop insight that enables attitudes and behaviours to be analysed. Literature serves as the vehicle for the child to learn alternatives (King and Schwabenlender, 1994, p. 15). A variant on this is 'Cinematherapy': "a therapeutic technique that involves careful selection and assignment of movies for clients to watch with follow-up processing of their experiences during therapy sessions. It can be used as a stimulus for discussion in therapy or as a metaphorical intervention" (Sharp, Smith and Cole, 2002, p. 270).

Research evidence: King and Schwabenlender (1994, p. 15) review briefly some of the evidence on the use and effectiveness of bibliotherapy. They suggest that the approach can increase the child's awareness of their problems and promote change through non-confrontational approaches to modify maladaptive behaviours; it can empower children to think, feel, and act in more productive ways; it can influence emotional adjustment, especially when group discussions occur. It has been used with children with learning disabilities, children who have been sexually abused and those who have mis-used substances. Limitations include: it may not be an appropriate strategy for every child; children may not identify with the characters in the book or they may use them as scapegoats; children may be unwilling to read the material or discuss areas of conflict or discomfort. Carter (1994) cites The Literature Project (Miller, 1993) as an example of a literature-based reading programme that focused on the needs of adolescent females with behavioural/emotional disorders or at risk: "Using novels and short stories written by and about women, the project seeks to introduce young women to female characters who are self-reliant, confident, and able to accomplish goals despite difficult circumstances. Students participating in the project have demonstrated improved self-concepts and self-confidence" (Carter, 1994, p. 8). King and Schwabenlender (1994, p. 15) suggest that bibliotherapy "may be used carefully as an instructional and values clarification system but should not replace other ongoing therapies". Thus, while there is some anecdotal evidence that bibliotherapy can be helpful, it should not be considered as a stand-alone therapeutic intervention for pupils with SEBD. Similarly, there is a "paucity of research on the effectiveness of cinematherapy as a therapeutic technique" (Sharp, Smith and Cole, 2002, p. 271).

5. Circle of Friends

What it is and rationale: Like any child, pupils with challenging behaviour need to feel a sense of belonging. "A process known as 'Circle of Friends' can help students build relationships with their classmates. Students who volunteer to be part of a particular student's 'circle' offer support and friendship. The circle meets on a regular basis as a team; a teacher who coordinates the circle can help problem solve any issues that come before the group" (Carter, 1994, p. 9). The Circle of Friends (CoF) approach was initially developed to help people with disabilities become more included in their local communities, and then extended to reintegrate into mainstream classrooms those pupils who experienced special educational needs and who had been educated separately. More recently it has been used to support pupils with SEBD in the educational setting by enlisting the help of the other children in their classes and setting up in each class a 'circle' of friends (Newton, Taylor and Wilson, 1996; Newton and Wilson, 1999). This group helps to set, monitor and review

weekly targets in a meeting facilitated by an adult. They also provide agreed support to facilitate the inclusion of a pupil who is experiencing problems and to help them achieve their targets (Frederickson and Turner, 2003). The CoF approach is at the opposite end of the continuum of interventions from approaches based on ignoring difficult behaviour. It is a systemic approach that recognises the power of the peer group to be a positive as well as a constraining or exacerbating influence on individual behaviour. Efforts to increase the inclusion of a pupil with SEBD within their peer group 'circle' can therefore be very powerful.

Research evidence: As Frederickson and Turner (2003) acknowledge, few evaluation studies have been conducted on Circle of Friends. Those that have been conducted to date have reported encouraging results, often using qualitative case studies. However, it is not possible from the evaluations conducted to date to reliably attribute any changes in behaviour to CoF interventions. However, a small study conducted by Frederickson and Turner (2003) on *primary* school-aged pupils with EBD using random selection showed a consistently positive effect of the CoF intervention on social acceptance by classmates even though few changes were obtained on measures of children's perceptions and behaviour. The authors suggest that there is potential value in developing Circle of Friends for use in schools, not least of which is to help pupils with SEBD become more included and accepted by their circle of classmates. Anecdotal evidence (Becker, Sempik and McCrossen, 2003, p. 13) also show it can have beneficial outcomes. This is an approach that warrants more critical use and formal evaluations of its effectiveness. See also 'Peer Support Programmes'.

6. Cognitive Behavioural Therapy (CBT)

What it is and rationale: The *behavioural approach* is typified by a concern to achieve change in observable behaviour. Both assessments and therapeutic interventions are systematic and focused primarily and directly on items of behaviour ('target behaviours'), particularly those behavioural responses that have become habitual for the individual. The *cognitive approach* is linked closely to the behavioural approach but oriented more towards attitudes, assumptions and cognitions. It is often combined with behavioural approaches (as in *Cognitive Behavioural Therapy* - CBT) and uses many of the same techniques to help the patients to control their behaviour (Royal College of Psychiatrists, 1997, p 5). Thus, CBT combines elements of both behavioural and cognitive approaches: "CBT interventions for antisocial behavior often try to help children perceive ambiguous social situations in a non-hostile manner, generate more assertive (vs. aggressive) responses to possible social problems, evaluate the potential consequences of such responses, and enact adaptive solutions. In addition, CBT interventions for antisocial behavior have also included components of self-monitoring, self-reinforcement, and relaxation" (Bennett and Gibbons, 2000, p. 3).

Behavioural approaches can often make use of a *contract* - a method of formalising expectations, rights, responsibilities, goals and outcomes between pupils and educators. It is most often a written document, agreed between children and teachers/therapists. Behavioural approaches can also use *home notes* - an assessment of a pupil's academic and/or behavioural progress that is sent home periodically for parents to review and sign and return to school. Home note programmes frequently request that parents apply some type of rewards for a positive report and mild reductive consequences for a poor report (Rhode et al, 1993). A strength of a home note system involves the school-to-home and back-to-school communication cycle, informing parents of their child's progress and allowing the use of consequences in the home that are rarely available to the teacher. See also 'Coping in Schools Programme'.

Research evidence: Mpofu and Crystal (2001) argue that there has been much more treatment studies on conduct disorders with CBT than any other therapy. Bennett and Gibbons' (2000)

meta-analysis reviewed 30 studies comparing child-based cognitive behavioural therapy for anti-social behaviour. They found that child-based CBT interventions have a "small to moderate effect" in decreasing anti-social behaviour among children. These interventions were also found to be more effective when used with older children - adolescents and older primary school-aged pupils - rather than younger primary school children (p. 9). They also found that CBT may be more effective when parents are also included in treatments. Mpofu and Crystal (2001) confirm that CBT is more effective as a treatment for adolescents than with younger children. One of the reasons for this is that adolescents are likely to be more developmentally mature in perspective-taking and expressive and language abilities. They are also likely to be less easily distracted. Mpofu and Crystal suggest that multi-modal interventions (which include CBT *and* other approaches), may provide greater benefits than CBT alone. The authors also conclude that while CBT seems to achieve short-term gains for some children, it is not successful with more severe cases or when clients have other disorders as well. The evidence also indicates that a well-designed *home note* system can improve academic performance and classroom behaviour. Studies suggest that where pupils take part in a home note scheme their concentration and participation in class can improve; they complete work (including homework) more carefully; and they can achieve at an appropriate level (Atkeson and Forehand, 1979; Broughton et al, 1981).

7. Coping in Schools Programme

What it is and rationale: The Coping in Schools Programme focuses on teacher/pupil interactions and works towards cognitive behavioural change to improve those interactions. It can be used as a reintroduction programme for pupils with EBD in specialist settings, which involves a number of stages, including assessment, preparation, and support once pupils had transferred from specialist education provision back into mainstream classes (McSherry, 1996, 2002). A Reintegration Readiness Scale is used to help assess whether or not a pupil is ready to be reintegrated back into mainstream teaching from other specialist settings. Group work is used to help prepare pupils to reintegrate into mainstream classes: "This group provides an opportunity for pupils with the same long-term aim (mainstream reintegration) to share their fears, hopes and concerns. Pupils can set their own guidelines for group behaviour and format. This approach proved particularly effective as it gives pupils ownership of the process…" (McSherry, 2002, p. 36). The Programme can also be used as an early intervention strategy for pupils experiencing some problems in their mainstream classes. See also 'Transition Groups'.

Research evidence: McSherry (2002) provides an evaluation of the Coping in Schools Programme, showing its importance and its effectiveness in helping pupils with EBD to reintegrate into mainstream education: "over a four-year period 27 pupils were reintegrated from the EBD special school; 81.5% of those reintegrated over this period maintained their mainstream placement" (p. 37). See also 'Group Therapies/Group Work'.

8. Counselling

What it is and rationale: "Counselling involves a helping relationship in which a counsellor works with a client to clarify the nature of a problem experienced or presented by a client, and to explore possible solutions" (Galloway, 1990, p. 66, cited in Lane, 1996, p. 46). A broad distinction can be made between generic and specific counselling. The latter can be specific to a particular therapeutic model (for example, cognitive behavioural counselling) or a specified life event or crisis (for example, bereavement counselling) (Department of Health, 2001). A distinction also exists between 'counselling' and the use of 'counselling skills'. Most teachers are required to use counselling skills in their interactions with pupils, and this can take place on three levels in mainstream schools (Hamblin, 1993): the *immediate,* classroom, level where counselling skills are used to provide a positive learning environment; the *intermediate* (often pastoral) level, where counselling skills are

used to help longer-term adolescent development and coping strategies; and the *intensive* level, where counselling is used to provide long-term support to pupils with more serious needs. This third level is often provided by specialist counsellors or agencies, for example in LSUs.

Research evidence: "Individual and group counselling sessions can help students learn to express their feelings openly and honestly with one another and share ways to cope with similar problems and experiences. Various counselling strategies can be used to resolve emotional and behavioural problems as well as encourage behavioural change. Counseling sessions may be facilitated by a psychologist, counsellor, social worker, or teacher trained in counselling techniques" (Carter, 1994, p. 15). Counselling can involve the use of different therapeutic approaches, including play therapy, art therapy, drama therapy, bibilotherapy, behavioural approaches, and so on. In a recent book on counselling in schools (Hornby et al, 2003) there is little if any mention of the need to evaluate counselling in schools to see which approaches may be the more beneficial for particular groups of pupils. Indeed, despite its widespread use, there is very little evaluation evidence on the effectiveness of counselling in helping children and young people to overcome social, emotional and behavioural problems. See also 'Individual Therapies'.

See Chapter 4 for an initial assessment of the value of a pilot Counselling project in Nottingham

9. Dance/Movement Therapy

What it is and rationale: The American Dance Therapy Association has defined dance/movement therapy as the "use of movement as a process which furthers physical and emotional integration of an individual" (cited in Ritter and Low, 1996, p. 249). "Dance/movement therapy is a unique, holistic approach of psychotherapy which encourages self-expression through movement. It is a primarily non-verbal therapeutic modality which promotes emotional and physical integration.... Within the dance/movement therapy context, children and adolescents are given the opportunity to creatively express their inner concerns, anxieties, and emotional conflicts in a safe, non-threatening manner" (Bannon, 1994, pp. 3-4). The therapy process begins with the establishment of a safe environment in which a therapeutic relationship, built on acceptance, respect, empathy and trust, can be developed. Through the experience of movement and verbal connections young people are able to identify and resolve conflicts.

Research evidence: There is little rigorous research or evaluation of dance/movement therapy (DMT) in any setting and with any group, and virtually nothing at all on its use within secondary school settings for pupils with SEBD: "research on DMT is rife with methodological problems, including lack of control groups, poor sampling and use of inadequate measures to assess change" (Ritter and Low, 1996, p. 258). What we know about its effectiveness, therefore, is gleamed from studies (usually small case studies) of its use with particular groups. For example, "feedback" from the use of dance therapy in a 45-bed state run facility for emotionally disturbed children and adolescents in the US suggests that "residents have been able to achieve both short and long term goals" (Bannon, 1994, p. 7). Improvements in self-control, self-esteem, interpersonal relationships and self-expression were recorded. Residents "have demonstrated the ability to focus and stay on task in the classroom, which has, in turn, affected their academic performance" (Bannon, 1994, p. 7). However, Bannon's paper provides no details of the research methodologies used, and cannot be considered to be at all rigorous, especially given that those who had dance/movement therapy also had other therapeutic interventions, and the effects of each of these cannot be disaggregated. Ritter and Low (1996) provide a meta-analysis of a number of evaluative studies of the effects of dance/movement therapy with a variety of subject groups. They suggest that the psychological and physical improvements that have been attributed to DMT can be categorised into five areas: re-socialisation and integration within a larger group system; nonverbal creative expression for

emotional expression; total self- and body-awareness and enhanced self-esteem; muscular coordination, broader movement capabilities and tension release; and enjoyment through relaxation. However, they report that while there is some evidence that DMT can have 'modest' beneficial outcomes for children, including those with anxiety, there is scant evidence on its effectiveness for pupils with SEBD. See also 'Music Therapy'.

10. Drama Group Therapy

What it is and rationale: It is argued that dramatic techniques can assist pupils with SEBD to assume responsibility for their own behaviour. Drama can help children become aware of and deal productively with their feelings and emotions. Classroom-based activities can include puppetry, role-playing, charades, pantomimes, plays, games, etc. Dramatic situations can build group cohesiveness; positive interactions among children can promote social-skills development (King and Schwabenlender, 1994, p. 16). Stephenson (1993) outlines the use of drama as a therapeutic approach for pupils with EBD. Drama in the educational or therapeutic setting has its roots in *playing* rather than the play: "Child-centred drama is essentially play guided by the teacher along specific lines to provide learning experiences in such areas as decision making, language development, imaginative creativity, co-operation with others and the acquisition of person and social skills" (Stephenson, 1993, p. 170). Drama therapy focuses on the interpersonal problems of the individual and assists in the working though of these problems: "The main strength that drama therapy has is that it necessitates active participation and allows scenarios to be experienced from different viewpoints by the same individual, in a safe setting, where a range of approaches can be tried out, or rehearsed, without the consequences which would accrue in a real life situation" (ibid, p. 172). The main principles that guide Stephenson's approach to drama therapy are that participants should be given opportunities for self-discovery within an atmosphere of mutual trust and toleration; that staff members should participate fully; that positive regard, self-discipline and the growth of self-esteem should be actively encouraged (ibid, p. 171). Stephenson goes on to outline the practical arrangements that are needed for an atmosphere of trust to be developed. She suggests that the "main techniques which seem to be effective with young people include gestalt, psychodrama, sociodrama, trust and encounter exercises" (pp. 173-4) (see also Box R1, 'Different types of drama therapy'). Thus, "Therapy is not something that the leader gives the group; it is the shared outcome of people working seriously and playfully together" (p. 181).

Drama therapy can make use of role play: "Role playing is an effective method that helps children encounter various levels of tension and relaxation while also learning to recognize their own stressors" (King and Schwabenlender, 1994, p. 14). Children often model their behaviour, responses and emotions on significant adults, including parents, care givers, and teachers. Young people often learn by imitation and will model adults' behaviours. Role play can therefore be used as part of other therapeutic techniques with children who need to develop an understanding of appropriate roles, particularly to develop greater self control and socially acceptable behaviour.

Box R1:
Different types of drama therapy
(from Stephenson, 1993, pp. 174-5)
Gestalt: Concerned with the here and now. The focus is on how things happen, not why.
Psychodrama: a creative technique which involves the acting out of problems, conflicts, relationships in the past, present or future in a group setting with a dramatic format and theatrical terms.
Sociodrama: similar to psychodrama but is more concerned with collective issues rather than problems of an individual. It offers catharsis and insight and concentrates on role training.
Trust exercises and encounter games: aim to raise awareness about ourselves so we can break down the personal barriers that we erect and respond to each other in a more open and spontaneous way.

Research evidence: A school-based randomised controlled trial (McArdle et al, 2002) allocated 122 children at risk of behavioural or emotional problems, with a mean age of just over 11, to drama group therapy or to a curriculum studies control group. Each group ran for an hour a week for 12 weeks. Significant effects, as reported by pupils themselves, were associated with both interventions. However, the teachers especially highlighted the positive effects on pupils attending the drama group therapy. The researchers concluded that group therapy had the greatest impact on the most disturbed young people and that this beneficial effect was sustained a year later. Drama group therapy is superior to no intervention and, compared to the curriculum studies control group, appears to also accelerate change: "The findings indicate that group intervention targeted on at-risk children, and that focuses on psycho-social development, enhances subjective well-being and the adjustment of children to school…The findings suggest that education and health professionals and managers should consider including group-work-based early interventions in the development of new health services or in the overall management of behavioural and emotional problems in school" (McArdle et al, 2002, p. 711).

A small-scale evaluation of a drama therapy group at Beechwood secondary school, Slough (George, 1999) found that, for eight of the nine pupils referred to the group as a result of problematic behaviour, there was some improvement in their behaviour over the course of attendance, although a close reading of the report shows that five of the pupils went on to be involved in at least one incident serious enough to warrant a further period of fixed term exclusion. The pupils' accounts indicated that most enjoyed the sessions and valued the opportunity to express their feelings and have some influence over the content. Most thought their behaviour had improved. Heads of year agreed that the behaviour of most of those attending had improved since the sessions started, especially when drama therapy was being used alongside other interventions. However, this evaluation is far too small and limited in design to determine the effectiveness of drama therapy, although, alongside the McArdle et al study (2002), there is limited evidence to suggest that drama therapy can be useful in providing a group-based opportunity for creativity and joint working, and which can lead to more positive perceptions of self. Nor is there robust research evidence evaluating the effectiveness of role play for secondary school-age pupils with SEBD. See also 'Group Therapies/Group Work'.

See Chapter 4 for an initial assessment of the value of a pilot Drama therapy project in Nottingham

11. Family Therapy

What it is and rationale: Family therapy is "any psychotherapeutic endeavour that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family unit, or its subsystems, and/or the functioning of individual members of the family" (Gurman, Kniskern and Pinsof, 1986, p. 565, cited in Chamberlain and Rosicky, 1995, p. 459). See also Box R2.

Box R2:
Different types of family therapy
Solution-focused brief therapy: aims to help families manage the problems associated with their child's emotional and behavioural problems by working on their own solutions to these problems.
Functional family therapy: aims to reduce disorganisation in families by altering chaotic family routines and communication patterns that maintain anti-social behaviour.
Multi-systemic therapy: aims to do all that which functional family therapy does, but also addresses factors within the adolescent and within the wider system.
Treatment foster care: aims to modify conduct problem-maintaining factors within the child, family, school, peer group and other systems by placing the child temporarily within a foster care family in which the foster parents have been trained to use behavioural strategies to modify youngsters' deviant behaviours.

Functional Family Therapy (FFT) reflects an integrative approach to treatment that relies on systems, behavioural and cognitive views of dysfunction. Clinical problems are conceptualised from the standpoint of the functions they serve in the family as a system, as well as for individual family members. A child's problematic behaviour is assumed to be the only way some interpersonal functions (e.g. intimacy, distancing, support) can be met among family members. The goal of treatment, therefore, is to alter interaction and communication patterns in such a way as to foster more adaptive functioning. Treatment is also based on learning theory and focuses on specific stimuli and responses that can be used to produce change (Kazdin, 1997, p. 167). Kazdin suggests that FFT requires the family to see the clinical problem from the relational function it services within the family. The therapist points out interdependencies and contingencies between family members in their day-to-day functioning and with specific reference to the problem that has served as the basis for seeking treatment. Once the family sees alternative ways of viewing the problem, the incentive for interacting more constructively is increased (Kazdin, 1997, p. 167). Treatment goals focus on increasing reciprocity and positive reinforcement among family members; establishing clear communication; specifying behaviours that family members desire from each other; negotiating constructively; and helping identify solutions to interpersonal problems.

Research evidence: A number of comprehensive reviews of the literature in the 1980s and 1990s have shown family therapy to be a promising method for the treatment of child and adolescent conduct disorders. Carr's (2000) review of the literature on the effectiveness of family therapy for 'child-focused' problems suggests that there is a reliable evidence base to show that family therapy interventions are effective for a wide range of child-focused problems (p. 50). This evidence base supports the evaluation of family therapy as an effective treatment either alone or as part of a multi-modal or multi-systemic treatment programme for child abuse and neglect, conduct problems, emotional problems and psychosomatic problems. Chamberlain and Rosicky's (1995) literature review also suggests that "family therapy interventions appear to decrease adolescent conduct problems and delinquent behavior when compared to individual therapy, treatment as usual, or no therapy" (p. 445). However, the authors point out that there is a significant number of families who have not had such positive outcomes, especially 'multiply stressed' families. Here there is evidence that many families drop out of treatment and show high levels of resistance. The authors suggest that the available literature indicates that family therapy "is more difficult to implement for adolescent populations from multistressed families and may be a necessary component of treatment but perhaps not a sufficient strategy, in and of itself, for producing clinically significant behavior change" (p. 450). Family therapy has also been found to be less effective with adolescents (those aged over twelve and a half) and for adolescents who engage in both overt and covert problems - such as aggression and stealing.

While there are few outcome studies that have evaluated explicitly *functional family therapy,* there is a growing body of reliable evidence, using controlled studies, that FFT can be effective for delinquent adolescents and multiple offender delinquents. The evidence shows that FFT has led to greater change than other treatment approaches (for example, client-centred family groups, psychodynamically-oriented family therapy) for these groups of children. It has been shown also to be better than various control conditions (e.g. group discussions and expression of feeling, no treatment control groups). Treatment outcome is reflected in improved family communication and interactions and lower rates of referral to and contact of children and young people with the courts. Gains have continued in follow up studies up to 2.5 years after treatment (Kazdin, 1997, p. 167).

12. Group Therapies/Group Work

What they are and rationale: "Group work is a technique for helping young people to recognise and accept their feelings and to respect the feelings of others. It can be employed in a variety of contexts and for a variety of purposes" (Coppock and Dwivedi, 1993, p. 278). Group-based therapy, as opposed to *individual treatment,* "is much more conducive for sharing of feelings because, if one member is able to do so, others are helped by the processes of identification, modelling and projection" (Dwivedi, 1993, p. 299). Group therapy is also more economical than any other approach, because one or two therapists can work with a number of young people at the same time. However, in opposition to this view, Harper (1993, p. 71) suggests that "Clinical experience favours the provision of *individual* therapy as the treatment of choice. Once an ability to bond and relate is established, use of group treatment resources may then be possible and more appropriate". Harper acknowledges that group work therapy has a key role to play: "The provision of experiences and responses which address developmental imbalances are the cornerstone of effective group treatments" (p. 70), but the use of group work must be appropriate to the particular developmental stage of the children concerned: "Prior to commencing groupwork, a thorough assessment of the potential group member's emotional, cognitive, and social functioning is vital if provision is to be accurately targeted" (Harper, 1993, p. 70). The use of group work in secondary schools is less prominent than in primary schools, but it is now beginning to achieve greater eminence (Decker et al, 1999).

Research evidence: There is robust and reliable evidence that group therapies *in general* can be more effective than *individual* forms of treatment, although this might suggest that individual and group therapies are alternative forms of treatment rather than treatments which are more appropriately used with specific types of child-related problems. The evidence suggests that group work within schools can have both immediate (Cooper, Arnold and Boyd, 2001) and longer-lasting (McArdle et al, 2002) beneficial outcomes for pupils who have, or are at risk of social, emotional or behavioural problems, and can accelerate change within individuals. There is also an established literature that identifies the beneficial outcomes of school-based group work for pupils with SEBD. Coppock and Dwivedi (1993) suggest that there is "great potential in the school setting for groups whose purpose is the promotion of mental health and the helping of children with emotional and behavioural problems" (p. 267). They discuss the advantages of setting up such groups - methods of co-operative learning - within schools. These advantages include a familiar environment; pupils may build rapport quickly with others that they already know; positive effects for the group will also benefit the school itself. The authors suggest that group work can help pupils form better relationships with peers and teachers that can directly affect their behaviour in the classroom. The authors go on to outline the differences between groups, the practical considerations which need to be taken into account, the rules that are required, the processes involved, confidentiality issues and so on. However, the authors present little evidence on the effectiveness of group work in comparison with other forms of therapy.

One study that does assess the effectiveness of group work is the meta-analytic review conducted by Hoag and Burlingame (1997). Utilising 56 outcome studies published between 1974 and 1997, this meta-analysis examines specifically the effect of group treatment with children and adolescents aged 4-18. However, because the texts analysed also refer to primary school-aged children, and just three quarters of these studies took place in school-based groups, the findings are only partially relevant to our current focus on SEBD. Having said that, however, Hoag and Burlingame's meta-analysis of various types of group treatment (including preventative programmes, psychotherapy, guidance groups, etc.) indicates that "group treatment was significantly more effective for children than wait-list and placebo control groups…. That is, the average child or

adolescent treated by group treatment is better off than 73% of those in control groups" (p. 234). This meta-analysis strengthens and supports conclusions in the current literature which show the benefits of group work in general, and on a wide age-range of children and adolescents, who have a range of needs (not just those with behavioural disorders, but also children with social-skills problems, children of divorced parents etc). Children from higher socio-economic status seemed to fair better from group work. One other finding from this meta-analysis is worthy of mention here. Around one quarter of the studies in the meta-analysis took place in clinical group settings - including both inpatient and outpatient settings (as opposed to being school-based). The findings of this meta-analysis suggest that studies in the school setting were significantly less effective than studies in clinical settings. Further research needs to be conducted, therefore, to determine whether group work in clinical settings is more effective than group work within schools for pupils with SEBD. However, other studies indicate group work can have beneficial outcomes in different contexts. McSherry (2002, pp. 41-42) reports the specific use of group work to facilitate the explorations of the emotional and cognitive demands pupils with EBD face when moving from specialist educational settings back into mainstream education. Group work can be particularly effective in helping pupils to prepare for reintegration into mainstream classes (see also 'Coping in Schools Programme'). McSherry concludes that "Initial evaluations of the group work approach indicate that pupils who participate find it helpful, parents are very positive about the input their child has received, and mainstream teachers find it useful for target setting and in developing an improved understanding of EBD" (McSherry, 2002, p. 42). Finally, Kazdin (1997, p. 172) warns that group therapy can *impede* improvement when children with conduct disorders are placed in a group together. He cites research where children with disorders are placed in groups with non-antisocial youths: "Those placed in a group of their deviant peers did not improve; those placed with nondeviant peers did improve". See also 'Drama Group Therapy', 'Nurture Groups', 'Coping in Schools Programme'. In contrast to group work approaches are individualised therapies, which focus on working with individual children. See 'Individual Therapies'.

13. Homeopathy

What it is and rationale: Homeopathic medicine is individualised treatment rather then one-size-fits-all. It is based on the individualisation of treatment, assuming that each child is unique and needs a medicine that specifically matches their pattern of symptoms. It is suggested that homeopathy offers a viable solution for handling emotional and behavioural problems that is safe, natural and effective (Reichenberg-Ullman and Ullman, 1999, p. 82).

Research evidence: Reichenberg-Ullman and Ullman suggest that there are well over one hundred documented studies of the effectiveness of homeopathy with a range of client groups, a number of which are double blind (1999, p. 123). In reviewing their own caseload of over 1,500 children whom they have treated, they estimate a 70 per cent success rate in children who receive two years of consistent homeopathic treatment. While a significant positive shift often occurs within 4-6 week after taking the medication, a minimum of two years of treatment is needed to assure that the improvements are maintained over time (p. 79). The authors present many case studies of how homeopathic treatments have helped individual children with a range of social, emotional and behavioural difficulties.

In a later study, comparing the use of the medication methylphenidate (MPD) with homeopathy for 115 children aged 3-17 with ADHD, Frei and Thurneysen (2001) found that homeopathy compared very favourably with medication. Homeopathy, like MPD, is a palliative treatment. Long-term follow up studies over many years would be necessary to determine whether a curative effect can be expected. The authors concluded that "In cases where treatment of a hyperactive child is not urgent, homeopathy is a valuable alternative to MPD. The reported results of homeopathic treatment appear to be similar to the effects of

MPD…In preschoolers, homeopathy appears a particularly useful treatment for ADHD" (p. 183). Because homeopathy requires an individualised prescription, it is difficult to treat in a situation where an improvement has to be immediate. The choice of the correct homeopathic medication is dependent on the individuality of the symptoms, and therapeutic trials may be needed to get the correct medicine. Substantial improvements can often be seen in just 4 weeks, and the majority of children who do respond to homeopathy will have done so within 6 months (Frei and Thurneysen, 2001, pp. 186-7). Advantages of homeopathy over MPD are: easy administration; a continuous treatment effect over 24 hours; no side effects except for a possible short initial aggravation; and no abuse potential. For many parents this last point is the most important concern (Frei and Thurneysen, 2001, p. 187). Additional advantages are that homeopathy is safe and gentle and will only change the child's personality for the better. It will not make the child depressed, sleepless, take away their appetite or remove their spark and enthusiasm. It is also tolerated well by oppositional children; it is relatively economical in the long run; and it can heal physical as well as mental and emotional problems (Reichenberg-Ullman and Ullman, 1999, pp. 82-3). However, much more research, especially randomised controlled trails, will be needed to determine whether homeopathy is an effective treatment for pupils with SEBD and how it compares with other therapeutic interventions. See also 'Pharmacotherapy (Medication)'.

14. Individual Therapies

What they are and rationale: "Individual therapy and counselling are well established as ways of providing therapeutic help for individuals who are experiencing emotional difficulties and many different theories have been developed on which such interventions can be based" (Smith and Cooper, 1996, p. 4; Cooper, Smith and Upton, 1994, p. 52). Smith and Cooper (1996) outline three broad theoretical underpinnings that help us to understand the dominant approaches to individualised (as opposed to group therapies or group work) approaches to working with children with SEBD (see Box R3). The research evidence on specific individualised approaches, such as counselling, are discussed throughout this A - Z.

Box R3:
Theoretical underpinnings of individualised therapies

Dynamic psychotherapy: this refers to a group of theories that share a common focus on the inner world of feelings and emotions and a belief that change occurs by helping 'troubled' children to gain insight into the links between present events and previous experience. Approaches here would include work that focuses on relationships and efforts to uncover anxieties, build firm attachments and strengthen self-esteem. The key to dynamic psychotherapy is the quality of the relationship that exists between the therapist and the child. This must be based on trust, in which the child feels able to engage in honest and direct communication and which will gradually lead to a greater acceptance of self and a growing understanding of the nature of the underlying 'disease and distress' (see also Cooper, Smith and Upton, 1994, p. 64).

Behavioural approaches: These start by defining a 'target' behaviour which needs to be changed, often using incentives and rewards to encourage and reinforce the desired behaviour. Undesired behaviours will be ignored so that they extinguish for want of reinforcement, or by adverse consequences. School-based approaches here would include identifying appropriate forms of rewards and sanctions and specifying individual programmes or 'contracts' (see also Cooper, Smith and Upton, 1994, pp. 73- 84).

Ecosystemic approaches: From this viewpoint, behaviour results from an interaction between a social environment and internal motivation, where change in one affects the other. By reframing an interpretation of apparently oppositional behaviour by children in a more positive way, cooperation can be promoted and confrontation is reduced. Approaches would involve assessments of the multiple and interactive factors that help interpret behaviour in more positive ways (Smith and Cooper, 1996, p. 4; see also Cooper, Smith and Upton, 1994, for an in-depth discussion of all these approaches).

15. Mentoring (including Learning Mentors)

What it is and rationale: A common characteristic of mentoring programmes is the pairing of a child at risk with one or more role models who are supportive and caring. The 'role model' may be a specialist mentor (such as a Learning Mentor - see below), other school staff, another young person within or outside the school or someone else who can fulfil the role (Sprick et al, 1993). Learning Mentors are one of the three main strands of the Excellence in Cities initiative. They work with teaching and pastoral staff to identify, assess and work with pupils who need help to overcome barriers to learning, including any behavioural difficulties. Their work typically takes the form of regular one-to-one sessions with pupils identified as requiring help, during which the pupil and mentor will agree targets for areas of concern (for example, attendance, behaviour and attainment), and talk through any concerns that the child might have regarding learning. Mentors will typically form a relationship with pupils, school staff and parents/carers in order to improve the pupil's engagement with learning.

Research evidence: An inspection by the Office for Standards in Education (Ofsted) found that learning mentors in secondary schools are making a significant effect on the attendance, behaviour, self-esteem and progress of the pupils they support; that the support of learning mentors is valued highly by pupils and their parents; and that the learning mentor scheme enables schools to provide appropriate and flexible support for pupils when they need it (Ofsted, 2003, p. 46). Learning mentors are the most successful and highly valued aspect of the whole Excellence in Cities programme. In 95% of the survey secondary schools, Ofsted inspectors judged that the mentoring programme made a positive contribution to the mainstream provision of the school as a whole and had a beneficial effect on the behaviour of individual pupils and on their ability to learn and make progress. Learning mentors were also seen as providing good value for money. Pupils generally saw their learning mentor as being someone they could talk to and trust: "The pupils valued most the fact that an adult in the school was making time for them and showing a real interest in their development. Some pupils, who were often disruptive in a classroom situation, were prepared to listen, try hard, and do their best to please the mentor. This brought about both academic and personal progress, which in turn inspired further effort and success" (Ofsted, 2003, p. 47). Teachers saw learning mentors as helpful both for the pupils involved and as means of reducing the disruption these pupils might have caused in class. Ofsted identifies a number of features of successful use of learning mentors: clearly defined roles for mentors and systems for referral to them; comprehensive staff briefing and training; good links with pastoral and academic staff; definite targets for pupils, with regular review; adequate time for regular meetings; well-organised records; manageable caseloads; and regular liaison with parents (Ofsted, 2003, p. 48). A few schools had also trained pupils to be peer group mentors, and successfully changed attitudes to learning among some boys in particular (p. 52).

A study by the London School of Economics (Shiner, Young, Newburn and Groben, 2004) evaluated the role of one-to-one mentoring with disaffected young people aged between 12 and 19. Almost 400 young people were recruited onto 10 'Mentoring Plus' programmes run by Crime Concern and Breaking Barriers. Many had been referred to Mentoring Plus by Youth Offending Teams, Educational Welfare Services and schools. More than half of those recruited went on to engage with the programme on a monthly basis or more often. The young people were at significant risk of social exclusion. Many had experienced substantial disruption in their schooling and family lives; truancy and disengagement were widespread; many of those who had left school had done so without any qualifications; and levels of offending and illicit drug use and contact with the criminal justice system were much higher than in the general youthful population. The young people were generally positive about both one-to-one mentoring and the 'Plus' element of the programme (a programme of education and training and a series

of social activities). Most felt that both components had been helpful to them. However, the programmes' impact was most evident in relation to young people's engagement in education, training and work. Those who participated in the programme were more likely to go on and engage in these three areas than a similar group of young people who were not on the programme. Where programmes were well implemented, this engagement was most marked. However, there was no clear evidence of the programme having an impact in relation to offending, family relationships, substance use and self-esteem.

Thus, while there is not a substantial body of research evidence on mentoring in secondary schools, the Ofsted and LSE reports indicate that learning mentors can help bring about significant positive outcomes for pupils with challenging behaviour and for their schools. See also 'Peer Support Programmes'.

16. Multisystemic Therapy (MST)

What it is and rationale: Multisystemic therapy is a family-systems based approach to treatment - a package of interventions that are used with children and their families. Family approaches maintain that clinical problems of the child emerge within the context of the family and thus focus on treatment at that level. MST expands on that view by considering the family as one system. The family is embedded in a number of systems including the family, peers, school, neighbourhood etc. Treatment may need, therefore, to address the alliances and sources of conflict in an effort to alter child behaviour. Peer relations at school, individual treatment of child or parents, may all be included in a treatment plan. At its heart, however, MST is a family-based treatment approach. Several family therapy techniques (for example, joining, reframing, enactment, paradox and assigning specific tasks) are used to identify problems, increase communication, build cohesion and alter how family members interact. Treatment goals include helping parents develop the behaviours of their children; overcoming marital difficulties that impede parenting capacity; eliminating negative interactions; and developing cohesion and emotional warmth among family members (Kazdin, 1997, p. 168).

Research evidence: Ollendick and King (1991) identify multisystemic therapy as one of ten treatments that meet the criteria for 'probably efficacious' status - that is, there is a growing body of reliable and rigorous research evidence pointing to its effectiveness (see Resource 2). Kazdin (1997) reports studies which have evaluated the use of MST with extremely anti-social and aggressive youth: "Results have shown MST to be superior in reducing delinquency, emotional and behavioral problems and in improving family functioning in comparison to other procedures including 'usual services' provided to such youths (e.g. probation, court-ordered activities…), individual counseling and community-based eclectic treatment" (pp.168-9). Follow-up studies up to 2, 4 and 5 years later show that MST youths have lower arrest rates than youths who receive other services. Research also shows that treatment can affect some of the critical processes that contribute to deviant child behaviour, including child-parent hostility and conflicts (Kazdin, 1997, p. 169). Thus, in summary, there is some evidence that MST appears to offer some real, and long-term, benefical outcomes for pupils with SEBD. See also 'Family Therapy'.

17. Music Therapy

What it is and rationale: Music is an integral part of all children's lives. Music therapy is the "controlled use of music to treat, rehabilitate, educate, and train children and adults who suffer from physical, mental, and emotional disorders. The therapeutic value of music is not related to the type of music used, nor the way in which the music is presented. It is related to the effect of sound on an individual and the feelings and emotional responses that are provoked by that sound" (Weller and Buchanan, 1988, p. 211, quoted in Carter, 1994, p. 30). Tervo defines music therapy as "the prescribed use of music by a qualified person to effect positive changes in the psychological, physical, cognitive or social functioning of individuals with health or

educational problems" (Tervo, 2001, p. 79). Tervo links music therapy with psychoanalysis: "Music can relax, stimulate or open up channels of self-expression at a deep personal level. The effectiveness of music therapy is based on transference and self-expression, not musical skills or ability" (p. 86). Music therapy can take place in many settings, including schools. Music therapists and music educators have used music to: alter mood and assess emotional problems; enable individuals to vent emotions; strengthen skills for effectively coping with stress; promote expression and develop self-concept; stimulate communication; develop social skills and encourage appreciation of others (King and Schwabenlender, 1994, p. 16; Carter, 1994, p. 30).

Research evidence: There is some small-scale anecdotal evidence that music therapy can be beneficial for certain groups, including people with learning difficulties (Wigram and Heal, 1993). Tervo (2001) shows how music therapy can be used in a psychoanalytical way with adolescents in serious adolescent crisis, in a hospital setting. Tervo argues that music, and in particular rock music, "can give adolescents the possibility to express, be in contact with and share among themselves feelings of anger, rage, grief, longing and psychological disintegration". It also provides them with "opportunities to experience closeness and isolation and to explore their sexual fantasies and feelings" (Tervo, 2001, p. 79). While there is experiential evidence from Tervo's caseload that this may well take place, there is no robust research evaluation to support or validate this overall assessment. DeCarlo (2001) reports an entirely different (non- psychoanalytical approach) to music therapy in which young, urban African American adolescents with behaviour problems participated in one group session per week for eight weeks, using rap music to promote the development of appropriate social skills related to morality, identity, judgement, decision-making, anger management, impulse control and crime and punishment. DeCarlo's assessment of group functioning was based on the communication and interaction patterns of group members. Few incidents required the group leader's intervention and there were high levels of cooperation. Student response was positive and students' communication and interaction patterns improved. However, this method of evaluation is far from robust. DeCarlo conceded that the rap therapy should be considered as one of several multi-level treatment options that will need to take place in a coordinated fashion to ameliorate conduct disorders with adolescents (p. 47). Hallam and Price (1998) report the effects of background music played in a classroom where ten children with EBD were undertaking mathematical tasks. While the study is small-scale and involves no comparison (control) groups, the authors concluded that there was significant improvement in behaviour and mathematical performance for all the children. The effects were particularly marked for those whose problems were related to constant stimulus-seeking and over-activity. Improvements were also observed in improved cooperation and a reduction in aggression during the lessons immediately following the study. In summary, there is no robust research evidence that confirms that music therapy leads to improvements in behaviour for pupils with SEBD by bringing their behaviour into the normative range for other children. There is, however, limited anecdotal evidence that it can be beneficial in promoting social skills and group understanding, and provide a calming influence, but, in the absence of any controlled studies, these benefits may be as much a product of the 'group process' as they are of the music itself. See also 'Dance/Movement Therapy'.

18. Nurture Groups

What they are and rationale: The nurturing of children is important to build up their positive self-esteem, because a child's behaviour is the result of self-perception (King and Schwabenlender, 1994, p. 15). The guiding principle behind Nurture Groups is that children who exhibit SEBD are often experiencing emotions and exhibiting behaviours that, developmentally, are appropriate to children of a younger chronological age. There is now a growing body of literature on Nurture Groups.

Research evidence: Cooper, Arnold and Boyd (2001) suggest that: "In the short term, Nurture Group placement appears to have had a positive effect on a significant proportion of pupils" (p. 165). The authors' interim findings compare the progress of 216 children in Nurture Groups with 64 matched pupils with social, emotional and behavioural difficulties (SEBD) attending mainstream classes and another 62 matched pupils without SEBD in mainstream classes. Only a small number of these children are secondary school age - this study is predominantly of children attending primary schools. Notwithstanding this fact, the research suggests that attendance at a Nurture Group is associated with positive social, emotional and behavioural progress, as measured by Boxall Profile scores (Bennathan and Boxall, 1998) and the Goodman Strengths and Difficulties questionnaire (Goodman, 1997, 1999). Interviews with teachers also indicate that the Nurture Groups are perceived to have a positive influence on schools as a whole. Parents whose children attended a Nurture Group were also less anxious and more optimistic about their children's development. See also 'Group Therapies /Group Work', 'Quiet Place/Quiet Room', 'Circle of Friends'.

19. Parent Management Training (PMT)

What it is and rationale: Parent management training refers to procedures in which parents are trained to alter their child's behaviour in the home. The parent meets with a therapist or trainer who teaches them to use specific procedures to alter interactions with their child, to promote pro-social behaviour and to decrease deviant behaviour. The training is based on the view that conduct disorder in children is inadvertently developed and sustained in the home by maladaptive parent-child interactions. The therapist will help the parents to develop different parenting behaviours, such as establishing clear rules for the child to follow, providing positive reinforcement for appropriate behaviour, delivering mild forms of punishment where appropriate (for example, time out, loss of privileges) (Kazdin, 1997, p. 165). McSherry (2002, p. 44) emphasises the importance of keeping parents informed of all developments in the strategies and programmes used with their children.

Research evidence: Ollendick and King (1991) show that it is only parent training programmes that can claim the status of 'well-established' approaches - that is they have been supported (validated) as effective by rigorous scientific research evidence (see Resource 2). Kazdin (1997) also suggests that parent management training is one of just four therapeutic approaches where there is growing reliable evidence of its effectiveness: "PMT is one of the most well-researched therapy techniques for the treatment of conduct-disordered youth… Treatment effects have been evident in marked improvements in child behavior on a wide range of measures including parent and teacher reports of deviant behavior, direct observation of behavior at home and at school and institutional (e.g. school, police) records" (Kazdin, 1997, pp. 165-6). Kazdin suggests that the research evidence shows that PMT can help bring the problematic behaviours of treated children within normative levels of their peers who are functioning adequately, and that the gains are often maintained 1-3 years after treatment. PMT alters multiple aspects of dysfunctional families, including maternal psychopathology (particularly depression) and the behaviour of other children within the family. Connelly et al (2001) show that the Webster-Stratton parenting programme can be an effective intervention in the management of clinic-referred children with behavioural disorders. Drawing on the available research evidence, Kazdin identifies those factors that impact on the outcomes of PMT. *Duration of treatment* appears to be important here, with short programmes (under 10 hours) being less effective than longer or time-unlimited treatment of 50 or 60 hours. Where parents are provided with *in-depth knowledge of social learning principles,* this too is beneficial. Fewer gains in treatment will occur for families with *multiple risk factors* (such as poverty, marital discord, parent psychopathology, poor social support etc). *Therapist training and skill* may also be important for beneficial outcomes. Thus, there is robust research evidence to suggest that parent training programmes can have beneficial and long-term outcomes for pupils with SEBD and their families.

20. Peer Support Programmes

What they are and rationale: By linking pupils with SEBD to a trained peer who can listen and support them, these programmes can offer pupils a source of help at a difficult time. Programmes can take a number of forms, including one-to-one listening, drop-in sessions, help after school, homework and lunchtime clubs, arts workshops, buddying, etc.

Research evidence: There is little formal evaluation of peer support programmes for pupils with SEBD. However, the Mental Health Foundation funded seven projects in London between 1998 and 2002 to develop systems of peer support with young people of secondary age, as a way of promoting their positive mental health. The evaluation report (Mental Health Foundation, 2002) found that peer support programmes helped pupils to resolve problems and gave them an opportunity to talk to someone who could be a support. Benefits to the peer supporters themselves included increasing their self confidence, communication skills and their sense of responsibility. The school also benefited through a reduction in bullying incidents, better teacher-pupil communication, and enhancing the school as a caring community. See also 'Mentoring'.

21. Pharmacotherapy (the use of medication)

What it is and rationale: Pharmacotherapy refers to the use of medication to change, alter or control emotional and behavioural difficulties. Stimulant medication (for example, methylphenidate) is frequently used with children diagnosed with ADHD, and it has some impact on aggressive and other anti-social behaviours. Frei and Thurneysen (2001) show how the use of methylphenidate with children with ADHD has risen significantly in many Western countries.

Research evidence: Psychostimulants (as they are called) "produce reliable short-term behavioral and attentional improvements, and there are emerging data that suggest that certain types of learning may also be improved, yet clear long-term behavioral benefits of psychostimulant treatment also remain to be demonstrated" (Braswell and Bloomquist, 1991, p. 288). Simeon et al (2000) show how risperidone may be useful for managing behavioural disturbances and psychotic symptoms associated with a wide variety of childhood psychiatric disorders. For most patients in their study a combination of risperidone and adjunctive pharmacotherapy was beneficial, although the authors recommend that controlled trials need to be undertaken. There is little evidence that medication can alter the *constellation* of symptoms (for example, fighting, stealing and so on) associated with conduct disorder. Reliable psychopharmacological treatments for aggression, and the constellation of other behaviours symptomatic of conduct disorder, remain to be developed (Kazdin, 1997, p. 170). Clearly, while medication can sometimes help to control challenging behaviour, it does nothing at all to deal with the problems and issues that may have contributed to that behaviour in the first place. Moreover the side-effects of medication, such as methylphenidate, can be considerable (Frei and Thurneysen, 2001). See also 'Homeopathy'.

22. Play Therapy and Non-directive Play Therapy

What it is and rationale: Play therapy refers to a "set of techniques that provides an atmosphere in which children can freely express feelings, concerns, and conflicts through play. The techniques offer materials that prompt freedom of expression, self-analysis, coping tactics, and renewed interest in the relationship between the children and the world around them" (Algozzine, 1992, p. 7:29, cited in Carter, 1994, p. 35). According to King and Schwabenlender (1994, p. 17) play is defined as the individual's exploration and interaction with the surrounding world. It is through play that children develop a sense of autonomy and learn to take risks, discover and create. Children with SEBD often display inappropriate content of play as well as patterns of play. During play therapy the teacher guides children in the play situation, helping them to discover and express feelings, gain confidence, etc. "Play therapy may help young students improve their self-concepts, change their behaviour,

improve their ability to make choices, reduce anxiety, and develop better social skills, increase empathy towards other children" (Carter, 1994, p. 35). Mindes and Murphy (1982, p. 135) suggest that play can be used as tension regulators, diagnostic evaluation tools, methods for developing social skills and group cohesiveness, and for providing a safe return to earlier stages of development.

A variant of play therapy is *non-directive play therapy.* According to Wilson and Ryan (2002) this is "a therapeutic approach which encompasses both play (including using art, music and role play) and verbal communication. Because adolescents choose which medium to use and the manner to use it in, this method seems well adapted to addressing adolescent concerns. It allows exploration of emotional difficulties in a creative, individually directed way on all levels of mental functioning. Behavioural, perceptual and motor levels, as well as cognitive and emotional levels, are activated and reworked spontaneously during non-directive play therapy" (Wilson and Ryan, 2002, p. 180).

Research evidence: Algozzine (1992, p. 7:29) suggests that for a play therapy programme to be successful, three ingredients are required: a willing and sensitive teacher or counsellor; a permissive play environment; and appropriate toys or materials. However, there is little robust or reliable research on the effectiveness of play therapy and non-directive play therapy. The research that exists is "sparse and not well formulated… Too often anecdotal reports of procedures that have not been well documented have been the major way data are presented" (Gladding, 1993, p. 113). One example of an anecdotal case study includes the work of Hughes (1996), who explores the use of play with pupils with perceived EBD. Hughes provides three case profiles of its application, although with no assessment of its effectiveness. Wilson and Ryan (2002) also provide a case study of the use of play therapy with two adolescents with emotional and behavioural problems. They show how play therapy, when combined with counselling, can help young people to develop personal insight and also build relationships with significant others: "The client-led combination of play therapy and counselling which is possible in a non-directive play therapy intervention seems to meet the dual developmental needs of troubled young people in their transition between childhood and adulthood" (Wilson and Ryan, 2002, pp. 179-80). Again, though, these conclusions are based on work with a very small number of children and cannot be generalised to all pupils with SEBD. As LeBlanc and Ritchie (2001, p. 150) argue: "Case studies and anecdotal reports represent the weakest forms of scientific research and lack internal and external validity of the research."

The lack of robust evaluative data on the effectiveness of play therapy is confirmed by other authors, despite them sometimes making broad claims for its usefulness. Mindes and Murphy (1982), for example, claim that: "The therapeutic utilization of play and games as a major curricular concentration offers potential for the enhancement of cognitive, social/emotional, and physical development of young emotionally disturbed adolescents" (p. 131). However, just a few sentences later, the authors continue that: "definitive evaluative statements about the results of the emphasis of play and games in this particular program are not made. In addition, data evaluating the program have not been collected to isolate particular aspects of the curricula. Impressionistic experiences, substantiated by outside observers of the program, indicate that the role of play and games in the curriculum are important determinants for student growth" (p. 131). Mindes and Murphy state that 'impressionistic' indications suggest that the 25 students who have graduated from a play and games programme, "in contrast to those from a more traditional self-contained special education approach, are found to be more ready to accept supportive help and know how to ask for it" (p.137). They go on to argue that rigorous evaluation of play therapy needs to be conducted. LeBlanc and Ritchie (2001, p. 149) also confirm that "Unfortunately, there exist few well defined and well-executed research examples of play therapy's

effectiveness". Current research on play therapy often fails to provide adequate validation because of (a) inadequate definitions of what constitutes play therapy, (b) research methodology that often relies on case studies, small samples and uncontrolled studies, and (c) inadequate or non-measurable determinants of treatment outcomes (LeBlanc and Ritchie, 2001, p. 150). LeBlanc and Ritchie's (2001) meta-analysis of play therapy outcomes with children (aged up to 12) shows that play therapy can be as effective as non-play therapies in treating children experiencing emotional difficulties. However, their study is based on children, not specifically pupils of secondary school age. Interestingly, the effectiveness of play therapy appears to increase where parents are also involved in play sessions with their children, and when children have had around 30 sessions (but not less than 10 sessions). It has also been suggested that play therapy may be better suited to younger children or those who have trouble expressing themselves verbally or artistically. For those who wish mainly to talk about a specific situation or directly examine behaviour, then play therapy is not appropriate (Gladding, 1993, pp. 108, 113). See also 'Counselling'.

23. Psychotherapy

What it is and rationale: Psychotherapy has been defined as "any intervention intended to alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior through counseling, structured or unstructured interaction, a training program, or a predetermined treatment plan" (Weisz et al, 1995, p. 452). Ritzo and Papilsky (1999) review a number of definitions of psychotherapy and follow the one advocated by Brent and Kolko (1998): "a modality of treatment in which the therapist and patient(s) work together to ameliorate psychopathological conditions and functional impairment through focus on 1) the therapeutic relationship; 2) the patient's attitudes, thoughts, affect, and behavior; and 3) social context and development" (Brent and Kolko, 1998, cited in Ritzo and Papilsky, 1999, p. 323).

Research evidence: In their meta-analysis of 150 studies of psychotherapy with children and adolescents, Weisz et al (1995) show that while the effects of psychotherapy with this group are beneficial, the effects are weaker than had been thought previously - they are more likely to be 'medium' than 'large' effects (p. 460). Behavioural methods (such as reinforcement techniques, modelling, desensitisation etc) show stronger effects than non-behavioural approaches (such as insight-oriented and client-centred approaches, discussion groups etc) (see also Weiss and Weisz, 1995). Weisz et al (1995) show that treatment had its strongest effects on problems specifically targeted in the treatment. This is of key importance. Where specific problems are targeted (for example, named problem behaviours), with a view to achieving a specified outcome, then these types of therapeutic intervention will be the most effective. Generic, non-targeted, therapies are less effective (p. 462). Psychotherapy also showed more beneficial effects for adolescent girls. Psychotherapy treatment may be as equally effective with *over-controlled problems* (for example, phobias/anxiety, social withdrawal, depression, headaches, etc.) and *under-controlled problems* (for example, delinquency, non-compliance, self-control problems, aggression and a combinations of these). The therapist's possession of strong interpersonal skills has been shown to improve the effectiveness of treatment, for example, with patients who misuse substances (Najavits and Weiss, 1994), although there is little research evidence to validate this with regard to the treatment of pupils with SEBD. In counselling too, "the personality of the counsellor is seen as the crucial discriminator between good and bad practitioners" (Wheeler, 2000, p. 81).
Kazdin (1997) suggests that of the 230 documented psychotherapies available for children and adolescents the vast majority have not been studied and among those that have, "none has been shown to controvert conduct disorder and its long-term course" (p. 163). At the same time, because the vast majority of approaches and treatments have not been evaluated empirically,

"there is no accumulated body of evidence in which treatments have consistently emerged as weak or ineffective" (Kazdin, 1997, p. 172). See also 'Counselling'.

24. Quiet Place/Quiet Room

What it is and rationale: The Quiet Place concept arose out of a concern to promote intervention at an early stage in the monitoring process with pupils experiencing emotional and behavioural difficulties in mainstream settings, with the intention of furthering pupils' long-term inclusion in regular classes. It is concerned to foster healthy emotional development and of taking into account the child's inner world. It shares common aims with Nurture Groups. Quiet Places are designed to work with high-risk families who have been identified as having children already presenting a lack of control and pre-criminal tendencies. While the focus is on the child, most work also includes the involvement of the wider family. The room itself is provided within the school and is designed to promote a sense of peace and relaxation, containing a range of soft furnishings etc. A variety of therapeutic techniques can be used, including neurolinguistic programming, sand play, story telling and metaphor work, all intended to further personal growth and development. Massage relaxation and reflexology can also be used (Spalding, 2000, pp. 129-130). A number of therapists can be involved, and children attend for an agreed number of sessions per week, usually for six weeks. Parents may also make use of the therapies on offer. The first Quiet Place was established in 1998.

Research evidence: Spalding's analysis of 22 *primary* school children who had attended a Quiet Room, compared with pupils in two control groups who had not, shows that the Quiet Place intervention has a positive effect overall on emotional development, although this was not supported by the statistical evidence based on the use of Boxall Profiles, but rather from the qualitative interviews conducted with teachers, parents and children. These interviews suggest that the Quiet Place has an overall calming effect, not just on the children but also on the school as a whole. Parents too observed that they saw the Quiet Place as a haven and point of growth for their children and, in many cases, for themselves. A follow-up to Spalding's (2000) evaluation, by Renwick (2001), shows that the methods for evaluating Quiet Places have changed, with a greater emphasis on structured teacher, parent and child interviews, and structured classroom observation, rather than Boxall Profiles. Observation of the change in behaviour of 54 primary school pupils attending a Quiet Place was compared with 54 pupils in a control group. Those attending a Quiet Room showed a (statistically) significant increase in positive behaviours and decreases in negative behaviour compared with the control group. Interventions may be slightly more successful in the case of boys than of girls, and younger primary school children. Those referred for support and the improvement of self-esteem show greater gains in self-esteem than those referred for behavioural difficulties, while those referred for behavioural difficulties show the greater improvement in impulse control. Thus, evaluations of Quiet Places as used in Liverpool primary schools suggest that they can have beneficial outcomes for primary school pupils with SEBD. Whether Quiet Places have beneficial outcomes for pupils with SEBD of secondary school age is as yet unknown as this therapeutic approach does not appear to have been used with this older age group. See also 'Nurture Groups' and 'Relaxation Training'.

25. Relaxation Training

What it is and rationale: "Relaxation training heightens students' awareness of their bodies and their ability to control their bodies. Relaxation training offers students a positive way to respond and control feelings of anger, anxiety, and fear. Basic techniques of relaxation include deep breathing and progressive muscle relaxation, visual imagery, counting to ten, meditation and yoga" (Carter, 1994, p. 43). Quiet Places (see above) can also involve the use of relaxation training. Tai-chi can also be used for relaxation training.

Research evidence: Deffenbacher, Oetting and DiGiuseppe (2002, p. 268) suggest that relaxation

interventions target emotional and physiological components of anger. In their review of the evidence on relaxation interventions and their effectiveness as part of anger management techniques, they suggest that relaxation interventions are effective and can have beneficial outcomes, even after a year. They suggest that because relaxation interventions have been successfully applied with several populations, they are a flexible approach that can have wide application. However, there is no robust research evidence yet available to show its effectiveness for pupils of secondary school-age with SEBD.

Additionally, there is little use, and consequently little evaluation, of the use of tai-chi with pupils with SEBD. One small study (Hernandez-Reif et al, 2001) of thirteen adolescents with Attention Deficit Hyperactivity Disorder (ADHD) found that after the twice-weekly (for 5 weeks) sessions, the adolescents displayed less anxiety, improved conduct, less day dreaming behaviour, less inappropriate emotions and less hyperactivity, and that these scores persisted two weeks later. However, given the methodology, it is impossible to say categorically that it was the tai-chi over and above anything else that was the cause of these beneficial outcomes, or that tai-chi had any longer-term benefits. See also 'Quiet Place/Quiet Room'.

26. Social Skills Training

What it is and rationale: "Social skills can be defined as the ability to initiate and sustain interpersonal relations that are both adaptive and culturally aligned" (DeCarlo, 2001, p. 40). Royer et al (1999, p. 4) report that many studies indicate that SEBD pupils do not want, have not developed or do not know how and when to use social skills necessary to be accepted in school. Thus, social skills training can prepare pupils to cope effectively with everyday and out of the ordinary situations. According to King and Schwabenlender (1994, p. 14), "Social skills training is an effective and necessary process of preparing students for integration into regular education". It is necessary for successful school functioning, development of friendships, peer group acceptance, and later citizenship. "Most researchers and practitioners are now considering social skills training (SST) as an essential component of any intervention program offered to EBD students" (Royer et al, 1999, p. 4). For students to learn social skills they need instruction and guidance in what to do and what not to do: "Students with emotional/behavioural problems often have difficulty in accurately perceiving social situations. They often have skills deficits, performance deficits, and self-control deficits. These students need opportunities provided to them to practice interpreting social situations and acting appropriately" (Carter, 1994, pp. 50-1). Social skills training typically includes such components as teaching the pupil to identify alternative pro-social behaviours and strategies, modelling such behaviours and strategies, having the pupil practice these pro-social skills in simulated or real-life settings, reinforcing these skills and teaching the pupil to self-monitor, self-evaluate and self-reinforce these skills in various settings (Kavale et al, 1997, p. 2). A variant of social skills training, assertiveness training, teaches children how to communicate feelings honestly and openly and to behave in ways to get their needs met without compromising other people's rights (Carter, 1994, p. 6).

Research evidence: Royer et al (1999) review the available research evidence on the use of SST and suggest that the literature shows that this intervention is limited in its effectiveness. Generalising and maintaining the social skills learnt is also problematic. Royer et al (1999) evaluated the effects of a social skills training programme and how it supported the transfer and reinforcement in the classroom of the skills learned. They found that while the secondary school-age pupils themselves reported some benefits in assertion and empathy, teachers and parents perceived no differences in behaviour problems, academic skills or social skills. Royer et al conclude that the complexity of EBD makes it mandatory to implement a range of interventions in the other living contexts of adolescents (home, classroom, school etc). Macdonald et al (2003) found that where social

skills training is used in tandem with group work for parents, there could be some advantages for children, and parents in particular reported an improvement in the social skills behaviour of their children. Kavale et al's (1997) meta-analysis examined the outcomes of social skills interventions for pupils with EBD. Their study also confirmed that SST has only limited, moderate, effect. They concluded that social skills training has relatively little empirical support for its overall effectiveness, despite its widespread use in treating emotional or behavioural disorders. See also 'Stress Management Education'.

27. Social and Therapeutic Horticulture

What it is and rationale: 'Horticulture therapy' is the use of plants by a trained professional as a medium through which certain clinically defined goals may be met. On the other hand, 'therapeutic horticulture' is the process by which individuals may develop well-being using plants and horticulture. This is achieved by active or passive involvement (Sempik, Aldridge and Becker, 2003, p. 3). Sempik et al suggest that the distinction between these two approaches is that horticultural therapy has a pre-defined *clinical* goal similar to that found in occupational therapy, while therapeutic horticulture is directed towards improving the well-being of the individual in a more generalised way. This can be, for example, an increased sense of self-esteem etc. The authors suggest that the term 'social and therapeutic horticulture' may better describe the process by which plants and horticulture are used to develop well-being and skills. These authors then review the available literature on the beneficial effects and outcomes of social and therapeutic horticulture with a number of vulnerable groups, including children with mental health problems. It is certainly well established that horticulture has been used to achieve social and psychological benefit for many disadvantaged groups, including children and young people.

Research evidence: There are a handful of small-scale and anecdotal research studies on the use of social and therapeutic horticulture for pupils with SEBD or mental illness. In their review of these studies, Sempik et al (2003, pp. 13-14) show that horticulture and gardening can have beneficial outcomes for children with behavioural or mental health problems. The studies conducted to date have usually been undertaken in a children's psychiatric unit (McGinnis, 1989) or in residential special schools (Nixon and Read, 1998; Reeves, 1998; Rookes, 1998), or in specialist schools (Kaiser, 1976). McGinnis (1989), for example, evaluated the use of a gardening programme with children hospitalised on a psychiatric unit because of conduct disorders and other emotional and behavioural problems. While her study is small-scale, she concluded that: "Through participation in this project, the patients experienced the pride of accomplishment, practiced teamwork, coped successfully with a long delay in gratification for their efforts and learned certain basic principles of botany and reproductive biology. They discussed feelings of fear, sadness, abandonment and pride, as well as family issues" (p. 91). Nixon and Read's study (1998) detailed the use of horticulture with two children with Multiple Complex Developmental Disorder and identified the advantages of gardening as therapy for children of this kind. A gardening project with eleven "emotionally disturbed, autistic and mentally retarded" adolescents (Kaiser, 1976, p. 21) found that pupils developed slight overall increases in self-esteem, awareness, responsibility, practical knowledge, work concepts and communication. While these small-scale, often anecdotal accounts, indicate that horticulture can indeed have beneficial outcomes for pupils with SEBD, far more research, using larger samples, and those utilising control comparison groups, will be needed to validate these claims.

28. Stress Management Education

What it is and rationale: Pupils with SEBD often exhibit more intense and frequent ineffective coping strategies than the average child. Their maladaptive behaviours can create rather than reduce further stress. Thus, children's coping strategies for frustration must be increased so that they can deal effectively with life's daily stressors. Stress management education can assist pupils with

emotional and behavioural problems to develop self-control (King and Schwabenlender, 1994, p. 14). Children need to feel good about themselves if they are to develop adequate stress management skills. Thus, building on 'positives' and the unique and special qualities of children is also important here. However, there is no robust research evidence on the effectiveness of stress management education for secondary school- age pupils with SEBD.

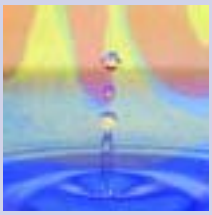
29. Technology/Computer Mediated Education

What it is and rationale: Luth's work (2002, p. 69) suggests that there are at least 52 Pupil Referral Units across the UK which use computer mediated education as part of their teaching and learning styles. The Time on Computer programme in the USA uses computers to reinforce appropriate behaviour. It merges computer-assisted instruction with a classroom management system that allows students to move through various levels that place increasing responsibility for behaviour change with the student themselves (Keyes, 1994; Carter, 1994).

Research evidence: A pilot study shows that the Time on Computer programme was effective in promoting and maintaining behaviour changes such as following rules and procedures for computer sessions, behaving appropriately before and during sessions, and completing specified assigned work before earning access to the computer (Keyes, 1994; Carter, 1994, p. 63). Casey and Ramsammy (1992) have used computers to "hook" disenfranchised youth back into school by building self-esteem while teaching them transferable computer skills. They found that the group of adolescents randomly assigned to a computer group facilitated by a school counsellor improved in their on task behaviour and increased in their trust and self disclosure to a greater degree than those adolescents assigned to a traditional counselling group and a group receiving no services at all. This pattern of beneficial outcomes is replicated in a UK study. Luth (2001, 2002) describes and examines the use of ICT to enhance the educational achievement of a group of pupils displaying a variety of EBD in a mainstream school setting. He suggests that computer mediated education (CME) "can be a powerful therapeutic tool in enhancing the educational experience of such students if careful attention is paid to the creation of a therapeutic teaching environment and the interaction of the student/curriculum and teacher/student interfaces" (2002, p. 63). Luth's data suggest that computer mediated education helped EBD pupils with their retention and assimilation of material, and helped motivate pupils in their learning by being able to control the situation with a greater degree of independence. He also noted that "there appears to be a perception on the part of the students that their overall behaviour in the computer context improves and they find themselves in less trouble" (2002, p. 71). Pupils also thought that CME increased their effectiveness in their thinking skills. Perhaps most importantly, Luth also observed that affective states such as anger and sadness are mediated in pupils when learning using a computer as an educative tool: "Their ability to settle into a task, remain on-task and refrain from distracting others were all interesting findings when compared to the behaviour some of the group evidenced in the classroom context" (2002, p. 72). Anger management also seemed to be enhanced by CME. Many of the behaviours that lead to disruption and distraction appear to be 'switched off' under CME. Thus, CME can lead to positive outcomes in terms of learning and attainment, and in terms of improved behaviours and emotional states. Luth concludes: "Our knowledge of the computer as an educational tool is well advanced; however, our understanding of a computer as a therapeutic instrument in the educational space between EBD student and teacher is only beginning to be understood" (Luth, 2002, p. 73).

30. Transition Groups

What they are and rationale: Transferring from primary to secondary school can be a stressful and difficult time for many pupils, and can have a knock-on effect for their learning and behaviour, particularly in the first year (Galton et al, 1999).



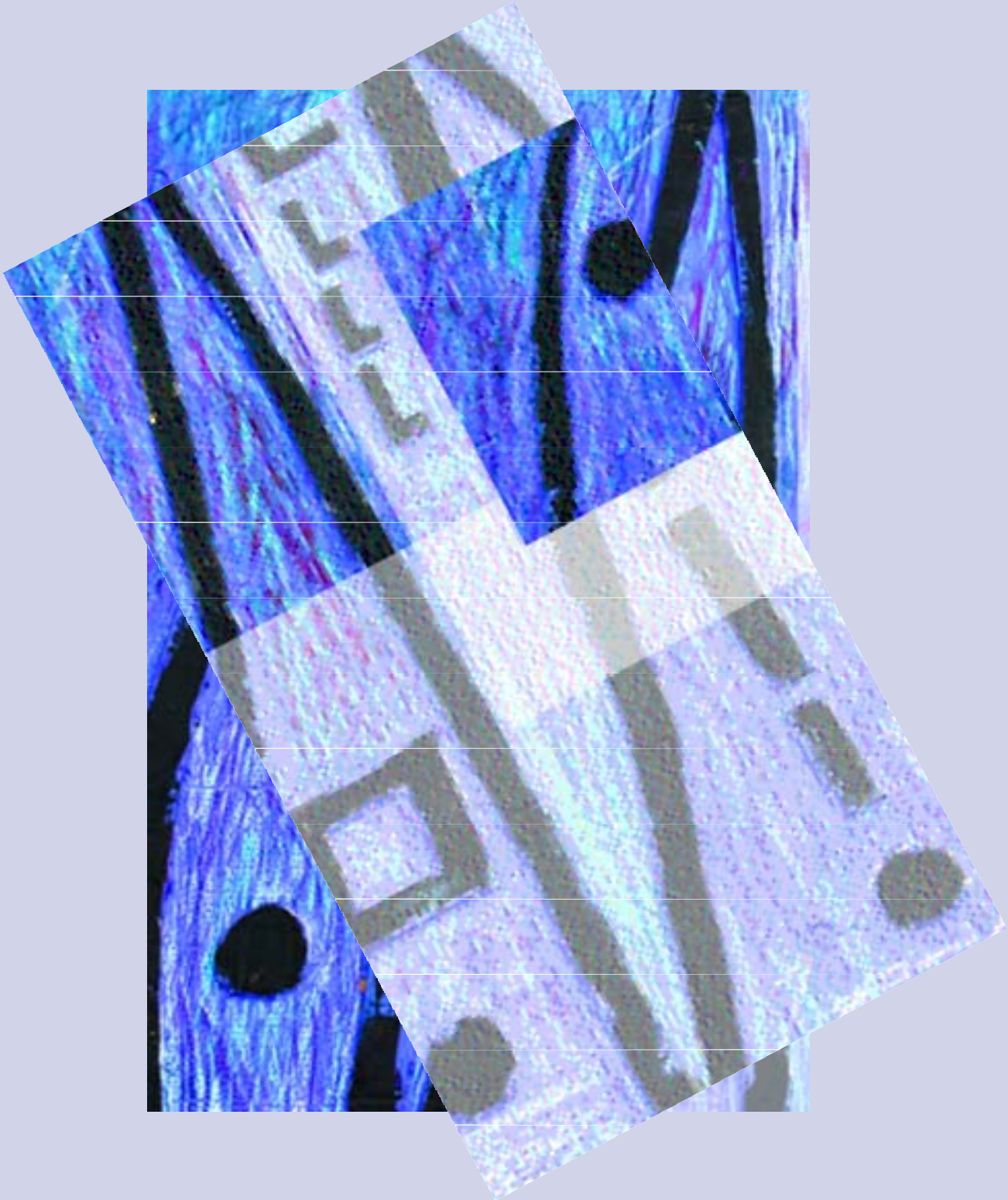
Transition groups are increasingly being identified as a way of supporting pupils who may have difficulty in adjusting in a new school. They can provide a pupil-centred approach to transition which helps to prepare pupils for the social upheaval of transfer. Groups are generally held in the last term of year 6, with some running on through the summer holidays. While they can contain some therapeutic elements, such as problem-solving and social-skills training, the focus primarily is on the transition to secondary school itself. This may also include visits and role plays. There is no evaluative evidence to determine whether or not they are an effective intervention with pupils with SEBD. See also 'Coping in School Programme'.

31. Water-related therapy

What it is and rationale: Water is an essential ingredient for a healthy body and mind. Water makes up 50-60 per cent of a male and 45-50% of a female's total lean body weight (Kumar and Clark, 1998, p. 190; cited in Kelly, 2004, p. 6) and every function is monitored and pegged to the efficient flow of water. "Water distribution is the only way of making sure that not only an adequate amount of water but its transported elements (hormones, chemical messages and nutrients) first reach the more vital organs … water used in taking a pill is immediately more effective in a dehydrated person than the chemical composition of the pill itself" (Batmanghelidj, 2000, p. 19, p. 150; cited in Kelly, 2004, pp. 6-7). Classic signs of dehydration amongst pupils can include a decline in attentive-ness, lethargy and increasing frequency of headaches. Water can be seen as a "magic elixir for learning" because it nurtures and supports the complex development, organisation and reorganisation of the learning thinking process (Hannaford, 1995, p. 138, cited in Kelly, 2004, p. 8).

Research evidence: There is some small-scale evidence to suggest that positive effects on both standards and motivation of pupils may be related to hydration. Water consumption at school (between lessons etc) may help motivate pupils and contribute to teaching and learning goals, never mind being good for their health. Kelly (2004) reports a small study of the use of water - both swimming-related and drinking - and how it was associated with beneficial outcomes for pupils with challenging behaviour. However, it is impossible to state categorically whether it is water consumption or other therapeutic aspects of the intervention that had the main positive effects. Far more research needs to be done in this field.

See Chapter 4 for an initial assessment of the value of a Water-related project in Nottingham



Resource 4

Relevant Publications and Bibliography

Saul Becker

This Resource is a listing of all the publications that are cited throughout this report and a few others that have informed the writing of the report. Readers who are interested in any of these publications or who may want to follow them up can get full publication details from this section. All books can be ordered from any good bookshop. Articles and specialist papers will be available through Inter-Library loans for those who have access to an academic university library. Alternatively, some of these publications may be available to education practitioners from their local Education Department library or other specialist libraries.

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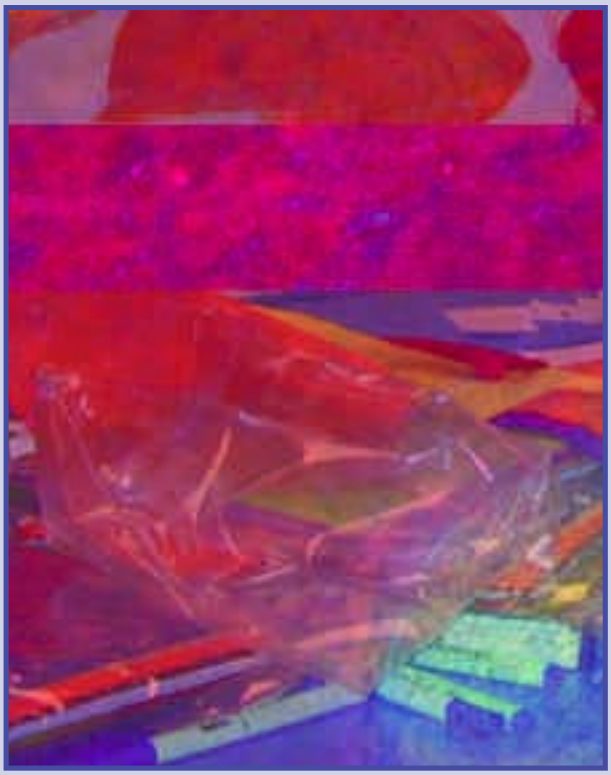

Resource 5

Useful Contacts

LOCAL CONTACTS

Excellence in Cities/City of Nottingham Education Department

Excellence in Cities
City of Nottingham Education Department
Sandfield Centre
Sandfield Road
Lenton
Nottingham NG7 1QH

Telephone +44 (0)115 9155555
www.nottinghamcityschools.co.uk

Chris Archer, Excellence in Cities Strategy Manager
Telephone: +44 (0)115 9150638
Email: chris.archer@lea.nottinghamcity.gov.uk

Carolyn Waterstone, Strategy Leader (Behaviour)
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City of Nottingham Secondary Schools

Big Wood Comprehensive
Bewcastle Road
Top Valley
Nottingham NG5 9PJ
Telephone: +44 (0)115 9539323

The Nottingham Bluecoat CE (VA) Comprehensive School and Technology College
Aspley Lane
Aspley
Nottingham NG8 5GY
Telephone: +44 (0)115 9297445

Djanogly City Academy
Sherwood Rise
Nottingham Road
Nottingham NG7 7AR
Telephone: +44 (0)115 9424422

Elliott Durham Comprehensive
Ransom Drive
Mapperley
Nottingham NG3 5LR
Telephone: +44 (0)115 9523838

Ellis Guilford School and Sports College
Bar Lane
Old Basford
Nottingham NG6 0HT
Telephone: +44 (0)115 9131338

The Nottingham Emmanuel School CE (VA)
Coronation Avenue
Wilford
Nottingham NG11 7AD
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Fairham Community College
Farnborough Road
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Nottingham NG11 9AE
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Farnborough School Technology College
Farnborough Road
Clifton
Nottingham NG11 8JW
Telephone: +44 (0)115 9744444

Fernwood Comprehensive
Goodwood Road
Wollaton
Nottingham NG8 2FT
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Greenwood Dale School - a DfES designated Technical College
Sneinton Boulevard
Sneinton
Nottingham NG2 4GL
Telephone: +44 (0)115 9103200

The Hadden Park High
Glenbrook Crescent
Bilborough
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Telephone: +44 (0)115 9135211

Haywood Comprehensive
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Sherwood
Nottingham NG5 3HZ
Telephone: +44 (0)115 9161443

Henry Mellish Comprehensive
Highbury Road
Bulwell
Nottingham NG6 9DS
Telephone: +44 (0)115 9157700

Manning Comprehensive School for Girls
Robins Wood Road
Aspley
Nottingham NG8 3LD
Telephone: +44 (0)115 9299401

River Leen Comprehensive
Hucknall Lane
Bulwell
Nottingham NG6 8AQ
Telephone: +44 (0)115 9159750

Top Valley Comprehensive
Top Valley Drive West
Hucknall Road
Nottingham NG5 9AZ
Telephone: +44 (0)115 9539060

The Trinity Catholic School
Beechdale Road
Aspley
Nottingham NG8 3EZ
Telephone: +44 (0)115 9296251/2

William Sharp Comprehensive
Bramhall Road
Bilborough
Nottingham NG8 4HY
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Pilot Therapeutic Projects in Nottingham City - Independent Providers (see Chapter 4)*

Drama Therapist, Gail Cullen,
Telephone: +44 (0)1476 870220

Homoeopathy, Shirley Thompson,
Telephone: +44 (0)115 9232899

Counselling project run by Iparq,
Telephone: +44 (0)115 9232899

Castle Arts, Jo Kemp,
Telephone: +44 (0)115 9153691

Apt City Arts project,
Telephone: +44 (0)115 9100565

** Please note that the providers of the pilot therapeutic projects discussed in Chapter 4 are listed here. These providers are independent of Excellence in Cities and City of Nottingham Education Department and both EiC and the Education Department hold no responsibility for these providers or for the services that they supply.*

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Department for Education and Skills
Caxton House
Tothill Street
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Telephone: +44 0870 000 2288
Email: info@dfes.gsi.gov.uk
www.standards.dfes.gov.uk/
www.dfes.gov.uk/behaviourandattendance/

Inclusive Solutions
49 Northcliffe Avenue
Nottingham NG3 6DA
Telephone: +44 (0)115 9556045
www.inclusive-solutions.com

National Foundation for Education Research
The Mere
Upton Park
Slough
Berkshire SL1 2DQ
Telephone: +44 (0)1753 574123
Email: enquiries@nfer.ac.uk
www.nfer.ac.uk

Office for Standards in Education (Ofsted)
Alexandra House
33 Kingsway
London WC2B 6SE
www.ofsted.gov.uk

Research Evidence in Education Library
(part of the EPPI-Centre)
http://eppi.ioe.ac.uk

Social, Emotional and Behavioural Difficulties
Association (SEBDA)
Ted Cole
SEBDA Head Office
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www.sebda.org

Improving Behaviour through Therapeutic Approaches: Research into Practice in Nottingham City Learning Support Units

Saul Becker (editor) Viv McCrossen, Fiona Becker, Richard Silburn, Pat Silburn, Carolyn Waterstone, Joe Sempik and Sarah Lawrie.

This report is the culmination of a pioneering two-year research and development project funded by Excellence in Cities. It is concerned with the use and effectiveness of therapeutic approaches and interventions for pupils who have social, emotional and behavioural difficulties in secondary schools.

Based on original quantitative and qualitative research conducted in the City of Nottingham, the report presents the results of a mapping exercise to establish what therapeutic services and approaches are being used by Learning Support Units in all Nottingham secondary schools. It also reports the findings from in-depth interviews with local pupils, parents and professionals. As part of the project, nine pilot therapeutic projects were established and a preliminary assessment of their purpose and value is also reported, drawing on the experiences and perspectives of pupils, parents, teachers, LSU managers and service providers.

Additionally, the report presents a series of useful Resources for professionals. One of these, a review of over 140 published research texts on the effectiveness of 31 different therapeutic approaches, provides a unique ordering of the available research evidence in the form of an A - Z of therapeutic interventions. Key messages from the research for practice are also highlighted, not least of which is the need to develop far more rigorous and reliable forms of monitoring and evaluation of therapeutic approaches, in order to be able to determine 'what works' and why.

This report will be an invaluable source of data and evidence for policy makers and practitioners who need to know about the importance and value of therapeutic interventions for secondary school pupils with social, emotional and behavioural difficulties.

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Improving Behaviour Through Therapeutic Approaches Research into Practice in Nottingham Learning Support Units Saul Becker (Editor)