Promoting the Well-being and Education of the Primary School Age Child

This is a short report on the 23rd annual conference of The Michael Sieff Foundation held at Cumberland Lodge, Windsor Great Park, on 21 and 22 September 2010. A full report including all speakers' material is available on the Foundation website at www.michaelsieff-foundation.org.uk. The conference was attended by a wide range of people involved in the policy and practice development of primary age services, from Central and Local Government, CAMHS, Children's Services, Education and Special Needs, Research and Voluntary Agencies.

By way of introduction I shall be quoting from the deliberations at the conference, without, given the time available, attributing to specific sources, but I should note that six of the eminent speakers are here today, David Utting, Dr. Eamonn McCrory, Dr. Eileen Vizard, Dr. Maggie Atkinson, the Children's Commissioner, and Christine Davies, together with Naomi Eisenstadt, our esteemed Chair.

Key themes which were discussed at this conference were:

- **the importance of and understanding child development;**
- **the importance of the effect on the brain of early life experiences**
- **the difficulty of learning for a child who is not in a state of well-being;**
- **the related need for early intervention, the role of the health visitor being noted;**
- **the centrality of the school in the community;**
- **the associated need for training of teachers on the well-being and development of children.**

One of the main conclusions of the Tickell Report published a few weeks ago was that personal, social and emotional development, communication and language and physical development should be identified as prime areas of learning in the Early Years Foundation Stage. These important needs had been highlighted at the Michael Sieff Foundation conference on Early Years in September 2009, but they are no less important at the primary school stage. Helping children to move through the vital stage of their life in primary school is an important and difficult task in modern society. It has to combine development, well-being and education within a complex structure in school and in the community.

Child Development

Most physical development occurs in childhood, adolescence and young adulthood, including brain development which continue into the mid twenties and possibly later. There is a dynamic tension between the effect of 'nature' (inherent child qualities) and 'nurture' (family and wider environment) which is moderated by the child's own resilience to bodily stresses like illness and environmental stresses such as poverty and abuse.

Children's learning is socially mediated and parents, carers, peers and teachers are all important in their education. Children think and reason in much the same way as adults. What they lack, and acquire during childhood, is experience; together with the ability to reflect on their own thinking and learning and to regulate their behaviour and social interactions. Children use their cognitive skills to work out their own explanations for what they observe, what happens to them. They construct reasons for the way other children and adults behave and they tend to be biased towards their own hypotheses, favouring information that endorses their existing 'theories of mind'. This confronts us with primary age children who have already concluded from the evidence in their everyday lives that they are somehow unloveable, 'naughty' and incompetent in ways that radically affect their preparedness to learn and their behaviour.

In order to promote healthy social development and learning and prevent serious long-term behaviour problems ways must be found to help children to adjust their misplaced theories about themselves. It is also important to change the evidence on which they routinely draw – the social, learning or environmental context. Severe behaviour problems among primary-age children are disruptive and symptomatic of multiple background problems that can include abuse and neglect. They also 'matter' because of continuities between behavioural disorders in childhood and conduct problems in adolescence and in adulthood. As many as 15 per cent of five-year olds may exhibit persistently oppositional and defiant behaviour. By the end of primary school, the proportion with diagnosable conduct disorders will be fewer than one in ten, but those who remain chronically antisocial will be moving to secondary school with a track record of low attainment, and exclusion among their peers. What follows will tend to be involvement in persistent and increasingly serious crime.

It is important for all disciplines to receive training on child development. Teacher training courses need to include child development (including physical, social, emotional and educational, with particular reference to safeguarding and the importance of promoting the well-being of the child), to enable schools to recognise and effectively support worrying or concerning behaviour through early identification.

Consequences and outcomes

Childhood maltreatment is associated with later psychopathology, including conduct disorder, antisocial personality disorder, anxiety, and depression. The neurobiological mechanisms by which childhood adversity heightens vulnerability to psychopathology remain poorly understood. There is likely to be a complex interaction between environmental experiences (such as maltreatment) and individual differences in risk versus protective genes, which influences the

neurobiological circuitry underpinning psychological and emotional development. Brain imaging research in children and adults is providing evidence of several structural and functional brain differences associated with early adversity. These in turn are likely to be associated with patterns of psychological adaptation that may ultimately increase a child's risk for later psychopathology.

Most children who are persistently antisocial at age six do not grow into chronically antisocial adults and career offenders. But severely antisocial children and their families need early help in preventing long-term disorders. Knowledge concerning risk and protective factors supports taking a public health approach to prevention. Risk factors that increase the probability of later problems have been found in communities, families, schools and among peer groups as well as children's individual characteristics. Likewise, protective factors buffer children against risk in otherwise difficult circumstances. Some risk factors relating to life stressors like poverty, unemployment, overcrowding and illness are mediated through their impact on parenting. Risk factors like low achievement and disruptive behaviour, are more specific to the primary school years.

The neurobiological changes associated with maltreatment can be viewed as adaptive responses to an early environment characterised by threat. Such adaptation may heighten vulnerability to psychopathology, partly due to the changes in how emotional and cognitive systems mediate social interaction. For example, early-established patterns of hypervigilance, while adaptive in an unpredictable home environment, may be maladaptive in other settings increasing vulnerability for behavioural, emotional and social difficulties.

Psychosocial risks in adolescents are high in the UK. The UNICEF (2007) report shows the UK to be among the lowest in terms of well-being in teenage years. High risks are common in UK adults, including family breakdown, single parenthood, domestic violence and clinical disorder such as depression, anxiety and substance abuse. All of these have common early causes in childhood experience of neglect and abuse. The prevalence of severe instances of neglect or abuse is relatively common in the community. Around a third of those exposed develop psychological disorder.

Childhood adversity in itself is complex. The family context may include deprivation, conflict or instability, negative behaviour by parents and others directed at the child. Neglect and abuse, physical, sexual or psychological are potentially the most damaging for the developing child and can have the greatest lifelong impact. In adolescence neglect or abuse results in increases by 2 to 3 times for teenage pregnancy, lack of planning in home leaving or teenage depression. Childhood neglect and abuse similarly leads to around twice the risk of domestic violence, adult sexual assault and separation from married/cohabiting partner. Despite very high social risks many may have coexisting positive experiences in terms of peer group, support and school achievement. Thus risk and resilience factors can coexist in our complex urban living. Four our purposes they damage the child's well-being and make him or her less available for education.

Assessment

Good standardised assessment adds to the analysis of complex child care cases for care planning. Assessment tools can be used with primary school-age children themselves and provide analysis of relevant social and developmental problems. These serve to develop the child's own narrative about adverse experience and stress, which can be triangulated against parents' accounts. They also provide a platform on which the child is given an opportunity to have their own voice heard.

This can be translated to the classroom. Educators have historically paid little attention to evidence of effectiveness in developing policies and practices but research can show how to improve the outcomes of primary and secondary education. The category with the strongest positive outcomes includes methods such as co-operative learning, enhanced classroom management and motivation, and teaching of the understanding of learning skills. What the evidence tells us is that the way to improve students' learning is to train teachers in these specific teaching methods. Effective programmes are ones that give teachers effective tools to use to increase pupils' motivation, comprehension, and ability to solve problems.

Improving Well-being

As the Munro Review has recently emphasised, early intervention and prevention are the most cost effective ways of ensuring good outcomes for children and young people. This requires a strong partnership between providers of universal services, such as schools, providers of specialist services, such as social care teams in local authorities, with clear targeting of interventions bridging the gap between the two.

In order to achieve this there are two principles that need to be applied:

• Intervention should be based on clear evidence so that it meets real need rather than a perceived or imagined need.

• Delivery of intervention and the decision making around this delivery should be as localised as possible so that there is the possibility of stepping up to more specialized provision or stepping down from a targeted intervention to universal services.

In terms of family-focused prevention, the evidence highlights the effectiveness of behavioural, skills-based parenting programmes. Among primary schools, remedial strategies, used for both literacy and numeracy, apply lessons gained from effective programmes like the Reading Recovery programme. Programmes can enhance social competence, self-control, emotional understanding, positive self-esteem, personal relationships and problem-solving. Provided we choose and implement our interventions carefully, we know enough to take effective preventive action.

The gap in outcomes between vulnerable and excluded children and others can be narrowed, within a context of improving outcomes for all. **Christine Davies, Chief Executive Officer at the Centre for Excellence and Outcomes in Children and Young People's Services talks about Narrowing the Gap in outcomes between vulnerable children, young people and their families and the whole population**. It is one of the most significant challenges facing the UK. Despite significant

investment in schools and in public services generally over the last 10 - 15 years, 'the gap', however measured (i.e. education, health, employment), has remained stubbornly wide. The urgent need to address this is vital, not only as the key to the UK's capacity to compete economically in an increasingly competitive global market but also as the bedrock for social and community cohesion.

This contribution will focus on what local, national and international evidence tells us is likely to make the most significant difference to the outcomes for vulnerable children and young people - both within schools and beyond the school gate (working with parents and carers, communities and all other services which have responsibility for improving the life chances of children and their families).

Services can be provided in locally based, multi-disciplinary teams, working in clusters, which may include health visitors, nurses, social workers, family support workers, education welfare officers, primary mental health worker and the youth service. Each community will find its own solution – the key is that they work together. Additionally collaborative working makes better financial sense.

Children's centres can be successful with other services sited within them, even district nurses or dentists. There is a real role for school nurses and social workers within schools, which enables them to discuss with teachers concerns about a child, and then they can signpost on to specialist services and achieve accelerated access to services for children. Since the conference the Government has announced plans to increase the number of health visitors.

Kevin Williams, Chief Executive of TACT speaks about these issues as they relate to children in the care system. Though not a focus of the original conference, it provides a useful example of related practical issues.

Children in care do not do well at school. Indeed, the only demographic that performs more poorly are travellers' children. There are many reasons why this is the case. Many will be traumatised, with 80 percent coming into care following abuse, neglect, family dysfunction or having a family in acute stress. Often they will have had chaotic childhoods with little structure. Even after coming into care many will have had schooling severely disrupted through placement change. Many face other challenges. Seventy three percent of school age children who have been in care for more than twelve months have some form of special educational need (SEN).

It is against this background that they will be competing against children who have not experienced such traumas. As a consequence, only 12 percent achieve more than 5 A*-C GCSEs while six percent go onto higher education. Looked after children are eight times more likely to be excluded from school than their peers.

Despite this many children in care perform extremely well. A well supported secure foster placement allows a child every opportunity to perform as well as any other child. Ninety percent of TACT children of care leaving age go on to college or employment. We have recently published research where 81% of children in TACT care described their experiences at school as either 'Excellent' or 'Good'.

While placement stability is crucial to academic achievement, there are a range of factors that can impact disproportionately on children in care. Education reform is one of the central planks of the coalition Government's policy programme. However, recent changes leave children in care particularly vulnerable. The Education Bill, currently passing through Parliament, will remove the process of appeal against permanent exclusions. It also allows teachers enhanced powers to search pupils, including in situations where the teacher is of a different sex and no-one else is present. For the many children in care who have been abused, and for their teachers, this could lead to worrying and potentially volatile situations.

The Government's desire to increase the number of privately run academies and free schools will mean increased competition. While the government has assured TACT that children in care will still receive priority admission, academies will not be obliged to prioritise them in the way LEA schools are. With the right to appeal against exclusions also limited, there is a danger that academically competitive academies might seek to avoid taking on children from a low achieving group. Furthermore, Ministry of Justice proposals to remove legal aid for educational cases will impact most significantly upon those groups most likely to need access to education tribunals.

None of these measures are targeted specifically at children in care. However, they are more likely to be adversely affected. Children with SEN also tend to be disproportionately affected. For example, they are also eight times more likely to be excluded than other children. As many of those in care have SEN this can be a 'double whammy'.

Because of this it is vital that the extra support and services for looked after children is maintained. There has been recent encouraging news. The Government has recently announced that a bursary scheme for children aged 16-19 in education, which replaces the education maintenance allowance (EMA), will see increased payments for children in care. However, with budgets being squeezed, funds allocated to schools for children in care through the pupil premium need to be ring fenced. Other vital services for children in care, such as Virtual Head Teacher programmes and LACES (Looked After Children Educational Support) are extremely effective but will be vulnerable to cuts.

An area of particular concern for TACT is the growth of Foetal Alcohol Spectrum Disorder (FASD). FASD is an umbrella term that describes a range of effects that can occur in a child whose mother drank alcohol when pregnant. It is a lifelong, incurable condition with a very conservative estimate of 7000 children affected each year in the UK. Traits of those affected by FASD include poor memory, hyperactivity, short attention span, difficulty in communicating or coping with social situations. However, it can be diagnosed and, with the right strategies in place, much can be done to help those affected.

Children in care are particularly at risk. Alcohol misuse will frequently be a factor when children are taken into care. Unfortunately awareness of FASD is limited and diagnosis infrequent. In a busy school environment a teacher who is unaware that a child has FASD will not know that their lack of attention or progress is because they 'cannot' rather than 'will not'.

TACT believes that undiagnosed FASD is blighting the lives of far too many children and disrupting their education. We want diagnosis as a matter of course where maternal alcohol intake has been a factor in a decision to seek a care order. Teacher training in SEN should include awareness of FASD. SEN support and statementing should better recognise FASD and the strategies that can mitigate its impact.

As TACT's own research shows, there is no reason why being in care should adversely affect children. Stability, support and awareness of the disadvantages looked after children face means a positive school experience can be the platform to achievement.

David Ford and Helen Colbert, Head and Deputy at East Sheen Primary School give some practical reminders and solutions from the front line. In their local context they look at the changing role for schools, achieving good outcomes for every child, safeguarding [CAF and Enhanced CRB] and assessing risk, the need for Cross Agency contact, the development of the SENCO role and the importance of community cohesion. They identify school concerns and emphasise that schools are no longer here to simply educate but to support children and families. Families respond best when trust and confidence are in place and where they have established relationships. They identify barriers to good practice from organisational inconsistencies and poor communication.

So in summary we should reconceive the role of schools as a resource at the heart of the community, not just an educational one, providing for the extended needs of pupils, families and community. For those children whose needs are beyond the capacity of the school, and who therefore require the application of the Common Assessment Framework, there should be a robust interagency response.

Schools should do an audit of their community, and should be encouraged to collaborate, and learn from their work with parents and families and determine a common purpose. With the other services with which they are working they should be enabled to speak a common language, and have common values, and deliver a common purpose. The structures and processes need to be underpinned by a culture of co-operation and high aspiration for all children, with a shared sense of purpose and language, driven by leaders who 'walk the talk'. We need to ensure that the workforce is appropriately trained and supported to work with and communicate with children and families.

Conclusions

The community approach adopted can assist in the early identification of developmental delays, individual and family difficulties and provide services to improve well-being. For me this was the central message which emerged from the conference. Children who are comfortable in themselves will be more amenable to education and learning, and thereby be better able to achieve higher standards in educational outcomes.

Early intervention can demonstrably save huge amounts of money over a lifetime. Demonstrably in relation to those who cause expense through crime and emotional ill-health and demonstrably in relation to those who learn better.

The current economic climate will prove challenging for all those in public service, but with strong professional and community relationships and clear and focused planning, such localism will have a major part to play in sustaining the progress towards better outcomes for all.

Presented by Richard White, Secretary of the Michael Sieff Foundation

The full report of the conference, including speakers' material and the speeches of Tim Loughton, MP, Parliamentary Under Secretary for Children and Families and the Children's Commissioner for England, Dr. Maggie Atkinson, is available on the Foundation's website at www.michaelsieff-foundation.org.uk .