The Psy-Disciplines go to School: Psychiatric, Psychological and Psychotherapeutic Approaches to Inclusion in one UK Primary School

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Abstract

A growing body of research, largely from the global North, and particularly from North America, highlights the increasing psychiatrisation, medicalisation, and psychologisation of children and childhood, and suggests that schools and educators play a key role in these processes. This increasing diffusion of psy-expertise within educational spaces signifies a cultural shift that has profound effects on teacher and student subjectivity, and on institutional and professional practices. Educators in many countries are said to be on the 'front-line' in identifying mental health issues, recommending treatment pathways, and sometimes helping to administer psycho-pharmaceuticals. The alacrity with which educators engage in these practices varies internationally, with reported occurrence being much higher in the United States and Canada, compared to the United Kingdom, where there is a lack of research.

Drawing upon a case study in a UK primary school, this paper makes an original and timely contribution to research into UK teacher's perceptions of inclusion in relation to Social, Emotional and Behavioural Difficulties (SEBD) and, in particular, Attention Deficit Hyperactivity Disorder (ADHD), as they navigate the interface of psychology and education. Contrary to some previous research, the educators in this study viewed the distribution of psycho-pharmaceuticals negatively, and showed a preference for psycho-therapeutic approaches to inclusion. This research provides much needed empirical findings to a growing but largely theoretically informed body of research exploring whether, and if so then how, educators are implicated in the mobilisation of psy-expertise within children's lives.

Keywords: ADHD, inclusion, psychologisation, psychiatrisation, psy-expertise, SEBD

Educators in many countries, mainly of the global North, are said to be on the 'front-line' in identifying mental health issues (Atkinson & Hornby, 2002), undertaking a hybridised, semi-official role in mobilising psy-expertise in relation to Social, Emotional and Behavioural Difficulties (SEBD) and, in particular, Attention Deficit Hyperactivity Disorder (ADHD) (Rafalovich, 2005). A growing body of research highlights the increasing psychiatrisation, medicalisation, and psychologisation of children and childhood, and suggests that schools and educators play a key role in these processes (Brunila, 2012; Conrad & Bergey, 2014; Ecclestone & Hayes, 2009). While the psy disciplines, according to Petersen and Millei (2016), are central to contemporary modes of pedagogy, and have historically shaped educational practices (Harwood, 2006), exploration and critique of how they operate within education has been sporadic. Yet, the diffusion of psy-expertise within educational spaces is significant in that it implies a cultural shift that has profound effects on teacher and student subjectivity, and on institutional and professional practices.

Despite international attention to and debate over the rise of SEBD and ADHD diagnoses in children, Harwood and Allan (2014, p.17) point out the surprising lack (with the exception of research discussed below) of scholarly attention paid to schooling as a site of psychopathologisation, despite psychopathology being 'an integrated thread in the contemporary education landscape'. For Kristjánsson (2009), the increase in pathologisation of children in education has resulted in the modification of the role of educators in managing, categorising and normalising difference. This relates to the need to frame children as 'disordered' in order for them and their families to access the limited financial and educational support on offer in mainstream educational settings – a need which has, in turn, provided one channel for psy-expertise to become embedded within the education system (Allan, 2003).

Harwood and Allan (2014, p.159) trace how schools act as 'key sites in the production of psychopathology', acting as sites of medicalisation – places where medication is administered, compliance is supervised, drug effects monitored and referrals made (Harwood, 2006, p.93). The alacrity with which educators engage in these practices varies internationally, with

reported occurrence being much higher in the United States and Canada, compared to the United Kingdom (Malacrida, 2004).

With a few exceptions (Harwood, 2006; Harwood & Allan, 2014), there is a distinct lack of research engaging in a detailed exploration of the experiences of UK educators working within an increasingly psychologised and medicalised education system. Consequently, the central purpose of this research was to acquire a deeper understanding of the experiences of a small number of educators in their negotiation of the complex terrain of SEBD, and to explore whether, and if so then how, educators are implicated in the diffusion of psy-expertise within their pupil's lives. Drawing upon empirical data from a case study of a mainstream primary school in a socio-economically deprived area of the UK and with a high-intake of students with SEN diagnoses, this research was structured around the following research questions:

1) Do teaching professionals play a part in the identification, diagnosis and management of SEBD?

2) What role, if any, do educators appear to play in mobilising psy-expertise in relation to SEBD in schools?

3) What is the extent of SEBD-specific training opportunities for mainstream educators?

And, 4) what are the key approaches and forms of support to enable the inclusion of children with SEBD in mainstream schooling?

In contrast to previous research, the educators in this study appeared reluctant to partake in any diagnostic or prescriptive processes, and instead showed a preference for psycho-therapeutic approaches to inclusion within their school. Therefore, this research provides empirical findings into the use of psy-expertise within schools, and specifically how educators' resistance

to medicalisation in school may mobilise psychotherapeutic practices of inclusion (Harwood & Allan, 2014; Petersen & Millei, 2016).

The last two decades have seen a significant shift in the way in which children's and young people's behaviour is described and conceptualised, particularly within educational spaces (LeFrançois, 2013a; Tait, 2003). In response to the promotion of inclusion by the UK Government (Special Educational Needs and Disability Act, 2001; Equality Act, 2010), there has been extensive debate surrounding the best approaches to accommodate all children in a wholly inclusive way.

Psy-expertise has informed much of the discussion on inclusion. While psychology and education have long been firmly entwined (Harwood, 2006), for some, the increasing (although not wholly new) availability of psy-expertise within educational spaces marks increased recognition of children's distress, or at least an ambivalent re-shaping of how we understand childhood, and life, more generally (Rose, 2006). For others, it signifies the pathologisation of children, and the attribution of children's behaviour to individual rather than socio-political issues (LeFrançois, 2013b; Timimi & Taylor, 2004). Critical accounts of 'psy' approaches to the 'treatment' of SEBD emphasise the individualising and pathologising properties of the 'psy complex' (Rose, 1999) and particularly how children with an SEBD-diagnosis come to be framed as 'problem learners' (DuPaul & Weyandt, 2006). Yet the psy-disciplines also operate in distinct ways, with different implications for children who are, for example, prescribed psychopharmaceuticals than those who receive therapeutic interventions (although interventions may co-exist).

The most commonly assigned diagnosis of SEBD for children in the UK is ADHD, with estimated prevalence rates amongst school-aged children in Britain ranging from 0.5 per cent to 10 per cent (Cooper, 2008; McCarthy, Wilton, Murray, Hodgins, Asherson & Wong, 2012).

A diagnosis of ADHD has particular relevance to schools due to the fact that the pattern of behaviours most frequently associated with its diagnosis are in direct contrast to the predominantly ordered and regimented practices (sitting still and quietly for extended periods of time) of most mainstream educational settings. Thus, the promotion of psychostimulant medication (for example, methylphenidate), as a 'treatment' for ADHD, often focuses on the drug's apparent ability to enhance the educational performance of the child taking it, raising various ethical questions surrounding the place of psycho-pharmaceuticals within schools (Carlson, Pelham, Milich & Dixon, 1992).

Research on the use of psychopharmaceuticals in schools has tended to be US centric. This is unsurprising when for so long the US has been the 'epicenter of ADHD' (Lloyd, Stead, & Cohen, 2006, p.3). However, research is increasingly showing the globalisation of SEBD, and especially ADHD (including increasing usage of medication), across diverse countries, including some global South countries, such as Brazil and India (Conrad & Bergey, 2014; Polanczyk et al., 2007). Timimi and Maitra (2005) claim that 'rapid growth in the prescribing of psychotropic medications to children is happening in many countries of the South...suggesting the Western individualised biological/genetic conception of childhood mental health problems is spreading to the countries of the South' (Timimi & Maitra, 2005, p.23). While little research has focused on the role played by educators in the globalisation of ADHD, teacher perceptions differ globally, with Harwood and Allan (2014) finding differing approaches between educational professionals in Scotland, and those in Australia, the USA and England. In Scotland, more professionals engaged in pedagogic practices that emphasised context rather than medicalised understanding of children's behavior.

Teacher perspectives are important because their understanding of SEBD shapes their practice within the classroom (Kos, Richdale, & Hay, 2006). Previous research suggests teachers and

other school personnel are often the first to suggest the diagnosis of ADHD in a child (Phillips, 2006; Sax & Kautz, 2003) and yet findings also show that teachers tend to feel insecure about dealing with behavioural problems (Walter, Gouze, & Lim, 2006) and hesitant to accept responsibility for students with special needs (Pijl, 2010). McMahon (2012) found that trainee teachers in Australia had largely medicalised views about ADHD, while being more open to critical discussion about SEBD more generally. Meerman et al. (2017, p.1) suggest that a medical approach to ADHD as a neurodevelopmental disorder may be misguided and can make non-medical professionals, such as educators, feel inapt, potentially leading to the (expensive) 'outsourcing of behavioural problems'. Although such outsourcing may be psychological rather than medical, bearing in mind that one well-recognised source of support for teaching professionals in the UK is the expertise offered by the school's assigned Educational Psychologist (EP). This involvement may encourage a psychotherapeutic perception of children's behavior within schools, potentially, although not necessarily, in distinction from a psychiatric understanding (Brunila, 2012; Ecclestone, 2011). Furthermore, psychotherapeutic interventions, such as the establishment of school-based counselling services, nurture groups, mental health literacy, psychological first aid, and the promotion of emotional intelligence, play a key role in many school's inclusion strategies (Bailey, 2013; Cooper & Tiknaz, 2007).

Methodology

The School

In an effort to allow for a richer understanding of the complexities and contradictions within this research area, we chose to employ a case study approach, working within a single school. Grange Park Primary School (pseudonym) is a mainstream, state school in the South of England. One of the authors (BB) had worked at the school as a Teaching Assistant a number of years before this research was conducted. At the time of the research, 45 of the school's 297 pupils had statements of SEN. Further to this, 66% of the school's population were eligible for

pupil premium, in comparison to the national average of 14.3% (Department for Education, 2016). An estimated 32 per cent of children attending the school experience income deprivation, whilst unemployment rates in the local area are considered to be some of the highest in the region (Ward Profile, 2013). The majority of Grange Park's residents live in low-rise social housing, relying heavily on state benefits (Ward Profile, 2013). Whilst our research aims were not concerned with household income and deprivation levels, it is essential that the socioeconomic context in which the school is situated is considered when examining the subsequent findings. This is particularly important given that schools in deprived areas tend to have more children diagnosed with mental health issues and taking prescription drugs for these issues (Harwood and Allan, 2014), raising a concern that social disadvantage is being medicated (Isaacs, 2006).

Data Collection

The data in this study are drawn from one focus group, lasting 90 minutes, and two semi-structured, qualitative interviews, lasting 45 and 75 minutes, as well as two written exercises completed by all participants. The data was collected across three site visits to the school. Accounts came from six participants who had been employed at Grange Park Primary for between five and fifteen years. The school's Head Teacher, and an Inclusion Teaching Assistant, Key Stage 1 Teacher, and Teaching Assistant took part in the focus group. In addition, the school's Special Educational Needs Coordinator (SENCO) and Pastoral Care Worker were interviewed individually as they were unable to attend the focus group. All participants were female. With the participants' consent, the focus group and interviews were recorded, and subsequently transcribed, ready for analysis.

All participants completed a set of individual written exercises before commencing the focus group and interviews. The first written exercise was a free-writing task. Participants were

encouraged to write down any key words or short sentences which came to mind when they read a set of four sentence starters relating to SEBD, the resources and training on offer, and challenges associated with these difficulties. The second exercise involved a hypothetical case study of a child displaying behaviours which are generally deemed to be symptoms of ADHD. Participants were asked to write down the steps they would take to best support the child in the scenario.

Ethical approval for this research was given by the University of Sheffield's ethical committee. Both the school and the participants were assigned pseudonyms in order to ensure their anonymity.

Data Analysis

A qualitative approach to research allows for the comprehensive description of the experiences of relevant individuals in a rich and textured way, allowing for an analysis which would be impossible from a quantitative standpoint (Clough & Nutbrown, 2002). Inductive thematic analysis (Braun & Clarke, 2006) was deemed to be the most appropriate mode of analysis in this research, allowing us to identify patterns of meaning and experience across the entire dataset collected from staff at Grange Park School.

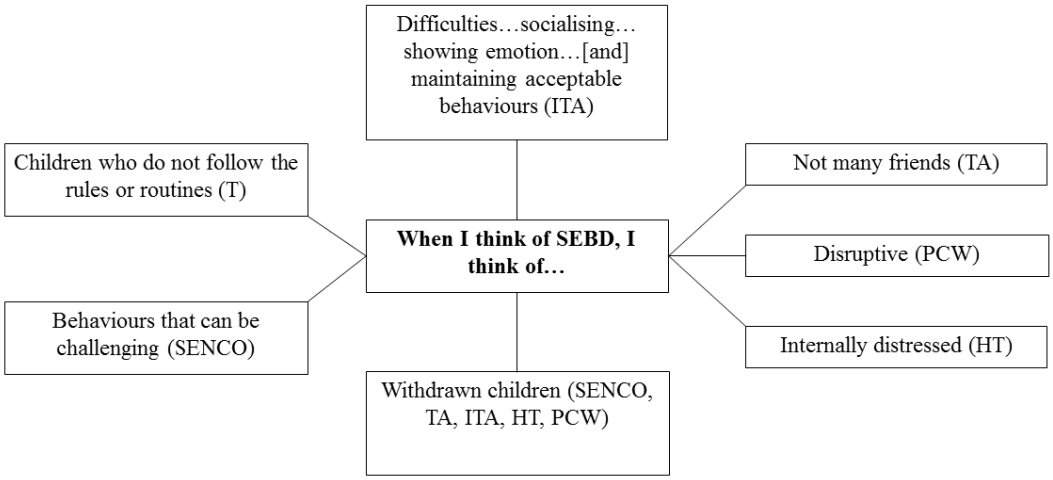
In line with Bryman's (2012) thinking on effective thematic analysis, we identified key patterns within the transcribed data collected from the interviews and focus group, through a rigorous process of data familiarisation, data coding, theme development and revision. Firstly, the original recordings were listened to, and subsequent transcriptions read, several times. This process of "repeated reading" (Braun & Clarke, 2006) allows for complete data immersion, which can pave the way for the coding phase. The codes which were assigned to the data identified key features in the transcriptions. The next stage in analysis involved searching for themes which effectively encompassed larger sections of the dataset, by combining groups of

codes under one descriptive heading. Seven overarching themes were identified, which broadly fitted the four research questions of interest.

Analysis

The Psy-Disciplines and Social, Emotional, and Behavioural Difficulties in Schools

A free-writing exercise was distributed to all participants prior to interviews, with the aim of exploring individual perceptions of SEBD, using the sentence starter "When I think of SEBD, I think of...". Contrary to previous research which highlights an education system highly influenced by the medical model of SEBD (Malacrida, 2004; Phillips, 2006), participants' responses showed little medical influence in their definition or conceptualisation of SEBD (see Figure 1).



However, whilst there was little evidence of a medicalised view in this exercise, participants were quick to associate the label of SEBD with 'problematic' behaviours, suggesting a broader association between SEBD and constructions of 'problem learners'. Furthermore, the behaviours described by participants appear to be framed in an individualised way, with little

consideration of the contexts in which SEBD may arise. The tendency of professionals to discount wider societal and political issues, when considering the exhibition of SEBD, is not unique to Grange Park School (DuPaul & Weyandt, 2006) (although it contrasts with the approach of the educators in Scotland in Harwood and Allan, 2014).

Do Teaching Professionals Play a Part in the Identification, Diagnosis, and Management of SEBD?

Research in North America has found high levels of collaboration between psychiatric and psychological professionals and educational staff (Conrad, 2005; Malacrida, 2004). In this research we asked the participants who they would consult with if they had concerns about a child and their learning: "If I believed a child was displaying signs of an SEBD, I would seek information from...".

Most responses from participants focused on the use of school-based services or external psychological agencies, with little significance placed on the medical or psychiatric services currently on offer to the school. In fact, the most frequently named individuals by participants were the school's SENCO, Pastoral Care Worker and the Educational Psychologist (EP), on whom there was a firm reliance. The staff's repeated acknowledgement of the role of the EP implicates some level of psychologisation within Grange Park Primary as it indicates a reliance within the school upon psychological expertise to accommodate for challenging or 'problem' behaviours (Ecclestone, 2011). This also shows that psychologised as well as medicalised views of SEBD can lead to the 'outsourcing' of behavior management – in this case to an EP (Meerman et al. 2017).

Despite the use of open-ended questioning within this research, no participant broached issues of diagnosis or medication independent of more direct questioning.

Overall, having analysed the transcripts and written pieces emerging from the research, we have identified three primary factors that might play a part in participants' lack of inclination to discuss (without prompting) medication and diagnosis: 1) there is a perception that diagnosing and medicating is the role of the 'superior' medical professionals and has no place within the school; 2) there is a distinct lack of training available for staff regarding diagnosis and medication; 3) negative associations surrounding the administration of psycho-pharmaceuticals exist within the school. Each factor will now be examined in turn, with exemplar transcript to illustrate each theme, and a comparison made between findings and pre-existing research and theory.

What Role, if any, do Educators Appear To Play in Mobilising Psy-Expertise in Relation to SEBD in Schools?

The staff at Grange Park Primary expressed distance from medical decision-making, considering expertise to lie with doctors:

Pastoral Care Worker: When it comes to medication, the only thing I can offer...is to say "Go to the doctor - consult with the medical team."...I cannot give parents advice on whether I think, because it is an opinion, on whether I think their child should be medicated....[The medical team] are so much more qualified than us in the pecking order of a diagnosis of ADHD. We would just follow what they say. (Individual Interview)

Inclusion Teaching Assistant (Inclusion TA): I've had a parent who asked if I thought Ritalin would help calm down her child and help with his negative behavioural difficulties. My response was to remain professional and explain that I am not qualified to make that decision. (Focus Group)

Teaching Assistant: I would say the decision to medicate should be made by a paediatric doctor and, perhaps, their parents and the Ed Psych would have some input. (Focus Group)

These accounts directly contrast with the more medicalised conduct of educators described in previous research (Phillips, 2006; McMahon, 2012). Although this is consistent with Meerman et al.'s (2017) findings that educators may feel inapt when faced with a medicalised discourse of ADHD. Grange Park's SENCO maintained that she would not introduce the idea of medicating a child without a parent or carer asking for guidance first. Even then, she stated her advice would simply be:

SENCO: I would always say that we get mixed results in school, so it really is down to the doctor. (Individual Interview)

The resistance of Grange Park Primary's staff to partake in the diagnostic process of SEBD is consistent with Malacrida's (2004) work which described the involvement of British educators in the endorsement of medication as a form of treatment as virtually non-existent, in comparison to her Canadian participants. Malacrida concluded that the British educators in her study reflected a low degree of medicalisation and psychiatrisation in British educational institutions.

The practice of monitoring a child's behaviour is considered to be an essential element, both pre- and post-diagnosis/prescription, to inform and guide the professionals in the medical/psy sector who have administered the psycho-pharmaceuticals to the child (Conners, Pitkanen & Rzepa, 2011). The SENCO and Pastoral Care Worker specified that:

SENCO: We will monitor their behaviour. The Conner's Rating Scale will come from the doctor and either I will fill it out, or the Nurture Group Team, or I sometimes ask the Class Teacher.…So we score their behaviour up against these sample statements. It's quite

basic, which limits how much we can tell them, how much we can expand upon or express any concerns. But yes, we'll feedback on their behaviour through that. (Individual Interview)

Pastoral Care Worker: I've told staff when a child has started on medication...And then we look out for changes...and with conversations with the child as well, how they're feeling, how's their day going. We assess how they're doing. (Individual Interview)

Despite recognition here by the SENCO that rating scales and check-list technologies are 'basic' and limiting, there seems little scope for this process, and the medical authority that underlies it, to be questioned by educators who often have little chance to liaise with medical professionals (a finding also apparent in Singh, Epstein, Stoute, Luebke & Ellis, 1994).

SENCO: I think the medical profession work very much in isolation and that, that is a bug bare for both schools and local authorities.…They will sometimes ask schools to provide information but when you read their report afterwards it very rarely reflects what we have said. Quite often, the parents will be asked about their child's behaviour in school, rather than the doctor contacting us, even though the parents don't see them in school, which leads to inconsistencies. (Individual Interview)

Similarly, the Pastoral Care Worker stated that:

Pastoral Care Worker: I've never worked closely with them, no. Really, it's just a referral… and then a report comes to us from the doctor. And we follow it. (Individual Interview)

Thus, despite guidelines about multi-agency working (BPS, 2000), the experiences of educators in the current study – understood in the context of other research (Montoya, Colom & Ferrin, 2011) – could be seen as demonstrative of a wider inadequacy in effective correspondence between the many professionals contributing to the management of a diagnosis

such as ADHD. A contributing factor to this may be unequal power relations evident in differing claims to authority and expertise between doctors and educators.

What is the extent of SEBD-specific training opportunities for mainstream educators?

Previous studies have reported that teaching professionals often feel that their pre-service and in-service teacher training related to psycho-pharmaceuticals is inadequate, with limited training opportunities to discuss why medication is prescribed and the side effects associated with its prescription (Ryan, Reid & Ellis, 2008). Responses from the staff at Grange Park are consistent with these findings.

Pastoral Care Worker: *I haven't had any training in it...Not for these sorts of medications. Other medications we have training in. Like for diabetes...Which is weird that we have training for all of the other medications and not one of the most dangerous ones….You know, you realise that it's a high-class drug…it can do quite a lot of damage.* (Individual Interview)

Inclusion TA: It's not that you've met with anybody or that you've read it in books or been trained, it's your experience of what worked with another child. (Focus Group)

Inclusion TA: *All I know is that parents said you can have a different type [of Ritalin].* (Focus Group)

SENCO: During teacher training you don't really get given very much [training]. So, most of my knowledge is stuff that I've just kind of gathered from working with children. (Individual Interview)

These samples of conversation, acquired throughout the case study, paint a picture of staff who feel that their training is inadequate with specific regard to the place of medication in their

school. The remark from the Inclusion TA suggests that staff are, in some instances, relying upon parents to inform them about the specifics of medication.

The free-writing exercises, focus group and interviews suggested that the participants in this study do not feel as if they - both as individuals and as a school - play a significant role in the process of psychiatrising or medicalising SEBD. It seemed that this distancing from medication was not simply due to a lack of training but was – in some instances – reflective of a definite anti-medication viewpoint. Whilst there were some notions of psycho-pharmaceuticals 'eliminating' or 'solving' problem behaviours, these comments were often followed by a negative association with psycho-pharmaceuticals:

Interviewer: Could any of you expand a little on your experiences of medication specifically within the classroom?

Head Teacher: Some of them, I've seen, it's made them really like-"

Inclusion TA: Placid

Head Teacher: Yes, sleepy, personality gone.

Inclusion TA: Yes! Yes. Lethargic!...And then they don't want to participate.

Head Teacher: Yes, and then they need to have sleeping tablets.

Nurture Group Leader: And you can see a bit of depression coming along. (Focus Group)

Inclusion TA: I would say that Ritalin can improve behavioural difficulties and concentration in some children. But, in others, it can make them appear sleepy, you know, with little enthusiasm to learn and participate in activities. (Focus Group)

Teaching Assistant: I know they say it can make them calm and able to focus but I would also say it can make a child withdrawn and unmotivated. And yeah, mean they're not sleeping, so then they have to take sleeping tablets. (Focus Group)

It appears that the educators within this research were at least partially aware of some of the side-effects associated with psychostimulants – knowledge seemingly acquired through their own experiences with medicated children, rather than any formal training or discussion with medical professionals. One notable perception was the notion that psychostimulants 'take away' the child, as illustrated by the following dialogue:

SENCO: I know there's a leaning towards parents thinking it's a good idea, because a lot of parents see that as an easy solution…But then, equally, there are parents who don't like medication because it kind of 'zaps the life' out of their children. (Individual Interview)

Inclusion TA: When he had the Ritalin, it really completely changed his personality...really quietened him down but – I felt – too much. I felt it took away 'him'...[He had one dose of Ritalin] in the morning and one in the afternoon. That's what made him really sleepy. But then it went to all day Ritalin, and that one was better as you got a bit of personality back in the afternoon. (Focus Group)

These responses are interesting when viewed in the context of pharmaceutical marketing of psychostimulants such as Ritalin, which frame medication as the answer to 'negative' behaviors, assuming an association between the 'good' and the 'quiet' child in their advertisements (Diller, 2000). Conversely, the staff at Grange Park appear to perceive these behaviours as part of what makes up that child – irrespective of whether the expression of these behaviours are problematic to teaching or not. This raises wider questions about the interaction of subjectivity, agency, and psycho-pharmaceuticals in children's lives.

While the psychiatrisation and medicalisation of SEBD in Grange Park School was almost entirely absent, it quickly became apparent during the research that Grange Park instead adopt psychotherapeutic approaches to inclusion.

A Psychotherapeutic Approach to Inclusion

The preference for non-medical alternatives to achieving inclusion by Grange Park educators is strongly illustrated in their completion, as part of this research, of a Case Study Scenario. The task provided participants with a brief outline of a fictitious student who was displaying behaviours typically associated with ADHD (see Box 1). Participants were asked to briefly outline the 'next steps' they would take in response to the exhibition of these behaviours. Acquiring a diagnosis or making a referral did not appear to be of high importance to the educators in this study (see Figure 2).

Box 1: Case Study Scenario

Sam is in Year 4. He frequently struggles to stay in his seat in the classroom and, even when he does, he finds it hard to not fiddle with everything on his desk. Sam also struggles to not blurt out his answers to questions and gets frustrated when he is expected to take turns during class activities. Sam is incredibly disruptive to other children in the classroom, he is frequently the main source of distraction, and you are worried that his behaviour is causing him to underachieve in school. What steps would you take to support Sam?

Box 1

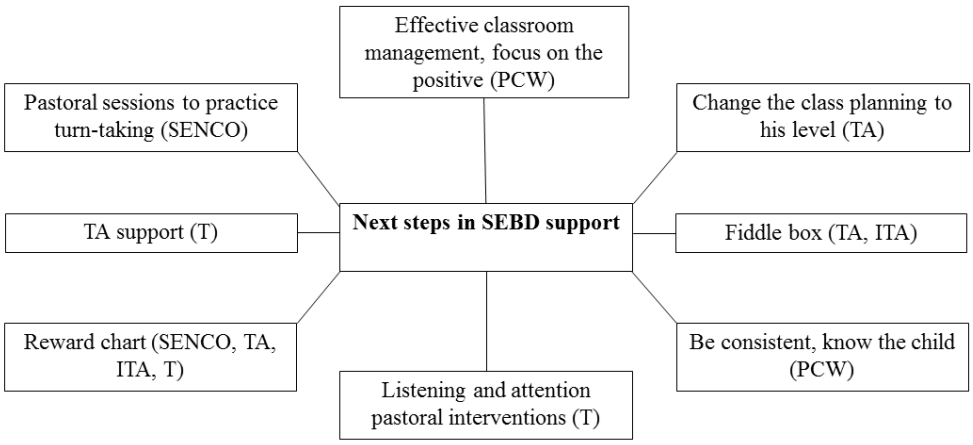


Figure 2

It is worth noting that each participant responded to this exercise independently, with no prior discussion between them. Participants consistently suggested that classroom management should be adapted to fit Sam's needs, and placed emphasis on using pastoral services to engage Sam in his learning, rather than immediately resorting to a referral to the SENCO or educational psychology services.

What are the key approaches and forms of support to enable the inclusion of children with SEBD in mainstream schooling?

One form of support preferred by staff at Grange Park to enable the inclusion of children with SEBD were Nurture Groups. The primary aim of many Nurture Groups is to facilitate the development of secure and trusting relationships between the Pastoral Care Worker and the other children in the Nurture Group (Bennathan & Boxall, 2013). Reports have suggested that the submersion into this accepting, understanding and secure environment can empower the members of the Nurture Group to develop the social, emotional and behavioural skills

necessary to successfully access the learning taking place in their classrooms (O'Conner & Colwell, 2002). The specific aims of the Nurture Group were outlined by Grange Park's Pastoral Care Worker:

Pastoral Care Worker: Well, the main thing initially is to get the child to access their learning again. With less support than they're having to have before the Nurture Group. They'll still go out and perhaps need support - it's not that it's a cure - but they'll hopefully need less.…[I]t's to give them control back of their learning. [We focus on] self-awareness, self-esteem, social skills in groups...Emotional literacy is a huge thing we focus on - probably the biggest - teaching them how to express their emotions in a better way.

Interviewer: And do those projects allow them to access the curriculum?

Pastoral Care Worker: Yes. Less than they should but more than they would have been.

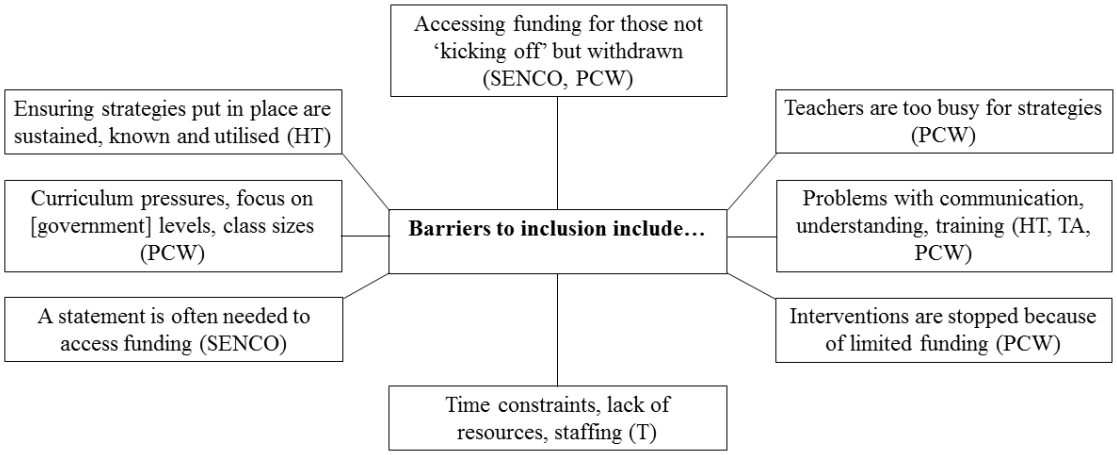
Here the Pastoral Care Worker admitted that the school's Nurture Group sessions allow many of its children, presenting with SEBD, to access more of the curriculum than they would have done were they to remain in the classroom. With the resources and funding available to them, Grange Park's decision to establish their set of Nurture Groups was the best 'solution' they could offer in their attempts to enable all of their children to access at least some of the curriculum. Nonetheless, the Pastoral Care Worker herself accepted that their system is not 'ideal' and that some of the children attending her groups were accessing 'less than they should' be in their learning.

There is an emerging view that, whilst certain interventions have the potential to transform a child from ‘at risk’ to ‘resilient’, there is also potential for this process to transform societal problems to individual-based, personal problems (Brunila, 2012; Burman, 2016). This concern

could be applicable to some of the children accessing the therapeutic services within Grange Park Primary. Many children working with the Inclusion Team in Grange Park are facing challenges outside of the school environment, with a majority of its pupils coming from low-income homes with a number of familial, and wider societal, risk factors.

If, as Brunila (2012) argues, therapeutic interventions can lead to the internalisation of societal problems, then the low-income environment these children have been raised in could come to be understood through the 'self'. Indeed, Bailey (2007, p.117) proposes that the therapeutic interventions offered by nurture groups for 'troubled communities' do so with the aim of 'substituting the naturalised deficits of community and family' by targeting the overt behaviour of the individual child. The encouragement of therapeutic interventions championed by schools such as Grange Park may promote the idea that the consequences of poverty and adversity can be resolved through nurturing a child's internal wellbeing. This may be problematic as it treats the individual child, rather than the political and economic conditions that sustain poverty, as the site of intervention, and in the case of psychopharmaceuticals, risks medicating child poverty (Isaacs, 2006).

Whilst Grange Park's apparent psychotherapeutic approach to inclusion could be criticised, particularly as it involves a number of children being removed from the classroom, equally it could be argued that its long-term benefits may be more inclusive than medicating a child so that they are able to remain in the classroom. Overall, Grange Park's approach to inclusion could be seen as reflective of the continuous challenges educators face when attempting to support children through an intricate network of political pressures, funding restrictions, cuts to child mental health services and societal factors that act as barriers to inclusion (as outlined by the participants in Figure 3).



The Pastoral Care Worker herself stated that one of the reasons the Nurture Group is needed within their school is because of the restraints put on teachers:

Pastoral Care Worker: I'm not saying Nurture is the be-all-and-end-all. I know it's not perfect but...it helps them in ways that our teachers just don't have the time or resources to...[T]eachers cannot physically think about, and act on, every single child's emotional wellbeing. They're here marking until 6 o'clock at night. Then, they go home and do more planning and working. They simply can't. (Individual Interview)

These barriers are important to bear in mind when assessing the success of a school's attempts at inclusion. The educators at Grange Park never ceased pointing out that even with all the best intentions in the world, if the funding, time, support and resources are not available then those intentions cannot become a reality.

Conclusion

This research addressed four main research questions. Firstly, it sought to understand the part played by educators in the identification, diagnosis and management of SEBD. Prior to the

analysis of our work within Grange Park, it could have been assumed that we would encounter a school heavily involved in the labelling, diagnosis and medicating of its pupils. Conversely, the experiences of our educators in this study constructed an image of a therapeutic school with a staff team tentative in their promotion of psychiatric labels and psycho-pharmaceuticals. In relation to our research question about key approaches used to enable inclusion, Grange Park champions the role of psychotherapeutic interventions, and specifically Nurture Groups, over psychopharmaceutical methods. Here we would conclude that the degree of both psychiatrisation and medicalisation within Grange Park Primary is significantly lower than the levels evident in research from educational settings in the US.

This leads into the second research question, which aimed to explore the part played by educators in mobilising different forms of psy-expertise. In the context of the educators at Grange Park, the use of psychotherapeutic interventions appear to be mobilised in resistance to medicalised and psychiatrised approaches to supporting children. While this form of resistance promotes non-pharmaceutical support, it still operates within a broader psy-complex (Rose, 1999) that could be said to individualise and depoliticise children's difference. Therefore, exploring alternative forms of resistance engaged in by educators would make a fruitful area of future research that has global significance given the globalisation of ADHD (Conrad & Bergey, 2014), and given that school-based mental health programmes are seen as a core tool in mainstreaming mental health within low and middle-income countries (WHO, 2010).

It should be reiterated that Grange Park Primary School is situated in an area of high deprivation whose residents have a low socioeconomic status. There is a risk here that psychotherapeutic discourse frames structural issues as 'resolvable' through interventions which focus, almost exclusively, on the need for improvement in an individual's emotional literacy, self-esteem, social skills and family dynamics. By viewing socio-economic issues through psychological

terms, wider societal or political problems, which contribute to these issues emerging in the first place, are largely ignored. Indeed there appeared to be little awareness amongst staff regarding the individualising properties of psychotherapeutic interventions. This may be reflective of educators' reporting having received little training (addressing our third research question).

The case study nature of this research means that its findings are restricted to the context of Grange Park Primary. However, the fact that our conclusions directly contrast those drawn from a large body of research in North America could signify a potential avenue for further research assessing disparities between the educational contexts and attitudes of North American and British educators, and furthermore, between educators in global South and North countries, as they negotiate an intricate web of social, political, economic and individual factors that mark the global terrain of SEBD. Further analysis of differential mobilisations of psy-expertise within schools globally is important because it signifies a cultural and educational shift that has profound effects on teachers and students, and on what we understand as being the purpose of education.

Declaration of Interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institution concerning intellectual property.

We understand that the Corresponding Author is the sole contact for the Editorial process. She is responsible for communicating with the other authors about progress, submissions of revisions and final approval of proofs. We confirm that we have provided a current, correct email address which is accessible by the Corresponding Author.

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Figure Captions

Figure 1. Participant responses to the free-writing exercise with the sentence starter ‘When I think of SEBD, I think of…’

Figure 2. Participant responses to the case-study scenario, outlining their next steps to support a boy exhibiting symptoms typically associated with an ADHD diagnosis

Figure 3. Participant responses to the free-writing exercise with the sentence starter ‘Barriers to inclusion include…’