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Assessment for special education in a child guidance unit

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Child psychiatrists are often requested to contribute to the formal special educational assessments of children for which the 1981 Education Act laid down a new procedure. Some of the evident aims were to enable some handicapped children to remain in ordinary school, to stress 'needs' rather than categories, to involve parents more closely in the procedures, and to emphasise the importance of the effect of the handicap on the learning process. The first year of this procedure was reviewed by Wardle (1986) who noted a number of advantages and disadvantages, and subsequently the College (1988) recommended that the working of the Act should be reviewed, particularly because of delays and the cumbersomeness of the procedures.

Similar reservations led to this study, which inquired into the views of clinic professionals involved and followed up the children through to placement. The setting was an inner-city child guidance unit administered by the education authority.

The study

All the cases assessed under the Full Assessment (FA) special education procedure from April 1983 to April 1986 were examined (Table I). These 70 cases were approximately 11% of the overall referrals to the clinic over that period. General administrative and clinical data were collected and the clinic worker most closely involved (psychiatrist, psychiatric social worker or child psychotherapist) was asked to rate the parent's and child's understanding of and attitude towards the procedure, to note any reasons for delay, and make any general comments.

The child guidance unit's role

The clinic had contact with many (61.4%) but not all of the cases before the procedure. FA was suggested by the education service in the majority of cases (82.9%), by the parent in 7.1%, by the clinic in 4.3%, and by other agencies in 4.3%. Clinic social workers (employees of the Education Authority) gave the 'initial letter' in 15.7%.

While there was an encouraging number of reports by parents – nearly half (48.6%) – and psychological reports were generally available (74.3%), medical reports were rarely available (4.3%), school reports were not available in 21.4%, and Education Welfare Service reports were available only in 2.9%.

There was multiprofessional clinic involvement in the majority of cases; usually cases were seen by a psychiatric social worker (87.1%) and psychiatrist (71.4%) or child psychotherapist (32.9%). The clinic teacher saw 12.9% of cases. Children were also assessed either by the clinic educational psychologists or by other local educational psychologists. Multidisciplinary and parental discussions always took place and in addition there were more formal case conferences involving outside professionals in 28.6% of cases and outside professionals and parents in 30%.

Appointments after assessment were offered in about two-thirds of cases (68.5%), of which the majority were kept. Treatment was thought to have been made more difficult by the procedure in 12 cases (37.5%).

Family attitudes

The parents' attitude towards and understanding of the procedure was rated as good in 34.3%, moderate in 37.1% and 'poor or unclear' in 25.7%. The child's attitude and understanding was rated much less favourably – as good in 15.7%, moderate in 32.9%, poor in 28.6% and unclear in 20%.

TABLE I
Characteristics of the population

		FA cases 1983–86	*All cases 1983*
Age	Under 5	1 (1·4%)	12 (6.3%)
	5–11	39 (55.7%)	80 (42.1%)
	12–15	30 (42.9%)	98 (51.6%)
Sex	M	57 (81.4%)	133 (70.0%)
	F	13 (18.6%)	57 (30.0%)
Ethnic origin*	ESWI	34 (48.6%)	98 (51.9%)
	AC	26 (37.1%)	49 (25.9%)
	Other	10 (14.3%)	42 (22.2%)

*Ethnic codings: ESWI is English, Scottish, Welsh or Irish; AC is Afro-Caribbean; Other includes W African (2), Italian (2), French (1) and children of mixed parentage (5).

Loss of education

One reason for parental dissatisfaction with the procedure was the loss of full-time education experienced by the children; 60% of the children were out of school for over one month continuously, from before the start of the procedure (35.7%) or after the start (24.3%). The major reasons for a child's being out of school were school refusal (21.4%), formal exclusion (19.0%) and informal exclusion because of behaviour problems (40.1%). In nearly all cases part-time home tuition was provided as an alternative.

Delays

A long wait for an outcome was frequent; in over two-thirds (68.6%) of cases this was over 12 months. Two cases moved away, and the remainder (30%) were placed in under 12 months. For all cases placed the mean time taken was 13.3 months (range 4–22 months); in three cases the procedure was terminated and in 11 cases there was either no placement by school leaving age or by the end of October 1986 (mean time 22.3 months, range 14–32 months).

Reasons for delay were thought to be due commonly to a mixture of factors: particularly complex needs (66.7%), family factors such as difficulties with gaining the cooperation of parents (50%), administrative delays (35.4%), or professional disagreements of emphasis (31.3%). Other less frequent difficulties mentioned were delinquency or social services involvement and waiting lists.

The effects of the delays were rated to be good in two cases, indifferent in nine, bad in 22 and not known in 15. These effects are easier to describe than to quantify; if the child remained in ordinary school until placement and had major difficulties the school found the wait frustrating; if the child was out of school and receiving home tuition this did not seem to be a problem for that service, and the one-to-one attention could be beneficial to the child, but the parents were often noted as being dissatisfied. The effects on the child were difficult to ascertain, but at least two boys became markedly more delinquent in the waiting period, and one girl took an overdose. However sometimes the wait provided an opportunity for more detailed assessment, for individual psychotherapeutic support, or for clinic remedial teaching.

Outcome of the procedure

Of the 56 children provided for, 23 were placed in boarding schools – all except one being special schools for 'emotionally and behaviourally disturbed children'; 29 were placed in a variety of day 'special' provision; four were maintained in ordinary school with extra support.

First knowledge of the outcome of the procedure was informal in 71.4% of cases, by letter in 19.6%, and from a copy of the 'statement' in 8.9%. The statement was received within two months of placement in 25%.

Sex and ethnic differences

As in other child guidance clinics, an excess of boys is referred; this is even more marked among the 'FA' children and particularly so for the Afro-Caribbeans – of the 34 ESWI children 24 were boys and 10 girls, but of the 26 Afro-Caribbean children 25 were boys and only one was a girl (Fisher Exact Probability $P=0.01$).

There were no sex or ethnic differences as to whether the children were out of school but there were major differences in the reasons when this was the case. The boys who were out of school were more likely to be so because they had been excluded, formally or informally (24 of 35), whereas only one of the seven girls who were out of school had been excluded. Afro-Caribbean children (17 our of 18) were more likely to have been excluded than ESWI children (7 out of 19; Fisher Exact Probability $P=0.0003$). This finding is in line with the report from ILEA's Research and Statistics Branch (1988) which found that pupils from Caribbean backgrounds were over-represented among pupils suspended from both primary and secondary schools.

Girls were more likely to be out of school because of 'school refusal' (5 out of 7); this was less often the case with boys (4 out of 35). School refusal was never a cause for being out of school among the Afro-Caribbean children.

Although a higher percentage of Afro-Caribbean children (46.2%) than of ESWI children (29.4%) were placed in boarding school this was not statistically significant. There were no other placement differences.

Comment

This study of the special education procedure confirms others in finding evidence of delays and parental dissatisfaction, some of which could be reduced by better administrative and inter-professional communication and the provision of a 'named person' (in the Warnock sense) (Warnock, 1978) to keep the parents informed. The clinic's role was ambiguous as it rarely initiated the procedure, and the outcome was often essentially pre-determined by the child not being allowed to attend ordinary school.

In terms of provision, while special schools for emotionally and behaviourally disturbed children are widely used, there is little clear evidence of their efficacy. The usefulness of boarding schools also needs more research; when family tensions are high

both children and parents may be in favour of this option, and 'reception into care' may be avoided. However, questions have been rightly raised as to whether these schools, often in the countryside, provide appropriately for inner-city and ethnic minority children.

Does the Full Assessment procedure have any advantages? The involvement of parents is important and it is helpful that the full range of needs is looked at systematically; this is especially relevant for children who have learning difficulties as well as being emotionally disturbed. The possibility of support being provided within ordinary school is also an advantage.

What are the implications for good practice within the clinic? The procedure was achieved more satisfactorily when the family was already known to the clinic, when there was a meeting of all interested parties, and when the parents and child understood and supported the likely outcome.

However, despite any 'improvements' that could be made, more fundamental issues need to be addressed about the usefulness of a psychiatric contribution to achieve educational provision when learning difficulties and institutional rejection may be of primary relevance, the concept of 'emotional handicap' is so ambiguous, and so little is known about the outcome of currently available types of provision.

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