



From a child who IS a problem to a child who HAS a problem: fixed period school exclusions and mental health outcomes from routine outcome monitoring among children and young people attending school counselling

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Background: Exclusion from school is a disciplinary tool with an increasingly recognised relationship to poor mental health among children and young people. We explored the relationship between mental health and school exclusion for a cohort of children and young people receiving one to one counselling. **Method:** We analysed routinely collected data from a diverse UK sample of children and young people aged between four and 16 years old and receiving school-based counselling ($n = 6712$ students from 308 primary and 61 secondary schools). Fixed period school exclusion rates (number of sessions) were compared between the academic year before and the academic year in which the child attended counselling. Mental health (Strengths and Difficulties Questionnaire) was compared at baseline and at the end of the intervention (after between 16–22 counselling sessions depending on the phase of education). **Results:** Despite more complex and severe initial difficulties, and facing greater adversity, children and young people who experienced school exclusion prior to counselling demonstrated a significant reduction in subsequent sessions of school exclusion in the academic year that the counselling took place (from two full school weeks to half a school week). Moreover, over 74% of the students had fewer reported exclusions and more than half (56.14%) did not have any further subsequent exclusions. They also had better mental health measured by the teacher reported SDQ (pre-intervention $M = 18.94$, $SD = 6.83$ vs. postintervention $M = 15.67$, $SD = 7.56$, $t(310) = 8.23$, $p < .001$) or by the parents (pre-intervention $M = 18.09$, $SD = 6.42$ vs. postintervention $M = 14.0$, $SD = 6.99$, $t(171) = 7.71$, $p < .001$). **Conclusions:** School-based mental health interventions may positively influence educational engagement as well as mental health. Providers should, therefore, monitor both to explore the impact of their interventions. The identification of poor mental health may alter staff perceptions and management of challenging pupils, which future studies should explore.

Key Practitioner Message

- Exclusion from school is strongly related to poor mental health in children and young people so we should be concerned that rates of exclusion from school have been increasing in some countries, such as the UK, over the last 5 years.
- On average, the children in our study who had experienced at least one fixed period exclusion in the year prior to attending counselling lost significantly fewer school sessions to exclusion in the year of their counselling.
- Exclusion from school is particularly associated with Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorder, which other research suggests is unresponsive to counselling.
- We suggest that attending counselling supports children with emotional symptoms while also indicating vulnerability to staff in the school, thus influencing their perceptions and management of the child's behaviour.
- Future research should explore these issues with a counterfactual (perhaps children on a waiting list) to see whether we can replicate our findings, and then to explore the mechanisms by which counselling or mental health support in school results in reduced exclusions.

Keywords: Counselling; intervention; educational psychology

Introduction

Behaviour management and disciplinary actions applied in schools can be challenging issues for both parents and educational professionals (Graham, White, Edwards, Potter, & Street, 2019; Kaplan, Gheen, & Midgley, 2002). Exclusion from school (henceforth, school exclusion) is a disciplinary tool that removes students from the school environment on a temporary or permanent basis (DfE, 2019). The most common reason cited for school exclusion is to deal with persistent disruptive behaviour (DfE, 2019), but evidence consistently suggests that school exclusion has been applied disproportionately to disadvantaged groups of children (Gazeley, Marrable, Brown, & Boddy, 2015; Graham et al., 2019; Strand & Fletcher, 2015), including those with poor mental health (Ford et al., 2018). The risk profile for school exclusion is characterised by multiple vulnerabilities including lower socio-economic status, the presence of special educational need (SEN), poorer academic attainment, looked after child status, and English as an additional language, alongside Black ethnicity, and male gender (DfE, 2019; Paget et al., 2018; Strand & Fletcher, 2015). The presence of psychopathology has also been identified as an important predictor of future exclusion, especially for boys (Tejerina-Arreal et al., 2020). Combined, these factors render those who experience school exclusion some of the most vulnerable learners within contemporary education.

Exclusion exacerbates these vulnerabilities and predicts negative long-term consequences for many children. School exclusion has been associated with poorer academic and social outcomes, poverty, risk of criminal activity and poor mental health (Apland, Lawrence, Mesie, & Yarrow, 2017; Ford et al., 2018; Gill, Quilter-Pinner, & Swift, 2017; Ministry of Justice, 2012; Parker & Ford, 2013; Public Health England, 2014; Sanders, Liebenberg, & Munford, 2020). Thus, the impact of school exclusion on an individual is enduring and wide-reaching.

Whilst schools are in a unique position to identify problems early, facilitating targeted intervention (Fazel, Hoagwood, Stephan, & Ford, 2014; Fazel, Patel, Thomas, & Tol, 2014), little is known about effective practice to improve the trajectories of at-risk groups who have experienced school exclusion. A systematic review exploring exclusion interventions identified school-based counselling as an area showing promise, producing a small, transient but significant decrease in exclusion rates (Valdebenito, Eisner, Farrington, Tfofi, & Sutherland, 2018).

Furthermore, there is evidence to suggest that counselling has an important role to play in enhancing learning and effective school environments (Pearce et al., 2017), and in particular may be useful at exploring underlying psychopathology associated with children struggling to cope at school whilst minimising teacher burden to intervene. However, more research is needed to characterise nuanced risk, unmet need, and effective provision before best practice recommendations can be made.

The present cohort study explores the relationship between school exclusion and mental health for children

and young people who received one to one counselling. It aims to answer the following research questions:

- Research question 1: Is there a difference between the characteristics and mental health of the children who have experienced exclusion compared to those who have not among those attending counselling?
- Research question 2: How does mental health, as well as the prevalence and number of sessions missed due to exclusion compare before and after counselling in the subgroup with prior fixed period exclusions?
- Research question 3: What predicts improved mental health in the whole counselling sample and in the excluded subgroup?
- Research question 4: What predicts reduced exclusions in the excluded subgroup?

Methods

Ethics and consent

This study was registered with Place2Be's Research Advisory Group. As the children were under the age of 18 years old, parental/carer consent was gathered for the use of anonymised data in evaluation, including for use to support analysis for publication or presentation. Only anonymised data were analysed in line with the charity's General Data Protection Regulations compliance.

Participants

Over 8000 children and young people ($n = 8516$) received one to one counselling provided by the charity in schools across three countries; England ($n = 7553$), Wales ($n = 191$) and Scotland ($n = 772$). These children attended 314 primary schools ($n = 6802$) and in 62 secondary schools ($n = 1714$) between August 2017 and July 2019. The sample was split into two cohorts by the academic year in which their intervention took place (2017/2018 and 2018/2019) when comparing to national statistics on fixed period exclusions. The mean age was 9 years old ($SD = 2.53$) but ranged from 4 to 16 years old; 53.88% were male. Most (99%) of the schools were state-funded. We excluded children or young people with missing data on fixed period exclusions, which provided a sample of 6712 (see Figure 1).

Procedure

Children and young people are usually referred to the Place2Be's one to one counselling by a member of school staff, but sometimes by parents/carers or the children themselves. The charity's school-based counsellors are therapists qualified in counselling at Level 4 in the UK Qualifications framework (the equivalent of a university degree) and are members of a professional counselling body (for example, British Association of Counsellors and Psychotherapists). The counsellors undertake a systematic assessment and formulation, which involves meeting with the teachers, parents/carers and the child/young person. Formulation follows an explicit framework and aims to identify strengths as well as difficulties, the source of the presenting issue and the urgency of the case (for more details see Toth et al., 2020). The clinician sets out their plan for the child / young person and the expected outcomes from the work and makes a recommendation of the type of intervention needed. The counselling is offered once a week in a 40–60 min session. The average duration of counselling in one academic year was 22 sessions for primary school pupils and 16 sessions for secondary school pupils.

Measures

Background characteristics. Counsellors collected data in a bespoke database with pre-defined categories on important

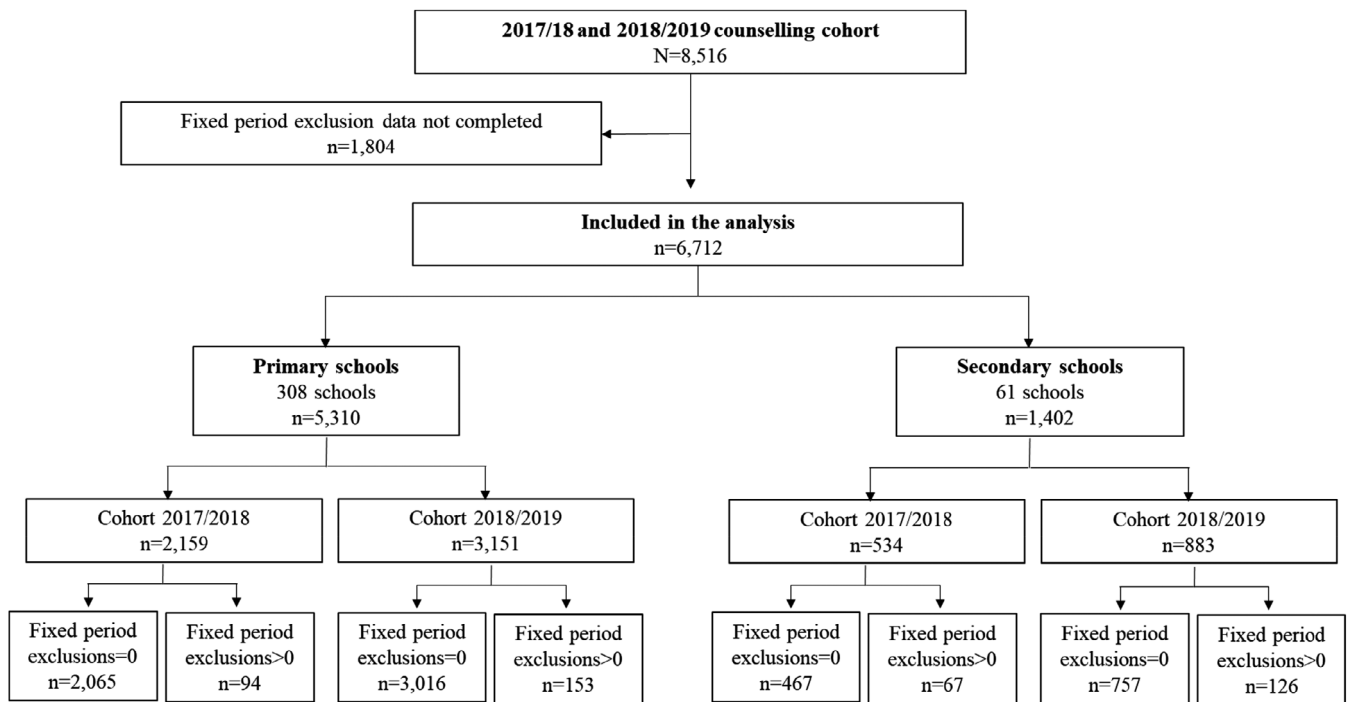


Figure 1. Flow chart of sample for the school-based counselling service

background characteristics, which comprise: age, gender, ethnic group, eligibility for free school meals (FSM), pupil premium, looked after child status, child protection plan, English as an additional language, SEN, household composition and the family's involvement with different agencies (e.g. Child and Adolescent Mental Health Services – CAMHS) as part of their initial assessment. The pupil premium is a grant given by the government to schools each year to improve attainment of disadvantaged children and decrease the attainment gap.

Presenting issues. Presenting issues were selected from a pre-defined bespoke list of 21 difficulties (see Toth et al., 2020 for more details). Examples of issues that children can experience include general, social or separation anxieties, troublesome behaviour, ongoing family tensions or eating difficulties.

School fixed period exclusion/suspension. Based on the information provided by the school, the mental health practitioner recorded whether the child/young person was excluded for a fixed period in the academic year prior to the intervention (pre-intervention) and in the academic year in which their final counselling session took place (follow-up). Fixed period exclusions were reported in terms of sessions missed; with a session equating to half a school day. A dichotomous measure of reduction in the number of exclusions was calculated, assigning the value of one when the number of fixed period exclusions at pre-intervention was smaller than the number of exclusions at follow-up.

Mental health. Mental health was measured using parent and teacher versions of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ is a validated tool (Cronbach alpha .73, test-retest reliability of .62) comprising 25 items and five subscales measuring emotional symptoms, conduct problems, hyperactivity/inattention, peer problems and pro-social behaviour. Each item is rated from 0 (not true) to 2 (certainly true) with higher scores indicative of more significant problems except for the pro-social scale, when a smaller score indicates more problems. A total difficulties score is derived by summing the subtotals of the first four subscales and ranges from 0 to 40. From the total difficulties score, the SDQ enables, based on cut-off points, the classification of

students as normal (teacher 0–11 points; parent 0–13), borderline (teacher 12–15 points; parent 14–16) or abnormal (teacher above 16 points; parent above 17 points), before and after the intervention. To assess improvement in mental health difficulties over time, the clinical recovery indicator was used. Individuals were said to have clinically recovered if they had moved below the cut-off point of the abnormal category after counselling.

Analysis

Data were analysed using STATA 14 (StataCorp, 2015). Inferential statistics were used to explore whether children/young people with missing data on fixed period exclusion differed from those with complete data. Similarly, inferential statistics were used to explore possible differences in background characteristics, presenting issues and mental health difficulties between students with no fixed period exclusions and those who had at least one fixed period exclusion in the academic year prior to counselling. Summary statistics were also presented for our sample in comparison with English national statistics. Comparisons could not be made for Wales or Scotland as they either report different statistics or on a different timeline. As the national statistics are released by academic years, we presented these comparison tables by splitting our sample in two cohorts. Logistic regression explored the associations between background characteristics and mental health status before counselling and the likelihood of clinically recovering after counselling as well as to examine the significant predictors of the likelihood of improving exclusion in the year of counselling (dichotomous measure).

Results

Missing data

Over 79% of the children/young people had data on fixed period exclusions at both pre and postcounselling ($n = 6712$). There were no differences between children or young people with missing and complete data on fixed period exclusions in relation to ethnicity, having English as additional language, SEN, family type, parental qualification level, parental mental health. Students with

Table 1. Background characteristics of students with fixed period exclusions

	Not excluded <i>n</i> (%)	Excluded <i>n</i> (%)	<i>p</i> Value
<i>Year group</i>			
Year 1	500 (8)	25 (5.7)	.000
Year 2	697 (11.1)	29 (6.6)	
Year 3	838 (13.4)	46 (10.5)	
Year 4	975 (15.5)	44 (10)	
Year 5	1119 (17.8)	67 (15.2)	
Year 6	934 (14.9)	36 (8.2)	
Year 7	359 (5.7)	39 (8.9)	
Year 8	340 (5.4)	57 (13)	
Year 9	253 (4)	57 (13)	
Year 10	179 (2.9)	28 (6.4)	
Year 11	78 (1.2)	12 (2.7)	
Total	6272 (100)	440 (100)	
<i>Gender</i>			
Male	3244 (51.7)	316 (71.8)	.000
Female	3028 (48.3)	124 (28.2)	
Total	6272 (100)	440 (100)	
<i>Ethnicity</i>			
White British	3610 (57.7)	231 (52.7)	.001
White Irish/Other	412 (6.6)	27 (6.2)	
Asian/Asian British	481 (7.7)	20 (4.6)	
Black African	266 (4.3)	24 (5.5)	
Black Caribbean	306 (4.9)	35 (8)	
Black Other	224 (3.6)	26 (5.9)	
Mixed ethnicity	641 (10.3)	45 (10.3)	
Any other ethnic group	312 (5)	30 (6.8)	
Total	6252 (100)	438 (100)	
<i>Free school meals</i>			
No	2834 (55.7)	183 (47.3)	.001
Yes	2257 (44.3)	204 (52.7)	
Total	5091 (100)	387 (100)	
<i>Pupil premium</i>			
No	2872 (50.5)	167 (40.7)	.000
Yes	2813 (49.5)	243 (59.3)	
Total	5685 (100)	410 (100)	
<i>English as additional language</i>			
No	5274 (84.2)	372 (84.5)	.857
Yes	988 (15.8)	68 (15.5)	
Total	6262 (100)	440 (100)	
<i>Child protection plan</i>			
No	5755 (91.9)	419 (95.2)	.013
Yes	506 (8.1)	21 (4.8)	
Total	6261 (100)	440 (100)	
<i>Subject to care order</i>			
No	5929 (94.7)	422 (95.9)	.264
Yes	333 (5.3)	18 (4.1)	
Total	6262 (100)	440 (100)	
<i>SEN</i>			
No	4499 (71.9)	254 (57.7)	.000
Yes	1761 (28.1)	186 (42.3)	
Total	6260 (100)	440 (100)	
<i>Family type</i>			
Other	4140 (66.1)	307 (69.8)	.115
Living with both biological parents	2123 (33.9)	133 (30.2)	
Total	6263 (100)	440 (100)	
<i>Parental qualification level</i>			
None	660 (21.2)	44 (25.6)	.178
Some	2446 (78.8)	128 (74.4)	
Total	3106 (100)	172 (100)	
<i>Parent has mental health problems</i>			
No	3228 (63.8)	216 (66.7)	.292
Yes	1834 (36.2)	108 (33.3)	
Total	5062 (100)	324 (100)	

missing data were, however, statistically significantly younger, more likely to be in the foundation year of primary school (as data for the previous year would not be available for many children in their first year of school), boys, be eligible for FSM, be in receipt of pupil premium, have a child protection plan, or a care order, and to be involved with a social care agency. These children and young people were significantly less likely to be involved with Child and Adolescent Mental Health Services (CAMHS) and Drug and Alcohol support agency than children with complete data. Statistically significant differences were also found for the referral pathways (see Table S1).

The Place2Be counselling cohort in relation to the national context

Fixed period exclusions within the Place2Be cohort were relatively rare and more frequent within secondary school settings, but slightly more common than seen in the national statistics for England (DfE, 2019, 2020). Thus, the percentage of primary school children from the charity's cohort who had fixed period exclusions was higher than the English national average (for 2017/18–4.4% vs. 1.4%; for 2018/19–4.9% vs. 1.4%). Likewise, in 2017/18, 12.6% (or 14.5% in 2018/19) of young people at secondary school were excluded from our sample, while in England, 10.1% (or 10.8% in 2018/19) were excluded (see Table S2). Furthermore, fixed period exclusion appeared to not only be more prevalent, but also for a longer period of time for the children and young people within the Place2Be sample. Thus, primary school aged children were excluded on average for 11 days in 2017/18 or 9 days in 2018/19, longer than the 1.8 days average for England (in both academic years). Young people from secondary schools who received counselling were excluded on average for 7 days in 2017/18 or 12 days in 2018/19 when compared to the national average of 2.1 days.

In terms of background characteristics, children and young people attending counselling were significantly more likely to be excluded if they were in primary school (below year 6, age 11), of Asian and other white ethnic or minority origin; but significantly less likely to be eligible

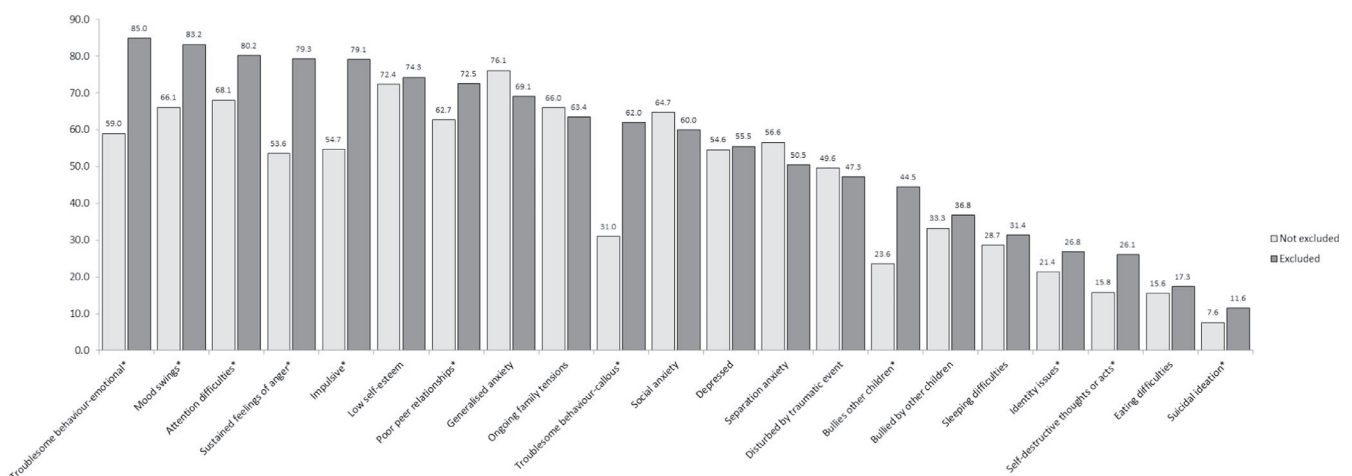
for FSM and to have a SEN status than the national statistics for England (see Table S3).

RQ 1: Is there a difference between the characteristics and mental health of the children who have experienced exclusion compared to those who have not among those attending counselling?

Within the Place2Be's cohort, children and young people who were excluded for fixed periods prior to their counselling were statistically significantly more likely to be older (excluded students $M = 10.41$, $SD = 2.77$; not excluded $M = 9.21$, $SD = 2.38$, $t(6710) = -10.15$, $p < .001$), male (71.8% vs. 51.7%), of ethnic minority origin (especially black), lower socio-economic status (FSM, 52.7% vs. 44.3%), and have SEN (42.3% vs. 28.1%) compared to the children who were not excluded (see Table 1). However, they were statistically significantly less likely to be subjects of a child protection plan (4.8% vs. 8.1%). Figure 2 indicates that students who were excluded had more presenting problems, such as self-destructive ideas, suicidal ideation and being involved in bullying.

Before counselling, children/young people with fixed period exclusions had statistically significantly higher average SDQ total scores than their peers with no fixed period exclusion, according to both teachers and parents. This was the case for both primary and secondary school samples (see Table 2). Moreover, excluded students had statistically significantly higher averages on the conduct (excluded $M = 5.06$, $SD = 2.56$; not excluded $M = 2.42$, $SD = 2.48$, $t(6432) = 21.04$, $p < .001$), hyperactivity (excluded $M = 7.08$, $SD = 2.74$; not excluded $M = 5.02$, $SD = 3.24$, $t(6436) = 2.72$, $p < .001$) and peer problems subscales (excluded $M = 3.32$, $SD = 2.32$; not excluded $M = 2.73$, $SD = 2.32$, $t(6434) = 5.03$, $p < .001$). Thus, students who were excluded were a particularly vulnerable group of children both in terms of adversity, but also in terms of poorer mental health.

RQ2: How does mental health, as well as the prevalence and number of sessions missed due to exclusion compare before and after counselling in the subgroup with prior fixed period exclusions?



* $p < 0.001$

Figure 2. Presenting issues of children (% indicating issue present) who did ($n = 440$) and did not have ($n = 6256$) fixed period exclusion. * $p < .001$

Table 2. Mental health (Teacher & Parent total SDQ) of students with fixed period exclusions compared with students without fixed period exclusion, pre-intervention

	Teacher total SDQ					Parent total SDQ				
	Fixed period exclusions		No fixed period exclusions		t test, p value	Fixed period exclusions		No fixed period exclusions		t test, p value
	N	Mean (SD)	N	Mean (SD)		N	Mean (SD)	N	Mean (SD)	
Primary schools	241	20.60 (6.50)	4.937	14.57 (7.25)	$t(5176) = 12.67, p < .001$	221	18.97 (6.70)	4618	16.47 (7.10)	$t(4837) = 5.11, p < .001$
Secondary schools	181	17.82 (7.41)	1072	13.33 (6.77)	$t(1251) = 8.15, p < .001$	161	18.32 (7.01)	996	16.67 (7.00)	$t(1155) = 2.67, p = .0058$
Total	422	19.41 (7.03)	6009	14.34 (7.18)	$t(6429) = 14.02, p < .001$	382	18.69 (6.83)	5614	16.51 (7.09)	$t(5994) = 5.84, p < .001$

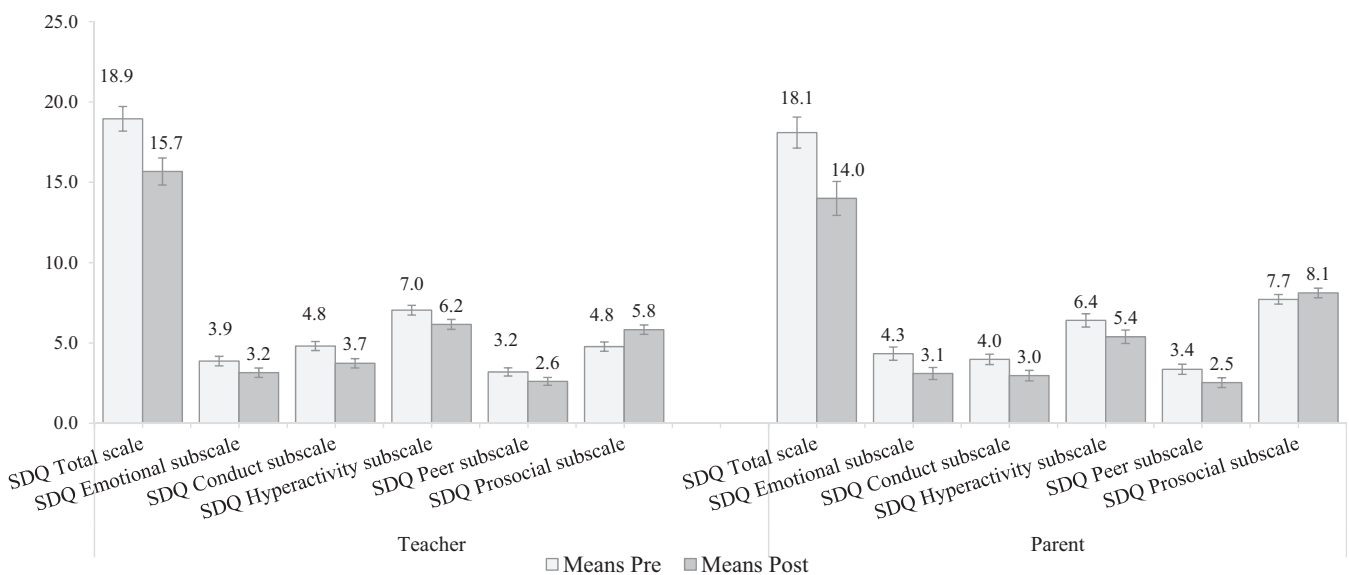


Figure 3. Mental health (Means of Teacher & Parent completed SDQ) of students with fixed period exclusions, before and after intervention

These students experienced statistically significantly fewer difficulties, as measured by the SDQ completed by both teachers and parents after counselling (see Figure 3). Thus, the mean SDQ total difficulties score reported by teachers statistically significantly improved from scores in the abnormal range ($M = 18.94, SD = 6.83$) to scores classified as borderline ($M = 15.67, SD = 7.56, t(310) = 8.23, p < .001$). Likewise, parents reported that total difficulties scores improved from 18.09 ($SD = 6.42$) to 14.0 ($SD = 6.99, t(171) = 7.71, p < .001$). The greatest improvement rates were observed in the conduct subscale according to the teacher and the emotional subscale according to the parent (Figure 3). Approximately 29% of these students also clinically recovered according to both teachers and parents, after counselling.

Counselling was associated with a significant reduction in both the number of fixed period exclusions and duration of exclusions in the year of counselling (see Figure 4). Almost three quarters (74.1%, $n = 326$) of the excluded group experienced a reduction in the number of fixed period exclusions from a mean of 24 sessions ($SD = 35.29$) before starting counselling, to 1.41

sessions ($SD = 4.15$) at follow-up ($t(325) = 11.55, p < .001$). Three quarters of the students who experienced reduced exclusion, did not have any subsequent exclusions in the year in which the counselling took place ($n = 247/326, 75.8%$ or $n = 247/440, 56.14%$ of those who had an exclusion initially). Findings were similar for primary and secondary schools and across the two academic years in which data were collected.

RQ 3: What predicts improved mental health in the whole counselling sample and in the excluded subgroup?

When predicting clinical recovery as reported by the parents for the whole sample, we considered the prior total SDQ score, background characteristic, parental mental health and exclusion status at the beginning of the counselling (see Table 3). SEN (OR = 0.77; [95% CI: 0.64–0.92]) and pre-counselling experience of exclusion (OR = 0.68; [95% CI: 0.48–0.95]) were significant negative predictors of clinical recovery. Thus, students with a SEN or who experienced exclusions were statistically significantly less likely to clinically recover than students without SEN or exclusions. The SDQ score before

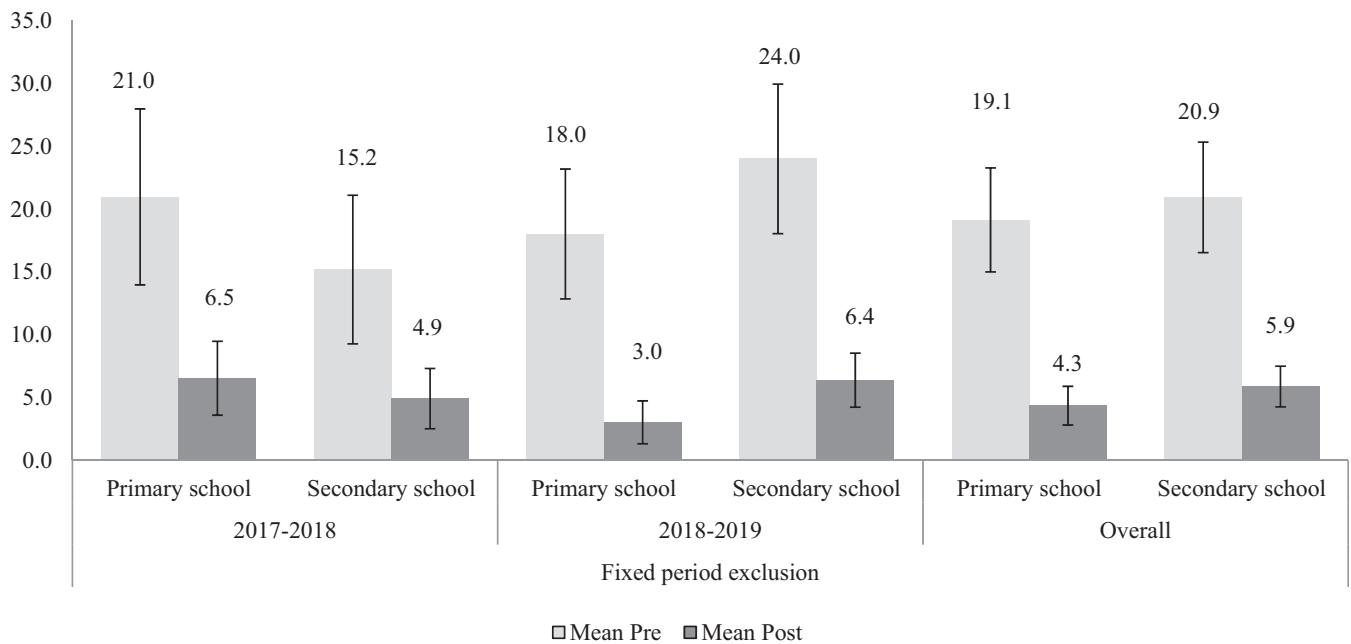


Figure 4. Means of fixed period exclusions (n total = 440) at pre-intervention and follow-up

Table 3. Predicting clinical recovery based on teachers' completed SDQ for the whole sample

	Odds ratio	SE	p Value	95% interval	Conf.
Total SDQ teacher before counselling	1.20	0.01	.00	1.18	1.21
Age	0.99	0.02	.73	0.96	1.03
Female	1.12	0.09	.18	0.95	1.32
SEN (compared to none)	0.77	0.07	.00	0.64	0.92
<i>Ethnicity (compared to white British)</i>					
White Irish/Other white	1.03	0.18	.85	0.73	1.46
Asian/Asian British	1.38	0.22	.04	1.02	1.88
Black African	0.90	0.19	.60	0.69	1.35
Black Caribbean	0.72	0.14	.09	0.49	1.06
Black Other	0.78	0.18	.27	0.49	1.21
Mixed ethnicity	1.30	0.17	.05	1.00	1.69
Any other ethnic group	1.20	0.22	.34	0.83	1.72
Living with both biological parents (compared to other)	1.10	0.10	.29	0.92	1.30
Parental mental health difficulties (compared to none)	0.86	0.08	.09	0.73	1.02
Excluded before counselling (compared to not)	0.68	0.12	.03	0.48	0.95
Intercept	0.25	0.05	.00	0.17	0.35
Number of observations	4363				
Log likelihood	-1892.13				

counselling was a positive statistically significant predictor, the higher the SDQ the higher the likelihood to clinically recover (OR = 1.20; [95% CI: 1.18–1.21]). For the excluded sample, the only statistically significant predictor of teacher reported clinical recovery was their initial mental health status when controlling for background characteristics (OR = 1.08; [95% CI: 1.03–1.13]).

RQ 4: What predicts reduced exclusions in the excluded subgroup?

In the logistic model predicting reduction in exclusions, gender and improvement in mental health were statistically significant and positive predictors, while controlling for age, pupil premium, care order, ethnicity. Thus, girls were twice more likely to experience

improvement in exclusions than boys (OR = 2.20; [95% CI: 1.03–4.71]). Similar odd ratio was found for clinical recovery (OR = 2.19; [95% CI: 1.08–4.43]); students who clinically recovered being twice more likely to reduce their number of school days missed due to exclusion when we controlled for their background characteristics shown to be associated with the risk of being excluded.

Discussion

Our findings suggest that students who were excluded prior to starting counselling were statistically significantly more vulnerable than students without exclusions. As in previous studies and the UK national statistics, they tended to be of Black/Black British ethnic origin, lower socio-economic status and to have

SEN (DfE, 2019; Graham et al., 2019). They also had significantly more presenting problems and more severe mental health difficulties than their peers with no exclusions, particularly in terms of behaviour and attention/ activity. Children with both conduct disorder and ADHD, who are experiencing symptoms of impulsivity, hyperactivity and poor concentration were shown to be the most likely to be excluded from school (Parker et al., 2015, 2019). At the same time, exclusion predicts subsequent worse mental health, which given the bi-directional relationship can precipitate a vicious circle of escalating difficulties for both the child and the school (Ford et al., 2018; Tejerina-Arreal et al., 2020). This, combined with the failure of reintegration and behavioural plans that address underlying difficulties, may explain why many children experience multiple exclusions (Bowman-Perrott et al., 2013). Sadly, exclusion continues to be implemented as a disciplinary tool, despite the lack of evidence to suggest that it is effective in improving the behaviour of individuals or school safety in the longer term (Huang & Cornell, 2020).

In our analysis, children who experienced exclusions prior to attending school counselling services were reported to have significantly improved mental health after counselling. The greatest improvement rates were observed in the conduct subscale according to the teacher and emotional subscale according to the parent. The improvement in conduct was unexpected as prior evidence indicated that counselling is less likely to improve conduct disorder or behavioural problems directly, but could help co-existing emotional problems and support the child to build healthier and more stable relationships (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002). We evidenced the anticipated improvement in emotional symptoms as well.

Counselling was associated with a significant reduction in school sessions lost to exclusions. Three quarters experienced fewer exclusions in the same year the counselling took place, half of them experiencing no exclusion at all. Not only did the majority of the pupils experience fewer exclusions, but the actual improvement in number of sessions was also statistically significant, decreasing from missing two full school weeks to just two and half days. This adds validity to the reported improvement in behaviour and is particularly important as schools welcome and need mental health services that could evidence their positive influences on children's mental health and outcomes linked to measures of accountability. Additionally, given that these pupils are more likely to be from disadvantaged families and have SEN, they are also more vulnerable to poor educational outcomes, therefore, keeping them in school as much as possible seems important and desirable.

The association between a positive outcomes of counselling, measured as clinical recovery, and improvement in exclusion was also evidenced in a contextualised model. In this model, we adjusted for the influence of other background characteristics shown to be associated with the risk of being excluded. Thus, students who clinically recovered were two times more likely to reduce their number of school days missed due to exclusion. This provides some indication that counselling might help reduce risk of school exclusions, especially for those

students whose initial exclusions were linked predominantly to mental health issues.

Strength and limitations

Our analysis benefits from fairly complete data from a large, mostly representative sample of children attending counselling from many schools with a robust measure of mental health. However, we lack the insights into the circumstances underlying each disciplinary infraction, or the decision process as well as key issues like teacher and head teacher attitudes and school characteristics, climate and culture. We only have data on children attending counselling, with no comparison group of children with similar difficulties who did not receive support to provide a counterfactual. We cannot, therefore, assume causality, although our observations provide tentative evidence of a potential benefit worth exploring further. Additionally, the exclusion measure at follow-up was recorded within the final year of intervention as opposed to after the intervention had finished, limiting our interpretations of the relationship between the reduction in exclusion and counselling and the ability to capture any other long-term outcomes or the sustainability of this reduction. These should be also considered when exploring further this complex relationship.

Possible explanations

As stated above, our study cannot prove effectiveness of counselling in reducing exclusion, but merely suggest it as a possibility. In addition, we can only hypothesise the mechanisms by which attendance at individual counselling might produce improvements in exclusion, particularly as there is little supporting evidence of individual counselling having a direct influence on classroom behaviour (Gatti, Grattagliano, & Rocca, 2019). The presence of a mental health service in school could help staff to understand and be more aware of mental health difficulties that children and young people experience (Banerjee, McLaughlin, Cotney, Roberts, & Peereboom, 2016). Moreover, a school-based mental health service might lead to changes in the staff's perception of children's condition once they receive mental health support from 'a child that IS a problem to a child that HAS a problem', which, in turn, might alter the management of conduct difficulties (Fazel & Newby, 2021; Moore et al., 2019; Parker et al., 2019, p. 2569). Attending counselling supports children with emotional symptoms, which might facilitate the child to emotional regulate and better manage their behaviour in school. This might be also the reason for girls benefiting more from counselling as girls tend to present more emotional difficulties than boys (Sadler et al., 2018). Another explanation could be that the presence of a counselling service in the school might enhance the teachers' beliefs in the collective self-efficacy shown to be linked to fewer exclusions (Gibbs & Powell, 2012).

Future research should explore these theoretical mechanisms by which counselling or mental health support in school might result in reduced exclusions. Researchers should differentiate between change in the teacher's perceptions of the child's behaviour and actual behavioural change. Additionally, future study should explore exclusions longer period of follow-up postintervention (e.g. 1 or 2 years later) in order to see whether any reduction in the exclusion is sustained for a longer

period of time. Economic evaluation of the impact on education hours saved would also be informative.

Conclusion

Our findings definitely indicate the importance of routine outcome monitoring to explore the effectiveness of mental health provision, and in addition, the need to consider all outcomes that might be influenced.

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Ethical information

This study was conducted as a service evaluation that was registered with the Place2Be Research Advisory Group. Parental/carer consent was gathered for all children included in the sample for the use of their anonymised data for evaluation in line with Place2Be's GDPR compliance.

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Supporting information

Additional Supporting Information may be found in the online version of this article:

Table S1. Characteristics of children with missing fixed period exclusion data ($n = 1804$) versus those with completed data ($n = 6712$).

Table S2. Description of exclusions at school level for the academic years 2017–2018/2018–2019.

Table S3. Comparison with national statistics on fixed period exclusions rates and background characteristics.

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