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LEARNING OUR LESSONS: SOME ISSUES ARISING FROM DELIVERING MENTAL HEALTH SERVICES IN SCHOOL SETTINGS

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This paper describes some of the complexity of providing Child and Adolescent Mental Health Services (CAMHS) input into school settings. Some reference is made to previous writing about psychotherapeutic work with schools, and also to recent government policy changes which are impacting on service delivery. There is discussion of the multiple levels at which interventions need to be conceptualized, and the issues arising when working within systems and organizations that have very different drivers, tasks, aims and cultures. It is argued that, given the complexity of the therapeutic task, clinicians need a high level of experience and robustness, and to be armed with understanding gleaned not just from individual psychoanalytic psychotherapy but also from psychoanalytic thinking about organizations, as well as about therapeutic communities, in order to function effectively. There is discussion of some of the typical institutional defences against anxiety and distress that arise when working with the most complex children and families in schools, and in particular the pressure to locate problems within individuals and to attempt to address such issues on an individual basis while leaving the institutional and systemic issues unaddressed. I suggest that such work demands a complex view of the role of the therapist, which includes taking on a role which has some similarities to working in therapeutic communities. Some vignettes are used to illustrate how one can do effective and useful clinical work with individual children, and with their families when wider systemic issues are taken seriously.

This paper is about developing therapeutic work in schools in a complex climate. The thinking is derived from various experiments in attempting to

deliver such therapeutic services in over 30 schools in three different NHS Trusts and in three separate local authority boroughs, initiatives that offered Child and Adolescent Mental Health Services (CAMHS) into mainstream primary and secondary schools, as well as units for children excluded from mainstream schools, and specialist schools such as for children with emotional and behavioural difficulties.

There are two main linked themes that the author tries to address throughout the paper. The first is the impact of the fast-changing social and political context that is posing an ever-increasing threat to the way in which child mental health services can be delivered successfully. The linked theme raises a question about therapeutic approach and technique, and suggests that, although there is a long and helpful tradition of psychoanalytic thinking about education and schools, to work effectively within a school context one needs to embrace ideas and philosophies from outside the traditional practice of clinic-based practice, and in particular utilize ideas derived both from psycho-analytically-informed organizational consultancy, but also from the thinking and practice of work in therapeutic communities.

Psychoanalytically-informed work in school contexts has a long history, with many helpful and seminal contributions, most of which retain salience and relevance for the contemporary practitioner attempting to step out of the relatively calm confines of the consulting room into the turbulent waters that are school life. Much of the most influential thinking has arisen from teaching and training several generations of practitioners working in schools (e.g. teachers/mentors), who have attended courses at institutions such as the Tavistock and who have then taken a form of applied psychoanalytic thinking back into such community settings. The writings of Wittenberg and Henry (Salzberger-Wittenberg et al. (1993) have been particularly helpful in this respect. For example, such thinking has enabled professionals to be aware of the dangers that arise when splitting and projection are rife and are used to defend against emotional pain, or when hidden but powerful transferences develop towards teachers, with the resultant hopes and pains, idealizations and denigrations. These writers, as well as others such as Osborne (Dowling and Osborne 1985), have been at the forefront of applying psychoanalytic concepts to such institutional settings, making us as practitioners painfully aware of the huge emotional challenges of the school environment. Many generations of teachers or special needs specialists have softened towards seemingly stubborn or recalcitrant students when realizing the emotional reasons why their pupils 'misbehave' or struggle to concentrate or study, and that these children are not simply being naughty or belligerent. Such professionals have often learnt the hard way about the dangers of not acknowledging the degree of dependency pupils can develop on staff, or indeed on institutions that they can seem to denigrate. Similarly helpful has been a psychoanalytic analysis of the kinds of defences which can be rife in school life, such as the kinds of mania often seen

before holidays that for many pupils may in fact be dreaded, or the spirals of activity and busyness through which staff tend to manage increasingly complex emotional challenges. Making sense of rivalry, splitting, envy and projections have all contributed hugely to the understanding of professionals in schools, as well as therapists working in such contexts.

In recent years there have also been important contributions from linked but related fields. Osborne and others have stressed the centrality of working with professional networks and systems in a thoughtful way; Dowling and Osborne (1985) and other colleagues from a systemic and family therapy tradition have helped us to take seriously the need to engage with whole systems, with networks, and indeed maybe most importantly, with the families of the children we are concerned with. Other writings (Barwick 2000) have focused on counselling and other aspects of the therapeutic encounter with pupils in school, and in recent years there have been some very pertinent contributions from Jackson (2002) regarding a psychoanalytically-informed form of school consultation, which is becoming increasingly influential and useful, working with all levels of the school hierarchy from support teachers to groups of heads, using psychoanalytic understanding in staff discussion groups.

Such writings and thinking remain central to any attempt to understand the workings of school life. However, in recent years there has been a major upheaval in the way children's services are being conceptualized and delivered which has in turn entailed a need to develop new ways of conceptualizing the therapeutic task within schools. There has needed to be more emphasis on the varied roles a clinician might play in a system which now expects therapists to 'take the clinic to the school' (Dowling and Osborne 1985), and concomitantly there is more of an idea that what is needed is less 'expert' consultation from 'on high' and more working within the system, 'rolling one's sleeves up', seeing children and taking on cases. Thus we have to conceptualize a role that includes undertaking more direct work with pupils, families and professional systems, which expects clinicians to do active work with cases that are extremely complex, and that are often too disorganized to ever make it to a traditional multidisciplinary clinic, and also a wish that clinicians should be sufficiently available that their status might change from the 'occasional visitor' to someone who is prepared to become much more a part of day-to-day school life. I think that this kind of work is best done by more experienced practitioners who retain clinic-based clinical time within a multidisciplinary team and ongoing support from peers and senior managers; too often the least experienced are sent out to do this work. The task requires a high degree of skill and experience, as well as a robustness and capacity to contain massive anxiety, to bear huge projections, to be sure enough in one's role and self to be able to be very 'ordinary' while always retaining one's therapeutic stance. Before going on to give examples of actual work, I will say something about the fast-changing external context.

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THE POLITICAL CONTEXT

The context in which such work now needs to be delivered has changed dramatically in the last few years, and this change has required a reconceptualization of the core tasks of the clinician within the school setting.

Services for children in Britain are being radically re-shaped in the wake of various government initiatives and policy directives. One hopeful aspect of these initiatives is that there is more understanding of the long-term and potentially devastating impact on society as a whole of poor mental health in children and parents, and government policy-makers have become more aware of the paucity of current provision and its uneven spread across the country. Policy has been put in place to ensure that something is done to change this, with radical plans being made to improve CAMHS.

Although CAMHS has historically been delivered by NHS-trained and employed practitioners (e.g. psychologists and psychiatrists), local authorities are increasingly leading on all Childrens' Services and the Department for Education and Skills [DFES] has superseded the DOH as the prime mover in terms of government departments for children. The primary policy driver influencing day-to-day work in Childrens' Services is 'Every Child Matters' (ECM), a hugely ambitious policy document and political project which grew out of the failures of safeguarding children as seen in the Climbie affair. ECM aims to deliver a comprehensive Local Authority-led range of genuinely joined-up provision for children and one of the main aims include developing Children's Trusts in each locality, spelling the end of separate Education and Social Services departments. Maybe more importantly for child mental health professionals, CAMHS and other traditionally NHS-run children's services, such as school nursing and even midwifery and health visiting, are also being co-opted into these new structures in some localities. Multi-agency delivery of services is a pivotal strand of these new initiatives, with local authorities being assessed on their ability to deliver multi-agency work into community locations. In a school context this would include ensuring the setting up of well-functioning multi-agency professional forums, which might include educational psychologists, school nurses, CAMHS workers, connexions workers, educational welfare officers and others, in order to carefully plan which service is taking responsibility for the different areas of a child's care.

The fact that the government has placed the lead functions in the hands of local authorities needs to be taken seriously. CAMHS has traditionally been delivered in the NHS by NHS-trained practitioners, but Children's Services generally are now being commissioned from budgets that the local authority have the lead on, and in some places local authority commissioners are taking over commissioning budgets from PCTs. Suddenly the autonomy and cultural specificity of NHS-based CAMHS is under threat. Yet this has occurred at the same time as a massive growth of hope about the future of CAMHS. While many NHS practitioners may not have heard of ECM, most in CAMHS at least

are more likely to be aware of another government document, the National Service Framework (NSF) for Children, Young People and Maternity Care. These documents, ECM and the children's NSF were born in separate government departments, ECM originating from the DFES and the NSF from the Department of Health (DOH). The DOH have of course published various National Service Frameworks, which set the standards for care and provision, others including for example one for mental health, for older people's services, for renal services, for diabetes, and many more. The Children's NSF has a section devoted entirely to CAMHS and sets out very clear standards for what should happen in terms of CAMHS delivery in forthcoming years, and indeed is a 10-year plan. This document was heralded as a huge triumph for CAMHS. The NSF group consisted of senior, respected and experienced clinicians absolutely committed to the cause of CAMHS, and the document gave huge confidence that government at last was going to take this area seriously.

Among the central features which the NSF outlines are the expectation that CAMHS will expand so that what is called Comprehensive CAMHS would be put in place with the overall aim of improving the mental health of all children and young people. The NSF has supported the continuity and importance of CAMHS in both traditional outpatient 'tier 3' services and more specialist, often in-patient, 'tier 4' services. However what is radically new about the NSF is that it has demanded that CAMHS needs to now be delivered in 'tier 2' community settings, such as GP practices and schools. This work must be delivered alongside other professionals through multi-agency teams, as well as working alongside and offering support to first line 'tier 1' professionals, such as teachers, GPs, and others who are generally the first point of contact for professionals. The aim is for services to be available across all tiers, with a new and firm emphasis on accessibility of services via community settings, with early intervention and prevention a priority.

This has been an ambitious policy directive which was to be supported by a large increase in funding, and indeed spending on CAMHS nearly doubled between 2003 and 2006, although the total national spend remains small compared to other areas, and NHS funding difficulties also now impact on the capacity to deliver all that the NSF expects. There was, for example, to be a large increase in workforce, so that, for example there would be 15 WTEs for a population of 100 000, and this workforce would be a genuinely well-trained multi-disciplinary one. This was an important and far-sighted initiative from the government, which has led to a policy document put together by leading and respected practitioners in CAMHS and has given professionals in the field high hopes that at last this often-neglected and 'cinderella' area of service delivery might at last be taken seriously and make more of an impact.

There might be some irony in the fact that in a climate that has stressed the importance of 'joined-up' multi-agency work the Children's NSF came out of a government department (the DOH) which was quite separate from and possibly

rivalrous with the department that drew up Every Child Matters [ECM], the DFES, and that these fault lines are often mirrored at a local level between Health, Education and Social Services. None the less there are large areas of overlap between the two documents, and it affords an opportunity for professionals and the local authority to forge proper joined up multi-agency working partnerships.

These developments have opened up new opportunities to broaden and expand child mental health work, to develop genuine joined-up work with other professionals, and most importantly, for children and families to access services that up until now they often struggled to find their way into. Indeed professionals such as teachers often have frequently attempted referrals to child mental health clinics of children and families who have dire needs, yet the most worrying cases, those which comprise chaotic families or children with parents who are unstable in other ways, often do not actually make it to the clinics where such help has traditionally been offered. The children referred in our deprived inner city schools are nearly always cases of the utmost seriousness. Our caseloads are, for example, full of serious abuse, neglect, refugee children, domestic violence, drug and alcohol use, mentally ill parents, sexualized behaviour. Such complicated cases are the bread and butter of our work in schools, and more often than not the families of such children have been wary of professionals, and historically have not received a service. These are the kinds of cases that have traditionally been seen as so complex that they need multidisciplinary work; the irony is that they are also often such complex and disorganized cases that they rarely make it to clinics where multidisciplinary teams work, and so all too often practitioners in schools (Special Educational Needs Co-ordinators [SENCOs], heads of year, mentors, etc.) are left struggling to 'hold the baby' with no specialist support.

THE PRACTICALITIES: BEING IN SCHOOLS

Given the changes already described, CAMHS practitioners have suddenly found themselves working in schools in new ways, and maybe more importantly, having to take their place alongside other professionals as part of multi-agency teams, and spending large amounts of time in a particular school. This kind of work requires a different mind-set and set of skills to that previously used by the experienced clinicians who would come into schools to briefly 'consult' about specific cases, or to offer some form of support or supervision. These new expectations have meant adapting to new cultures and a whole new set of assumptions. This work takes place at an intersection where NHS and education cultures meet, and we have found that often we are strangers, if not foreigners, to each other, speaking different languages, having different aims, tasks, preoccupations, expectations, understandings, and having to slowly and carefully learn from each other and give up some of our cherished shibboleths

in order to be effective in our work and useful to each other. For those of us trained in mental health, schools can seem to be genuinely alien cultures, and clinicians trained to work in more traditional therapeutic settings, such as outpatient clinics, have to work hard to adjust to the harsh realities of working much more 'at the coalface', without the protections that our normal clinics afford us.

Wilfred Bion (1961) was said to have once famously suggested that 'if there aren't two anxious people in the room, the two being both the therapist and the patient, then there was not much point in turning up to find out what you already know'. Schools can be extraordinarily anxiety-provoking places and I think that in relation to delivering therapeutic work in schools Bion need have no fear about there being insufficient anxiety. The question he and we might ask though is who is the patient that is anxious, and what is, and should, the therapist be anxious about. Schools are complex institutions attempting an array of difficult tasks in a fast-changing world; government policies and targets mean constant pressures on headteachers, on class teachers, on pastoral support systems, pressures to attract the 'right' pupils, to control bad behaviour, to do well in tests, to limit exclusions of pupils, to name but a few. Given this context, careful thought needs to be given to the role of the psychotherapist or mental health worker who is transplanted into an educational context, and in particular in the deprived inner city schools where we are being asked to ply our trade. Who the client actually is can be a moveable feast; at times it is simply a referred child, but often it will be the staff member who referred the child in a fit of anxiety, or the parents of the child, or an external social services system in some disarray, or the institutional culture or management structure of the school as a whole. The CAMHS practitioner often finds themselves adopting a subtle and careful position, never quite sure when one is off or on duty, nor where exactly to locate and deliver one's interventions. Rather like Dilys Daws' (1985) classic contributions about providing infant mental health input in GP practices by 'standing beside the weighing scales', one adopts an uneasy and complex position of being both inside and outside an institution; one's trips to staffrooms or along corridors can be for the purposes of being social, taking respite, providing consultation, feeding back about patients and much more. Echoing work in therapeutic communities, one is never fully off duty, and sometimes the most crucial and helpful work takes place in idle moments by the kettle in the staffroom, or in the car park. School life does not work in the way we 'tightly framed' psychoanalytic clinicians are trained to expect, and as much as we try to assert clear boundaries, we find that in order to be useful, we necessarily become a little uncomfortable as we take our place in the mêlée of school life, hopefully with one foot inside and another firmly in our own secure bases of clinical experience, psychoanalytic traditions and professional support structures.

As an example, we might briefly compare this kind of work to that which takes place in a clinic and witness how 'exposed to the elements' therapists in

schools can be. For example, in clinics most clinicians receive referrals only after they have been carefully filtered, generally scrutinized by a committee of senior practitioners who have the time to ask careful questions or seek more information from referrers. In schools, referrals are almost always in person, often a desperate reaction to an anxiety-provoking event, and just as often schools demand immediate action, to the extent that we can find ourselves accosted in corridors and on our mobile phones. In clinics when a referral is not accepted, the clinician is shielded and does not bear the flak and disappointment one receives in schools for daring to suggest a referral might not be appropriate. One is working without the support of a multidisciplinary team of colleagues, often as a lone practitioner, in a setting where one is rarely consulted, where things change from moment-to-moment, where you are not told that a child you were due to see is on a school trip, or even excluded from school. Rather than the relative luxury of bespoke therapy rooms in clinics, with receptionists welcoming patients, in school settings the work is often done in unsatisfactory rooms, often inconsistently available, often with sessions interrupted by teachers, and the work sometimes depends on the therapist personally calling a child out of the classroom and bringing them to the room. To add to our anxieties, our referrer is of course present before, during and after a session, scrutinizing and expecting 'results'. School staff are sometimes ambivalent about therapeutic work, on occasions stating explicitly that they want our help, while simultaneously subtly undermining the work, distrustful of thinking which smacks of the psychological. Teachers and school staff also often have a fantasy that we can and should take away the most complicated and disturbed children and then simply, and very quickly, bring them back 'cured'. These teachers, struggling with children from the most deprived backgrounds, often feel at the end of their tether and as if they are failing. They can end up feeling de-skilled, overwhelmed and useless, particularly by severely acting out children who get under their skins. Consequently our arrival in schools too often heralds great hopes, we can be placed on a pedestal and then when we fail to cure these children immediately we can come crashing down from our pedestal with a nasty bump, often the bearer of massive projections, projections it is a relief for them to pile onto us, as we now become the ones who have failed, or who are not much use.

WHO IS THE PATIENT ANYWAY?

For the therapist trained primarily to work one-to-one in a clinic consulting room, the shock of exposure to the diversity of demands, expectations and projections that one encounters in work in schools can be overwhelming.

One particular danger that too often hampers therapeutic work in schools is the idea that problems somehow reside in individual children and should be dealt with there. There can at times be too neat a match between the training of

a psychoanalytic psychotherapist to work one-to-one with individuals, and a common idea in schools that it is indeed within individuals that such problems arise. In schools, staffs are primarily trained to teach and each child is seen as an individual, but sometimes their context is forgotten. If a child is not learning, then the child is seen as having a problem, perhaps a learning difficulty, something internal to the child. If a child misbehaves, or is unhappy, or aggressive, then similarly the conventional understanding of this is that the child has a problem, the child needs help as the problem is 'in the child'; one should apply a dose of something, maybe detention, maybe help with anger management, maybe even therapy. This convenient but overly individualistic analysis can lead children too often to be sent for individual help such as counselling in schools, with the hope that the counsellor or therapist will 'sort them out'. Yet with such complex cases the work needs to be aimed at several levels of the system simultaneously. Often the most useful intervention is to work with the teachers, helping them to make sense of a child's behaviours; we always involve the parents as part of the treatment, something schools often find hard to stomach, sometimes retorting 'you are here to help the children, not the parents'. We insist on meeting with other professionals, such as social workers, educational psychologists or psychiatrists. If direct work takes place with a child or family then we always give feedback to teachers and get them to share information with us. This approach is a big challenge to schools where everyone is frantically busy, where they just want to 'get on' and teach, and we should, in their minds, just sort out these children for them.

Often what looks like an emotional or behavioural issue might in fact have its roots in something systemic. As a simple example, in one school with two parallel classes for children of the same age, several children were flagged up as needing therapy in one class, and yet none were referred in the parallel class. On the surface these referrals seemed appropriate; the referred children were evidencing signs of disturbance and were clearly struggling in many aspects of their lives and we wondered whether the first teacher had had an unlucky intake. Yet when a therapist observed the two classes in action we were struck by the contrast between the very well boundaried and experienced teacher in the class where no children had been referred, as opposed to the rather inexperienced teacher struggling to impose her personality on the other class with the so-called difficult children. Maybe the experienced teacher was more 'out of touch' with the emotional worlds of her children, maybe she deflected her anxiety or was slightly thick-skinned; however, we felt that therapy for the referred children would not be the answer to what really was a matter of both teaching technique and gaining support in managing the huge anxiety that working with such children gives rise to.

Indeed providing spaces for school staff to think about the arduous nature of the work, and to gain a more in-depth understanding of the emotional life of the children can have a huge impact on a school's culture and way of responding to

serious emotional and psychological issues, and this has been written about eloquently elsewhere by Jackson (2002). For example, in the same school I set up a support group for learning support staff, staff who often have to manage being dumped with the most worrying children, but have the least training and lowest pay and status. I encouraged them to talk about the children they worked with, what being with these children might stir up in them, and the kind of issues that arise in their practice. One child, Torvil, was flagged up as a worry, and described by several assistants as a 'spoilt brat' and 'annoying', and indeed disdain and despair were the primary emotions expressed. We soon realized that the assistant formally assigned to Torvil knew little or nothing about his background, and it became apparent that the teaching staff tend to keep such information to themselves. Other assistants in the group were glad to share the bits of information they had about Torvil, and with each nugget of information a new and different picture emerged and one could see their view of him softening. We learnt that he had been placed on the child protection register for neglect by Social Services, and was living with his mother at his grandparents' home, and that his grandmother had been awarded parental responsibility. It soon became clear to me that in such institutions the support teachers can feel rather like the children they care for; they are often told what to do with no warning, teachers do not share educational or behavioural plans with them, they might not be warned if there is an outing and a child is not there. This soon led to another intervention outside the group, speaking to the school management to facilitate class teachers and pastoral support staff to both share information and understanding about the children, and to jointly plan the work. Meanwhile the group members began to eagerly digest ideas about how deprived children such as Torvil see the adult world, how little they feel 'held in mind', how they might develop particular defences against overwhelming emotional experiences, and how they communicate their feelings in ways that can make workers like themselves feel inadequate and angry.

After one such group, with Torvil on my mind, I went to observe the 'nurture group' of which Torvil is a member. Utilizing an applied version of the observational methods developed by Bick (1968) and others can provide extremely useful insight into the functioning of a child, a class or indeed a whole school. In this instance I saw an impressive episode of teaching and emotional containment from an attuned teacher, Molly. Torvil himself struck me as a very fragile, open-faced boy, rather desperate for attention. Towards the end of the class Molly had the whole group sitting quietly on the floor as she talked about a forthcoming outing. Molly described the forthcoming outing, counting down the days, and she showed the kind of forethought we rarely see in school staff. The children looked excited, and Molly then said that everyone will have to be on time for the trip, and at this two children shift in their seats uncomfortably, one being Torvil. Molly said 'what's wrong?' and the girl and Torvil between them explained that they never get to school on time. Molly replied that the

grown-ups would make sure it happens this time, and they relaxed. She then said that all the children will have packed lunches and at this the same two shuffle around, and Torvil, looking somewhat shamefaced, said 'I really scared, I might not get a lunch'.

The depiction of Torvil as a 'spoilt brat' was fast losing its descriptive power in the face of this obvious deprivation and I was glad to hear soon after this that he was being referred to CAMHS. He had been aggressive, and more worryingly, he had shown extremely sexualized behaviour in school, and amongst other concerns, this mixed-race boy had a grandmother, the mother of his white mother, who said that the difficult behaviour is 'the black in him'. There were many ways to proceed here. We observed him in other settings, and this more in-depth and fine-grained observation not surprisingly revealed an extremely vulnerable boy who was struggling to manage both socially and academically. We met the class teacher and fed back our observations which were felt to be helpful, not least in thinking about how to help Torvil feel more positively held in mind. Such cases require interventions at several levels; as described, there was the teaching and support staff to think about, there was Torvil's own need to speak to someone, but more importantly we needed to gather together the relevant external professionals, such as the social worker, educational psychologist, the worker from the mother's rehabilitation programme, and we then worked to engage with the grandmother and mother. It was only after a lot of careful preliminary work that we could say the therapeutic work specifically for Torvil had begun, but as so often in these cases, we hope that some of the thinking and containment provided by other aspects of the work (e.g. work discussion groups, observations, feedback to staff) would have rubbed off on other aspects of the school system.

DIRECT CINICAL WORK – AN EXAMPLE OF APPLIED WORK

As already stated, this work requires a range of skills and aptitudes over and above the difficult enough task of ordinary clinical work with children or parents. Our thinking has increasingly been informed by psychoanalytic ideas about institutions (Menzies-Lyth 1992, Obholzer and Roberts 1994), as well as thinking derived from work within therapeutic communities (Hinshelwood 1987, Cooper et al. 1989, Gordon and Mayo 2004). This thinking allows clinicians to make sense, often retrospectively, of the complex range of institutional dynamics and projective pressures that fly around settings such as schools, and which we all become prey to. I would like to stress a particular aspect of thinking derived from the therapeutic community movement, which I think is particularly apt when working in schools, the thinking which highlighted mechanisms whereby particular subjects, whether children, or staff, or indeed therapists, can be cast in roles as somehow 'wrong' or not fitting with the dominant culture, and so seen as part of an 'out-group', as somehow 'bad', as

'beyond the pale' and needing to be 'got rid of', rather similar to the fate of the 'mad' (Foucault 1971) or insane (Laing 1982). Children like Torvil are often placed in such roles, as 'naughty', 'uncontrollable', 'bad', yet they also suffer from a profound sense of 'unease', of not being 'at home' in the institution, in society or in themselves. Projective mechanisms ensure that the behavioural sequelae of psychic pain, alienation, and the incapacity to make sense of overwhelming experience, too often gets translated into a moral or educational language, of children who are not being able to concentrate, are being 'contrary', have ADHD or conduct disorder, need discipline and much else. An idea that these children 'do not fit' often leads to literal and moral exclusion. On top of such exclusion by others, such children often seem not to 'feel comfortable in the institutions but also in their own skins', rather like Winnicott wrote of patients whose psyches do not 'indwell' in their soma, or Heidegger's (1971) statement that 'the real plight of dwelling does not merely lie in lack of houses'. Again, like in work with therapeutic communities, one aims for a safe external and then internal 'dwelling place' to combat the sense of being 'disarticulated from personal belonging' (Cooper *et al.* 1989: 37). Such a sense of alienation from their environment, which can be exacerbated as rejections at home and elsewhere are repeated in schools, can be ameliorated through work with the complex systems and structures around children, as well as in individual therapeutic work. The nurture group run by Molly described above might be seen as equivalent to the safety of the therapeutic milieu, and the complicated task so often is to extend that safety into the setting as a whole, by doing ongoing complex and subtle work with teachers and other staff.

I will now give a brief example of some work undertaken in the early days of the projects I was involved in, one that provided a steep learning curve. In this particular school, as often, the arrival of a therapeutic project was swiftly followed by the referral of several children to the service for individual therapy. It can be hard to withstand the pressure to rush into individual work, although this runs all manner of risks such as colluding with the dominant idea in schools, that the problems reside in children, and a difficulty many schools have in thinking about how the child's issues might be related to what is happening at home and in the surrounding systems

In this school we found that we were being asked to see a lot of acting out children, mostly boys, who were at risk of exclusion. All the referred children had already had temporary exclusions, school staff were often at their wits end about them, and we began to notice a culture develop whereby a child was flagged up not just as having a problem but as being 'the' problem in a school. The fantasy in the school was that if only this child was excluded then everything in the institution would improve and life would proceed smoothly. The inadequacy many staff felt when confronted with real behavioural problems in children often led to a rather desperate need to lay the blame somewhere. Not surprisingly the pattern was that as soon as they excluded a child designated

as *the* threat to the school, then another potential scapegoat popped up in his or her place. One of these children referred to us was permanently excluded quite quickly. With the next we changed tack, and became much more actively involved with the parents, the network, and the school system. This child did well, and we held him in school until transfer to secondary school. The next case, whom we will call Courtney, also became the focus of the anxiety of the whole school, and the individual therapeutic work described below was undertaken by Becky Hall, and I am grateful to her for allowing me to use this material.

Courtney, a 7-year-old girl, was referred as she was having tantrums and often cried for her mother during the day. She was described as a volatile child, unable to cope with transitions; she was struggling academically and occasionally hit out at other children in the class. She was often sent to school in 'unsuitable' clothes – tight jeans, cropped tops – and there was some suggestion of sexually precocious behaviour. Social Services became involved following her father's recent release from prison. His sentence followed an event, precipitated by depression, in which he had put his own life, and that of his family, at risk.

The family lived on a notorious local estate with Courtney's two teenage cousins for whom they had parental responsibility. The family was well-known to, and suspicious of, local services and their lifestyle was marked by chaos and disorder, including several bereavements of a violent and tragic nature, losses that remained extremely vivid to Courtney and her mother. In meetings Mother talked ceaselessly, Father anxiously paced around, it was difficult to bring meetings to a close, and the impression was of an extremely chaotic household with few boundaries, no privacy and little protection for children from adult life. Courtney attended an after-school club daily and was then left to play out, unsupervised, on the estate. In contrast to the school's picture of Courtney as a rather sexually precocious adolescent, the therapist perceived a desperate, greedy baby-like child and a demanding toddler. She refused to go to bed, demanded baths at midnight, helped herself to food at all hours and was put to sleep at night in her parents' bed with a bottle.

The parents too were extremely needy and the initial intervention included offering them regular support for themselves, to help with understanding Courtney, and also to help mend the link between the family and the school. Therapy began later, by which time the situation in school had begun to deteriorate. Her behaviour was increasingly violent as she 'attacked' staff and 'trashed' rooms. She was frequently excluded and the staffroom was bursting with stories about her. Our image of a sad, confused, desperate if angry little girl was eclipsed by the staff's view of someone monstrous, unlikeable and uncontrollable; the fact that she was a 7-year-old child seemed to have been forgotten.

Individual work began in which she stripped the dolls of their clothes with her teeth, climbed on the furniture, poured water on the floor, and begged for

new toys, making the therapist feel as if she was cruelly withholding things from her. Courtney's inability to say hello or goodbye gave some indication of the powerful constellation of feelings aroused for her by separations and re-unions. Patient-centred comments such as 'I wonder if you're feeling…' had to be quickly retracted when it became clear that Courtney could not tolerate feeling vulnerable; she would scream at her therapist, threaten her with chairs, and rush to the toilet. Talking in the third person ('There seems to be a Big Courtney here who wants to look after everything herself, and a Little Courtney who's a bit worried about everything she's got to manage'), and analyst-centred comments worked better. Yet still as breaks loomed Courtney would run from the room into the playground or cower behind dustbins screaming.

She stepped easily into the role vacated by the boy who was now doing much better, that of being 'the' problem for the school, having what Bion (1961) called a natural 'valency' for this role for which she was a perfect candidate. She was used to being unwanted and rejected, had little experience of structure or boundaries, was easily upset and overwhelmed, had little capacity to regulate her own emotions and made little sense of the hopes and expectations of the professionals around her who had 'her best interests' at heart.

Following one break, which coincided with a trusted staff member leaving, Courtney regularly ran out of class and off the school premises, and, as is typical with such children, she particularly did not manage unstructured times. She complained of illness, begged to go home, hit out at fellow pupils and 'attacked' staff who tried to restrain her, and she was excluded several times. Irrespective of what she was enacting for the institution, we knew that we had to intervene very actively to avoid a more permanent exclusion. Her parents continued to be met regularly, and in addition to meetings with the Special Educational Needs Co-ordinator (SENCO), we liaised weekly with Courtney's teacher and with the support staff within and outside the school, in the hope that we could help the system manage and make sense of what was happening. Courtney found it difficult to come to her sessions, and once there, would express her intolerance of painful feelings of any kind by running out of the room. Collecting a resistant Courtney from the classroom was almost a ritual public humiliation for the therapist, as Courtney prevaricated and delayed. In the therapist's words

> I tried hard to think about the break and its impact on her. I struggled to keep hold of the idea that Courtney, a child rejected from everywhere, might need to project some of this experience into me. I crossed the foyer passing a support teacher who rolled her eyes at me and tutted.

The senior management of the school seemed to experience Courtney's behaviour as an attack, and they responded punitively. She seemed to have become a receptacle for the negative feelings of the institution as a whole. Our view that she was a very worried little girl seemed to be completely at odds with the terrifying version of her in the staff's mind.

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The relationship between the school and Courtney's parents began to break down rapidly under the imminent threat of a permanent exclusion. Mother and Father felt that Courtney had been abandoned by the school and, in turn, seemed to feel abandoned themselves, and they stopped coming to their sessions. A common form of splitting in this work is between schools and parents; staff can blame parents in an effort to feel less bad themselves, and parents get angry with the school for not supporting them and their child. As therapists we suffered another level of projection, becoming identified with Courtney as the problem, and our attempts to feed-back to staff felt increasingly frustrated, and her sessions were regularly interrupted. Teachers who are doing their utmost to help the children in their care struggle when these children throw their best efforts back in their faces; they feel rejected, de-skilled, hurt, and often respond punitively, like a mother whose carefully prepared food is spat out or rejected. Children like Courtney are easy to give up on, and when staff cannot hold onto the idea that a child is being helped to have the future that society believes it should have, then the hopelessness and upset can be exacerbated, leaving staff wanting to blame, punish, exclude, do anything to gain temporary relief and respite. Courtney and similar children might be compared to psychiatric patients in the way the system labels and rejects them. Gordon stated about the insane 'It is social sanitisation. The unsanitary become the insane and the issue becomes one of disposal' (Gordon and Mayo 2004: 10), and if one translates bad for mad, and unmanageable for insane, then these children are indeed faced with a similar form of social ostracism, what schools used to call 'expulsion' and is now called 'being excluded', or even the more recent neologism 'secluded'.

In the light of the growing sense of crisis we called a network meeting that was attended by her parents, the family social worker, the headteacher, a member of the schools reading recovery programme, a member of the local authority inclusion service, the parent's therapist and our service. This felt like a pivotal moment and provided a space in which to think about the emotional complexity of the case. The impact was almost immediate, school staff began to view Courtney differently, she managed a full week in school, her parents attended their sessions again and the school invited us to contribute to their application for a statement of special educational needs. We were pulling together rather than blaming each other.

She gradually began to build up a growing trust and confidence in the therapy. This extract illustrates something of her difficulties and developments at this time. It seems to reflect her growing capacity to acknowledge separations and the mechanisms she used to defend against the more painful feelings they stirred up.

'Pretend this is my babe', said Courtney, holding up one of the dolls, 'And she has to go to hospital for three weeks'. 'Goodness', I replied, 'Three weeks, that does seem like a long time'. Courtney nodded

seriously. 'And we didn't see each other for three weeks because of the Easter break', I continued, 'I wonder what that felt like?'. 'Actually I checked on the computer', replied Courtney, 'and it was 16 weeks!'. 'I think it felt like you were left alone for ages', I said. Courtney hurled the doll across the room, 'Pretend you're my servant', she barked, 'Clear up this mess!'.

She even seemed to have been able to hold onto some of the good, trusting feelings about the therapy following the summer break and to have internalized something. The work with her parents picked up, and she settled well with intensive, regular classroom support, and in her therapy we saw a growing ability to tolerate some of the painful feelings stirred up around separations – where she once bolted from the room, or screamed at her therapist to 'Shut up!', she said 'Ssh, I know, it's half term'. She became able to say 'Hello' and sometimes even 'goodbye'. Her teacher commented on her acquisition of an emotional language and her parents joked that she now 'counselled' them at home. She expected to be thought about, and there was an increasing sense that the chaos of the outside world intruded less dramatically into the therapy.

Individual work was having an impact, but only when the adult network was held. Inevitably crises continually arose, and when the system around the family became in any way fragile then the previous concerns re-emerged strongly; for example, when staff left, or dad began to drink again, then her behaviour escalated, staff anxiety increased and words like 'exclusion' again began to be mentioned. Continuing to have a vigilant eye on the network, and on issues around the children, meant that we could deter such dramatic enactments. This required a lot of work with staff, to move nearer to what Tom Main (1977: 11) described, again in relation to therapeutic communities, as 'an atmosphere of respect for all, and the examination of difficulties … in a culture which is concerned with whole people'. This is a worthy goal to aim for, but maybe a more realistic aim is simply to be able to take a few tiny steps in that direction, which did happen with this case at various levels of the system.

CONCLUSIONS

Obholzer and Roberts (1994) have argued that our major national institutions often serve as a location for all manner of projections, hopes and expectations for the population. He writes that the NHS might be burdened with a role in relation to our fear of death, being seen as a 'keeping-death-at bay' service, while educational institutions carry the hope that our children will be equipped and skilled to live in the society of the future, and maybe mental health services bear other projected hopes, such as stopping us or our children from going mad. CAMHS, suddenly part of a broader agenda for Children's Services, is expected to provide help to community settings like schools alongside other professionals in a new multi-agency context. Similarly schools are being asked to play roles

which are new to them, such as being a site for the delivery of a whole range of other services, and this gives rise to a new weight of expectation. As social unrest, drug use, violence and crime increases, and as social services retreat increasingly to a more statutory role, schools are being asked to play a role in managing social breakdown, while bearing the hopes and responsibilities for the future of our children, and for society as a whole.

One of the dangers is that the educational system is massively projected into, by the general population, by parents, and possibly not least, by government. Research by many epidemiologists such as Wilkinson (2005) have consistently demonstrated that both physical and mental health declines in populations in direct proportion to the increase in inequality between the top and bottom layers of society, and that this gives rise to more social unrest, violence, more stress-related illness, and shorter life expectancy. Other recent research such as that commissioned by the Nuffield Foundation (Collishaw *et al.* 2004) has shown that adolescent mental health in this country has deteriorated much more than in other countries in Western Europe, and indeed only in America has there been a comparable deterioration. Schools are increasingly faced on a daily basis with the repercussions of this, with gangs and violence, with poor mental health in children and families, and even more so in the deprived inner city schools where we work. The idea in government and elsewhere that either different schools or better parenting should somehow be responsible for alleviating these social issues is maybe a projection too far for schools, parents and mental health workers. There is a danger that schools, parents, and particular children will bear the criticism for social failures.

Therapeutic work can of course help in specific cases when the interventions are aimed at several layers of the system as well as the individual child, as in Courtney's case. In the cases described work took place with children, class teacher, the SENCO, the support staff, the parents, the social worker and other external agencies, and where possible, the head. The most effective interventions include working with the overall culture of the school, and individual work is only part of a package; slightly changing the words of Tom Main (1980: 53) 'a community (*school*) may become therapeutic as a social organisation no matter what individual treatments are offered'. Schools show variable capacities to function as effective 'containers' of both feelings and attributes that can otherwise be disowned, split off and projected into others. It is clear that when the anxieties could be managed, when staff have a space to reflect on what is being stirred up, and people feel better about their work, then the culture of blaming and mutual projection can abate.

The kind of children and issues that one is confronted with in schools, such as in the example of Courtney, can too easily lead to feelings of inadequacy and helplessness, which in turn can lead to splitting and projection. Teachers can blame parents, parents feel the schools are failing their children, social services

are seen as letting vulnerable children down, heads blame local authorities for forcing schools to keep unmanageable children in schools, local education authorities blame schools for not managing children well, and as we as therapists come on the scene there is always the danger that we join in this projective merry-go-round, becoming simply the new blamed or joining in the blaming. We approach this work with both a belief in its usefulness and effectiveness, but also wary of the dangers of omniscience and omnipotence; neither schools nor therapists can ultimately compensate for society's failures, but some of these newer government expectations of delivering services into schools can still make a difference to the lives of particular children, families, staff and hopefully, schools as a whole.

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