Report of the Committee on Maladjusted Children / Department of Education and Science.

DEPARTMENT OF EDUCATION AND SCIENCE

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AND SCIENCE

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MEMBERSHIP OF COMMITTEE

(Appointed by the Minister of Education by Minute dated 4th October, 1950)

Chairman: Dr. J. E. A. Underwood, C.B.E., M.B., D.P.H. (Principal Medical Officer, Ministry of Education, until 30th June, 1951).

Dr. A. F. Alford, C.B.E., M.B. (Senior Medical Officer, Ministry of Education).

Miss E. M. Bartlett, Ph.D. (Psychologist to the Education Committee, Essex County Council).

Miss S. Clement Brown (Director of Child Care Studies, Home Office Children's Department Inspectorate).

Dr. H. M. Cohen, M.D., D.P.H. (Principal School Medical Officer, Birmingham County Borough).

Dr. E. M. Creak, M.D., F.R.C.P., D.P.M. (Physician in Psychological Medicine, Hospital for Sick Children, Great Ormond Street).

Dr. P. Henderson, M.D., D.P.H. (Principal Medical Officer, Ministry of Education).*

Mr. R. Howlett (Under Secretary, Special Services Branch, Ministry of Education).

Mr. W. F. Kemp (Headmaster, Bredinghurst School for Maladjusted Boys, London).

Mr. J. Lumsden (H.M. Inspector of Schools).

Mr. E. D. Marris, C.B. (Under Secretary, Special Services Branch, Ministry of Education, until 30th September, 1951).

Mr. E. W. D. Ray, O.B.E. (H.M. Inspector of Schools until 15th September, 1951).

Dr. W. Rees Thomas, C.B., M.D., F.R.C.P., D.P.M. (Senior Commissioner, Board of Control).

Mrs. M. J. Robinson, J.P. (Member of London Juvenile Court Panel).

Dr. W. P. H. Sheldon, C.V.O., M.D., F.R.C.P. (Physician, Hospital for Sick Children, Great Ormond Street).

Dr. A. Torrie, M.B., D.P.M. (Medical Director, The Retreat, York).

Mr. E. W. Woodhead (County Education Officer, Kent County Council).

Secretary—D. Neylan (until September, 1952) (Ministry of Education).
M. A. Walker (from September, 1952) (Ministry of Education).

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* Dr. Henderson succeeded Dr. Underwood as Principal Medical Officer of the Ministry of Education on 1st July 1951 and was co-opted as a member of the Committee at their ninth meeting on 6th July 1951.

FOREWORD

I HAVE been glad to receive this unanimous Report from the Committee on Maladjusted Children which was set up by Mr. George Tomlinson when he was Minister of Education. The Committee has covered much ground, and has made many interesting suggestions. Though these will need to be carefully considered in detail, I am sure we shall find that the Committee has indicated many useful ways in which the education, health and allied social services can work together more effectively for the prevention and treatment of maladjustment in children.

The Committee seem to me to be right in what they say about prevention and in the emphasis they lay throughout the Report on the need to treat the maladjusted child as part of the family, and, so far as possible, while he lives at home.

The Report is written in plain language, and one can hope, therefore, that it will be widely read.

DAVID ECCLES

October, 1955

NOTE ON THE REPRINTED EDITION

Since 1955 when the Committee presented this Report, developments have taken place in the provision made for maladjusted children, in many instances inspired by the recommendations of the Report. Minor changes in legislation have also been enacted. Readers should not, therefore, regard the Report as a source of precise factual information on the services now available or on the current statutory position. In the views expressed on the prevention and treatment of maladjustment of children, the Report remains a document of interest and value to those concerned to secure a further development of services.

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REPORT OF THE COMMITTEE ON MALADJUSTED CHILDREN

To the Right Honourable Sir David Eccles, K.C.V.O., M.P., Minister of Education

INTRODUCTION

SIR,

1. We were appointed in October, 1950, by the then Minister of Education, the late Mr. George Tomlinson, M.P., with the following terms of reference:

> "To enquire into and report upon the medical, educational and social problems relating to maladjusted children, with reference to their treatment within the educational system."

2. We have met in full committee on 57 days, and Sub-Committees have held a further 43 meetings. The list of organisations and individuals who gave oral evidence or submitted memoranda to us is in Appendix A. We have visited, individually or in small groups, a selection of the establishments providing treatment for maladjusted children. In addition, a number of local education authorities, and some voluntary bodies maintaining special schools, have answered questionnaires or provided information on specific points. Three local education authorities carried out for us pilot surveys on the incidence of maladjustment.

3. We are grateful to all those who have in any way helped us. We have been greatly encouraged in the performance of our task by the general concern we have found to improve facilities for investigating and treating maladjustment in children, and by the indomitable faith of those working with them.

4. Now that we have reached the end of our labours we feel bound to ask ourselves what we have achieved as a result of nearly five years' consideration of the problem referred to us. Those who may have expected from us a wholly novel insight into the nature of maladjustment or new and even revolutionary ideas about the way in which it should be treated will no doubt be disappointed with what we have to say. We do not even offer a tidy plan for dealing with the problem, nor have we been able to provide accurate estimates of its size.

5. In our view it would not have been realistic to attempt anything as ambitious as this. Too little is yet known about maladjustment in children and the ways in which it can be successfully treated to make it possible to generalise or to suggest ready-made solutions; fifteen years ago the very term "maladjustment" was not in common use.

6. We have therefore made a more pedestrian approach to the problem by considering, against the background of normal development, what we mean by a maladjusted child and by reviewing the arrangements at present available for treating and for preventing maladjustment. We have considered the various agencies in the field in relation to the education service, which itself occupies a central position inasmuch as it has continuous contact with the vast majority of children for ten vital years in their lives.

7. This is the first occasion on which a systematic review has been made of the various services available, and on which suggestions have been made for their proper co-ordination in the interests of the child. All are still

from which it emerged that, in a period of six months, 10 per cent. had suffered from definite and disabling neurotic illness and a further 20 per cent. from minor neurosis, and that neurotic illness caused between a quarter and a third of all absences from work due to illness of any kind.

16. Although the worst effects of maladjustment are seen among adults, it has come to be regarded as a problem of childhood. It is right that attention should be concentrated on childhood, as this is the time of life in which the individual has the greatest need of the care of others and in which most can be done to prevent maladjustment or to treat it. Further, if one child can be helped, not only will his family and the community benefit, but it may have repercussions on future generations: the maladjusted child of yesterday can be the maladjusted parent of today, and his offspring the maladjusted children of tomorrow.

17. The part which the education service has to play in the prevention, discovery and treatment of maladjustment is, as we shall show in the chapters which follow, of great importance. Ordinarily, school is the first community outside the family into which the child ventures. It should teach him to fend for himself, and at the same time the meaning of "give and take" and "do as you would be done by"; and it should direct his intellectual energy, which can lead him into difficulties if it is unexpended and becomes diverted into other channels. The first signs of maladjustment in a child may appear in school, and show in his reactions to his contemporaries, his teachers or his work.

18. The interest of the Minister of Education and the local education authorities extends beyond the confines of the school. The scope of the school health service was enlarged by the Education Act of 1944; and as this service covers those aspects of the diagnosis and treatment of maladjustment which belong to the realm of health, there is no need for a local education authority, in considering a particular case or form of treatment, to debate whether health or education is solely, or the more, concerned and make different administrative arrangements accordingly. It is an advantage that a maladjusted child can be treated within the education service as a child, and has not to be thought of just as a school pupil or alternatively as a patient.

19. The education service does not, however, work in isolation, but co-operates with all other agencies concerned, whether public or private. As will be seen in later chapters, co-operation is particularly close between the school health service and the hospital service, which provides a number of child guidance clinics and makes available the services of psychiatrists for many clinics run by local education authorities. Co-operation between these two services and the maternity and child welfare service is, as we shall see, also necessary if the problems of children under five are to be adequately tackled. It is often in these very early years that the seeds of future trouble are sown or the first symptoms appear, even though they may unfortunately not be noticed till a child goes to school.

20. The present is an opportune moment for a review of the means of treatment of maladjusted children. In recent years much attention has been focussed on the problems associated with juvenile delinquency and with deprivation of maternal care—the one often a symptom of maladjustment, the other a precursor of it. This has led to an increasing uneasiness at the difficulty in securing treatment for maladjusted children and to a concern to see that the treatment given is effective. We do not pretend to be able to offer any simple answers to the problems of maladjustment; we have set

ourselves an aim which is both humbler and perhaps, in the present state of knowledge, more useful—to make suggestions which will enable the psychological, educational and medical treatment of maladjusted children to develop on the lines which on present experience seem the most rewarding.

21. Certain difficulties must be faced at the outset. Adjustment is a matter of degree: there is a continuous gradation from satisfactory adjustment to extreme maladjustment, and no point on the scale at which one unmistakably ends and the other begins. There is of course every degree from very slight to total in an affliction like deafness, but deafness is a physical ill which can be more easily detected and, when it is detected, can be measured. The manifestations of maladjustment are in the realm of feeling and behaviour, so that precision is very difficult; moreover, observers in different ages and societies have looked on the same trait or mode of behaviour in different lights. Yet even if it proves impossible to define maladjustment at all closely, nobody can doubt that maladjustment exists, and it should at least be possible to identify it with sufficient precision for our purpose.

22. A further difficulty arises from the fact that a wide variety of medical and social services play a part in the prevention and treatment of maladjustment; and our enquiry has taken us beyond the boundaries of the education service. It was essential to survey children in all their relationships, from their first years, before we could consider what can and should be done within the educational system to cope with maladjustment.

23. A survey of the contents of the chapters in our report will show broadly how we have approached our task:

Chapter II provides a historical review of the treatment of maladjusted children in this country, showing the influence of developments in the educational, medical and other fields.

In Chapter III we attempt to describe normal development and progress towards maturity, and to show the part which both home and school play in this process. Before the nature of maladjustment is discussed, it is important to have a picture of the line of normal development from which a child may deviate, and to which he will, as we hope, return. In this way, too, attention is focussed on the normal rather than the abnormal as the beginning of all study of maladjustment.

Chapter IV is devoted to an examination of the nature and causes of maladjustment and a description of the forms it commonly takes.

Chapter V sets out the statutory authority for the discovery and treatment of maladjusted children, including the sources of the power to provide child guidance clinics as part of the education or of the health service.

The stage will then be set for discussing in turn in Chapters VI-X the different types of establishment or service providing treatment: the child guidance service, which involves a school psychological service as well as child guidance clinics, with the school health service working in close association with both; the day special school, the day special class and home teaching; the boarding home and foster-home, coupled with attendance at an ordinary day school; the boarding special school and the ordinary boarding school. We try to indicate the characteristics of each form of treatment and devote most of one chapter (Chapter VIII) to the points which should be considered before a decision is reached to treat a child away from home.

Chapter XI describes ways of providing for boys and girls who have been treated for maladjustment any help they need while they are still at school or after they have left, and explains why we regard this as an essential part of treatment.

Chapter XII deals with maladjusted children who are brought before a juvenile court and the extent to which the educational system is involved in providing reports about, and treatment for, them.

Chapter XIII explains the difficulties in the way of arriving at a satisfactory estimate of the incidence of maladjustment, and assesses the scale of the services required over the next decade in terms of the number of staff who may be needed in child guidance services, special schools and classes, and boarding homes.

Chapters XIV and XV deal with the training and supply of child guidance workers, teachers and house-staff. The shortage of child psychiatrists, educational psychologists and psychiatric social workers has already proved a serious problem ; and the lack of training facilities for teachers and house-staff working with maladjusted children has been a serious handicap in establishing standards in this new field of work.

Chapter XVI is concerned with prevention. We try to suggest what can be done by the health and education services and through other agencies, not only to detect and deal with minor difficulties and incipient maladjustment, but also in a positive way to prevent them arising and to support parents in the bringing up of children.

Chapter II

HISTORY OF THE TREATMENT OF MALADJUSTED CHILDREN IN THIS COUNTRY

24. The term "child guidance" was probably coined soon after the first world war but its history begins long before this. In its broadest sense child guidance has interested nearly all the classical writers on education from Plato onwards, but it was not until the 19th Century that the need for a scientific approach was realised by men like Darwin, Bain and Spencer. Well before the close of the century child psychology had become a recognised branch of scientific research and academic study in Britain. Francis Galton was the first to advocate the scientific study of the individual child, primarily with a view to practical recommendations about his treatment at home and at school, and later as an aid to selecting a suitable career.

25. In 1884 Galton opened an "anthropometric laboratory" in connection with the International Health Exhibition. One of his coloured publicity sheets explained that the laboratory had been instituted for the measurement of "human form and faculty". At first a charge of 3d. was made, but in a later note parents and teachers were asked to consider "whether it is worth your while to pay less than a shilling to have your boys and girls measured . . . either to learn their powers or to obtain timely warning of remediable faults in development". Galton evolved a case-history sheet for systematically investigating and reporting on individual children. He thought that a simplified version of this might be used for a "register or schedule" to be filled up by schoolmasters at four-yearly intervals on 29th February; for this purpose he suggested the establishment of smaller "laboratories" in connection with the schools. The work by Galton was extended and encouraged by Sully, who opened in 1896 the first "laboratory" in Great Britain exclusively devoted to psychology; teachers were invited to take their more difficult pupils there for examination.

26. Both Galton and Sully realised the importance of educating the public, and they gave much of their time to lecturing. In 1893 the British Child Study Association was established, which soon had branches in different parts of the country and helped to create widespread interest in child study. It was not long before many became convinced of the need for the work of the psychologist to be carried out within the education service.

27. By 1880 education had become compulsory throughout the country, and it soon became evident that many children were prevented by some physical weakness or defect from receiving full benefit from their education. In 1890 the London School Board appointed its first medical officer and by 1905 school medical officers had been appointed by 85 local education authorities. In 1907 local education authorities were given the duty to provide for the medical inspection of children in public elementary schools and the power to arrange for their treatment. In the same year a medical department was set up by the Board of Education. A circular issued by the Board at this time stated that the aim of the new legislation was ". . . the physical improvement and as a natural corollary the mental and moral improvement of coming

generations". Far-seeing school medical officers were already pointing out the need for a psychological service for school children. In his annual report in 1908 Dr. G. A. Auden, the school medical officer for Birmingham, wrote: "It is perhaps here that one of the most valuable effects of a Medical Department may be found, i.e. in the closer correlation of applied psychology and scientific investigation to the problems which present themselves in adapting the education to the individual needs and capacities of children. . . . The establishment of a practical Psychology Department in a University in close connection with the schools of the town would be of the greatest possible value towards the elucidation of the many problems which beset educational effort".

28. The provision of special schools for children of sub-normal intelligence, which had resulted from an enactment of 1899, focussed attention on problems associated with learning difficulties. In selecting children for these special schools, it was thought desirable to test their intelligence by a method which would not be affected by what they had been taught. Towards the end of the century Galton and others had experimented with forms of mental tests, but it was Binet in France who must be regarded as the greatest pioneer in this field. In 1905 he and Simon formulated a scale which with its subsequent revisions became a standard method for testing the intelligence of children. The earliest scale in general use in this country was Burt's adaptation of this scale for English conditions.

29. By this means it became possible for school medical officers in examining children to distinguish between innate dullness and backwardness due to other causes. A section on the diagnosis and classification of feeble-minded children in the Chief Medical Officer's Report for 1909 contains the observation: "A spurious form of mental deficiency is not infrequently associated with bad home conditions . . .". By 1913 a few authorities had established what were called psychiatric clinics for the purpose of diagnosing children who were considered incapable of benefiting from education in a normal school. The equipment of one such clinic at Stoke-on-Trent included a "dynamometer, an aesthesiometer, two mosaic tile boxes, five pill boxes carrying varying quantities of powder . . . for testing muscular sense"; nine pieces of wood covered with sandpaper, velvet or tin to provide rough, smooth and hard surfaces, for testing "tactile sensibility"; a similar series of wooden pieces shaped as circles, octagons, hectagons, squares and oblongs for testing "form sense", and "a card containing heads with figures of different quality, two pretty, two medium and two ugly to test aesthetic sense".

30. In 1913 with the passing of the Mental Deficiency Act, the Central Association for Mental Welfare was founded under the leadership of the late Dame Evelyn Fox. The fact that the service provided by the Association was the first one catering for children meant that maladjusted children as well as mentally defective children were brought to it for help.

31. In the same year the London County Council took the unprecedented step of appointing a psychologist, Mr. (now Sir) Cyril Burt, at first for an experimental period of three years. Amongst other duties Burt was charged "to investigate cases of individual children who present problems of special difficulty and who might be referred for examination by teachers, school medical officers, or care committee workers, magistrates or parents, and to carry out, or make recommendations for, suitable treatment or training of such children".

32. This appointment is a landmark in the history of child guidance in this country, but others besides educationists, school medical officers and psychologists had by this time become deeply interested in behaviour

problems of children. Many paediatricians had begun to take a particular interest in children whom we should now call maladjusted; as a result of his experience in the children's department at Guy's Hospital, Dr. Hector Cameron published in 1918 "The Nervous Child", a book which showed the close link between the emotional and physical well-being of a child.

33. In 1905 the first juvenile court in this country was opened, and the Children Act, 1908, required that juvenile courts should be specially constituted throughout England and Wales. Enlightened members of juvenile courts and of the various services concerned with the treatment of delinquent children added the weight of their experience to the demand for psychological services for children.

34. In 1925 Burt published "The Young Delinquent", a study based on case histories of children who had committed offences. He emphasised the complexity of the causes of juvenile crime and the need for careful investigation before treatment. The next year Mr. Clarke Hall, a prominent juvenile court magistrate, stated in a book called "Children's Courts" that he and other magistrates had received reports from psychiatrists and psychologists on individual children which had been of the utmost value in determining the right treatment. He went on to say: "Casual and fortuitous assistance of this kind however, though of the greatest experimental value, can never form a proper substitute for a regular official examination".

35. In the meantime the studies of the unconscious mind made by Freud and others and their development of the system of psycho-analysis were revolutionising psychiatry. The application of these and other new ideas to the treatment of shell-shock cases in the first world war brought for the first time a wide recognition of the fact that neurotic symptoms had emotional causes and could only be treated by investigating these. As a result of this changed outlook, in 1920 the Tavistock Clinic (The Institute of Medical Psychology) was established in London through the efforts of Dr. Crichton Miller; this was the first independent clinic to deal solely with patients suffering from psycho-neurotic symptoms. Although this clinic did not open a special children's department until 1926, it dealt with children before this date; indeed its first patient was a child. In the early 1920s some London teaching hospitals opened psychiatric out-patient clinics, which were mainly for adults but also treated children. Some mental hospitals saw the need of a different type of hospital adapted to the treatment of neurosis, and from its opening in 1923 the Maudsley Hospital gave special attention to children with this condition.

36. In the years after the first world war important developments also took place in education and in social work. Direct studies of children, particularly those carried out by Susan Isaacs in Cambridge, confirmed the need for a more individual approach to growth and learning in childhood. The establishment of professional standards in social work led to a demand for more specialised training in the understanding and treatment of individual difficulties and of family relationships.

37. While a new approach to children with behaviour and emotional difficulties was being evolved in these various fields in this country, another idea had been worked out in the United States which was to influence the development of child guidance in this country. The work of Adolf Meyer and others had brought psychiatrists and psychologists to realise that the conditions which they were treating could not be considered in abstraction from the earlier life and the social circumstances of their patients. This led to an interest in the problems of children, especially in the possibility of tracing the beginnings of delinquency, and in 1909 Healy founded the

Chicago Juvenile Psychopathic Institute for the purpose of studying delinquents. On his work here was based "The Individual Delinquent", a detailed study of 800 cases which was published in 1915. The importance of this work was that it focussed attention on the need for special clinics to deal with delinquents. Healy obtained from co-operating social agencies the background facts which he needed, but Boston Psychopathic Hospital appointed a social worker to their staff in about 1912 and later the Chicago Institute and other establishments followed suit. Thus the essentials of the American idea of child guidance—a clinic with a team of workers to carry out the medical, psychiatric, psychological and social investigation of individual children—had taken shape.

38. About 1920 the National Committee for Mental Hygiene in the United States, which had been founded in 1909 to improve conditions in mental hospitals, turned its attention to child guidance. In 1922 with the aid of the Commonwealth Fund* it opened the first demonstration clinic "to develop the psychiatric study of difficult pre-delinquent and delinquent children in schools and juvenile courts and to develop sound methods of treatment based on such study". The publicity achieved by clinics of this kind led to the idea of introducing a clinic with a team of workers to this country.

39. In 1925 Mrs. St. Loe Strachey, a magistrate with considerable experience of juvenile courts, visited the U.S.A. where she saw something of the child guidance clinics and met representatives of the Commonwealth Fund. When she returned to this country in 1926, she called a meeting of people concerned with the prevention of delinquency and others likely to be interested in the establishment of child guidance clinics on American lines. The same year a representative of the Fund came to report on the possibility of establishing a clinic here. As a result of this report and Mrs. St. Loe Strachey's efforts, a number of people representing various types of social work were invited by the Commonwealth Fund to visit the U.S.A. in 1927, and an offer was made to train a group of social workers in America in psychiatric social work in readiness for the opening of a clinic in this country. These offers were accepted by the Child Guidance Council which was set up in 1928 by the National Committee for Mental Hygiene and the Central Association for Mental Welfare "to encourage the provision of skilled treatment of children showing behaviour disturbances and early symptoms of disorder".

40. When the visitors to the U.S.A. returned, they presented a report to the Child Guidance Council on the development of child guidance clinics in this country. This report, which is remarkable for its foresight, emphasised the need for making clinics an integral part of the school system and the necessity of obtaining the co-operation of teachers. It advocated co-operation between clinics and hospitals, and suggested that, where hospitals had clinics of their own, the services of a psychologist at a child guidance clinic in the area might be made available to them. It recommended that clinics should pay great attention to preventive work, especially with the pre-school child, and for this purpose it advised that clinic staff should attend sessions at infant welfare centres.

41. Meanwhile in 1927 the Jewish Health Organisation opened the East London Child Guidance Clinic under Dr. Emanuel Miller; this was the first clinic in this country directly based on the American pattern. Two years later what is now called the London Child Guidance Training Centre was opened as a clinic in Islington under Dr. William Moodie, thanks to the generosity of the Commonwealth Fund which continued to give financial

* A private benefaction established in 1918 by Mrs. Harkness of New York "for the welfare of mankind".

help for many years.* This clinic, which was administered by the Child Guidance Council until 1930, from the beginning carried out training and it was the first centre in this country in which psychiatric social workers as well as psychiatrists and psychologists could be trained.

42. The Board of Education took an interest in these developments. In 1927 its senior medical officer, Dr. Ralph Crowley, had been on the visit to America organised by the Commonwealth Fund, and a reference to this and a note on child guidance clinics in America are to be found in the Chief Medical Officer's report for the same year. The report referred to the proposal for setting up the London Child Guidance Centre and concluded by saying: "It will be understood, however, that a fully established clinic with a full-time staff is appropriate only in large centres of population. Smaller communities will need to make arrangements on a much less ambitious scale. Speaking generally, the psychiatrist is likely to be needed in most areas for part-time only. The appreciation of the need of his services will develop in proportion as special attention is paid by the local education authority to the class, numerically large, of mentally retarded children among whom are found a large proportion of the difficult and maladjusted children".

43. At about this time forms of residential treatment for maladjusted children were being evolved. In the late 1920s a few independent boarding schools began to cater specially for nervous and difficult children. The first school set up by a local education authority for such children was a day school opened in Leicester in 1932. The authority had earlier in the year appointed a school psychologist, following the example given by London, and the psychologist's work was mainly concerned with children at this experimental school. The children there had been found misfits in the ordinary schools and the school work of many was below the standard expected from children of their intelligence. In 1932 a psychiatric social worker was appointed to help the psychologist and the Leicester school psychological service widened its scope to deal with children who had difficulties not associated with schools. The report of the service in 1933 made a clear distinction between scholastic and "clinical" (or maladjustment) problems, which by this year accounted for about 20 per cent. of referrals.

44. In 1929 the Tavistock Clinic advised that an eight-year-old girl, described as nervous, emotional and restless, should be sent away to a private home which took children suffering from rickets, debility and nervous disorders. The local education authority concerned asked the Board of Education to sanction the payment of the fee of 15s. 0d. a week charged by the home. The Board agreed to sanction the proposal as an experiment, regarding it as an arrangement under Section 80 of the Education Act 1921 "for attending to the health and physical education" of the child. The girl did not in fact go to the home, but went instead to a foster-mother who took a few difficult children, and the sanction already given was allowed to apply to the new arrangements. In this way the power of local education authorities to board out maladjusted children was established. Three years later a home for 25 maladjusted girls was opened in Northampton by the trustees of an orphanage, and the Board recognised for grant expenditure incurred by local education authorities in sending girls to the home. Before this decision was taken Sir George Newman, the Chief Medical Officer of the Board, wrote: "There can I think be no doubt at all that in the future the maladjusted child will more and more call for consideration by Local Education Authorities and the Board. The right line seems to me to be to respond to such a call with sympathy, knowledge and circumspection".

* From 1929 to 1940 the Commonwealth Fund also completely financed the first University training course for psychiatric social workers which was held at the London School of Economics.

45. In 1932 a local education authority for the first time opened a child guidance clinic when one was set up in connection with the Birmingham Education Committee's special schools service. The Medical Officer for Special Schools became its director, the authority's psychologist was put on its staff and a psychiatric social worker was appointed. At first the cost fell wholly on private funds: the Child Guidance Council gave the services of the psychiatric social worker and an anonymous donor paid the proportion of the salaries of the other workers which covered their child guidance duties. In 1935 this private assistance came to an end and the authority had to consider whether the clinic justified support from public funds. They decided that it had proved its value as an addition to the school medical service, and asked the Board of Education to recognise for grant expenditure in running it. Sanction was given, and in the same year the Board established the principle that an education authority could contribute to voluntary child guidance clinics in respect of services provided for children referred by school medical officers. As a result of these developments, child guidance clinics had now officially become part of the school medical service.

46. By 1939 there were 17 clinics wholly maintained and 5 partly maintained by local education authorities, apart from a number of clinics which had been established by voluntary bodies or hospitals. The names of 46 schools for "nervous, difficult and retarded children" were given in a register of this date as approved by the Child Guidance Council and the Central Association for Mental Welfare. The Board of Education were by now receiving so many applications from local education authorities for sanction to the boarding out of maladjusted children that a special form was drawn up to enable applications to be dealt with expeditiously.

47. The outbreak of war brought many of these promising developments to a standstill. Clinics were denuded of staff, and the training of personnel was disorganised. Evacuation, however, brought to light behaviour problems in a large number of children who had not previously been found difficult to manage in school. Some of these had been troublesome in their own homes; many others had appeared normal before both at home and school, but developed anxieties and disturbances as a result of being uprooted from their homes and transferred to strange surroundings. Hostels "for difficult children", that is for children who proved unbilletable, were set up as part of the Government evacuation scheme; and when a hostel was opened in an area where a child guidance clinic was operating, there was usually close co-operation between clinic and hostel. As time went on, local authorities were allowed to place in hostels in their areas any of their own children who needed residential care, provided that no evacuated children were thereby excluded. Evacuation had another compensation for reception areas: child guidance staff not able to carry on their work elsewhere were spread throughout the country to help with the difficulties of children separated from their families. In such ways the urgent need for full child guidance and other facilities for the treatment of maladjusted children came to be recognised, and by 1945 the total number of clinics had risen to 79.

48. A further impetus to the treatment of maladjusted children was given by the Education Act of 1944, one of the principles of which is that every child is to be educated in accordance with his age, ability and aptitude. Some children require special educational treatment either in ordinary or in special schools because they suffer from disabilities of body or mind including emotional or psychological troubles. The Act imposes the obligation to define in regulations the categories of pupils requiring special educational treatment. Previously only five categories of handicapped pupils had been

recognised, corresponding to the present categories of the educationally subnormal, physically handicapped, blind, deaf and epileptic. Among the six added by the Handicapped Pupils and School Health Service Regulations, 1945, was the category of maladjusted pupils.

49. Special schools and boarding homes for maladjusted children could now be approved by the Minister. A number of the hostels for difficult evacuated children were continued as boarding homes, and the success in war-time of the hostels also encouraged the establishment after the war of a number of boarding special schools. It is interesting that a few of the schools approved after the war as special schools had started as independent schools of the type mentioned in paragraph 43. In the Handicapped Pupils and School Health Service Regulations, 1945, conditions were laid down to ensure the effective and economical organisation of special schools, some of which would be provided and maintained by local education authorities and some by voluntary bodies. The second type of special school is financed primarily by the fees paid for children sent by authorities, but the regulations introduced a new form of grant with the special object of helping voluntary bodies to carry out much needed improvements to existing schools and to plan new schools in the post-war period.

50. Despite the gradual growth in the number of special schools, local education authorities found that it was impossible to obtain places in them for all the maladjusted children in their areas who needed to attend a boarding school. Provision was made in the Education Act, 1944, for handicapped children in such circumstances to be placed in schools not approved as special schools. Most authorities have sent some maladjusted children to independent schools, some of which specialise to a greater or lesser degree in dealing with this type of child. Authorities' arrangements have to be approved by the Minister, but it is not necessary for each individual proposal to be submitted for approval. The extent to which Authorities are making use of independent schools is shown by the fact that in December, 1954, 1,077 maladjusted children were being maintained by authorities in independent schools, compared with 1,157 in boarding special schools.

51. Meanwhile the National Health Service Act, 1946, made clear that the national health service is intended to secure improvement in people's mental as well as physical health, and the prevention of illness as well as its diagnosis and treatment. The Act placed an obligation on regional hospital boards to provide specialist services, which commonly include child guidance.

52. By December, 1954, there were 32 boarding special schools, 3 day special schools and 45 approved boarding homes. At the same date there were about 300 child guidance clinics, most of which were part-time ; 204 of these were provided by local education authorities, a very few by voluntary bodies and the remainder by regional hospital boards and teaching hospitals, which also supplied the services of the psychiatrist for 143 of the clinics provided by local education authorities.

53. Notwithstanding these developments, it is clear that the rate of discovery of maladjustment is very uneven in different areas, and that over the country as a whole the existing provision is inadequate. A county which at the end of 1954 had placed or wanted to place 236 maladjusted children in boarding schools and homes had a smaller child population than a county for which the corresponding figure was 97. At the same time there were 681 maladjusted children in England and Wales awaiting places in special schools. If we turn to the existing provision of child guidance clinics, at most clinics the waiting period is from three to six months ; at a few the time of waiting is even longer. In some areas there are no child guidance facilities at all.

CHAPTER III

NORMAL DEVELOPMENT

Development and Maturity

54. Education is deeply concerned with the process of maturing: indeed, it is in essence the means by which the immature are enabled to become mature. In this sense it takes place not only at school; the whole environment, both human and material, in which the child grows up is the true educative medium. Modern research suggests that the most formative influences are those which the child experiences before he comes to school at all, and that certain attitudes have then taken shape which may affect decisively the whole of his subsequent development.

55. No human being is fully mature, nor does the degree of his maturity remain constant. Under stress of violent emotion anyone can regress temporarily to a childish form of functioning—as when a man kicks and abuses the door which "will not" open. The level of a person's maturity will vary with his state of health, the ease or difficulty with which his basic needs are being met at the time, or the company in which he finds himself. In essence it may be said that the mature person is one who accepts the responsibility of ordering his own life and making his own decisions, and who does not act simply on the impulse of the moment.

56. A feature of maturity is that conduct becomes expressive and characteristic of the person himself. Principles and values are integrated into a coherent system which gives shape and stability to the personality. Inner conflict and indecision are thus reduced, and it becomes possible for an individual to exercise control and persistence, and to pursue remote ends.

Meaning of normality

57. Normal development, therefore, is development towards independence, stability and control, and the gradual drawing together and realisation of all a man's capacities. One very important point at the outset is the meaning to be attached to the term "normal". A criterion of normality is peculiarly difficult to obtain, for the following reasons:

(i) What is normal for one child may not be normal for another. Every child is unique, and his personality is a complex blend of hereditary traits and environmental influences—the latter including not only the people and objects round a child, but also the attitudes, feelings and events which affect him or to which he may respond. On a child's make-up will depend what is normal for him. A child of introverted temperament will, for example, normally be cautious in making friends with other children, but an extrovert will not. The child of high intelligence will normally not be slow in learning to read, but the dull child will.

(ii) Behaviour of a certain kind may be normal at one stage but not at another. It is natural for example for a very young child to be completely dependent on his mother, but it would be abnormal if this continued until he was much older.

(iii) Development takes place in many directions, and not all of a child's powers will mature at the same rate, though for good adjustment and healthy growth there should be some degree of harmony between them. Concentration on one aspect of growth may temporarily retard the growth of another, as when a baby becomes less vocal while he is perfecting manual dexterity, or a six-year-old more demanding and dependent while he is struggling with formal work at school. On the other hand, the development of one power often assists the development of another, as when a child of twelve months becomes more tractable as he begins to crawl, or a two-year-old as he learns to speak or becomes steadier on his feet.

(iv) Normal behaviour is not always "good" behaviour. All children will from time to time display behaviour problems, but, if development is taking place normally, so far from these holding up the maturing process they will promote it. Compare, for example, the frantic compulsive destructiveness of a maladjusted ten-year-old, which teaches him nothing and may so stifle his curiosity that he is unable to learn at all, with the dispassionate destructiveness of a normal two-year-old, which helps him to understand the material world better and so to control it.

58. From what has been said it is clear that the normal must be thought of as a group which includes wide variations rather than as a single type. This notion is generally accepted in the sphere of intelligence, where the normal group is thought of as comprising the central 50 per cent. of the population. Progress towards maturity is even more difficult to measure than intelligence, and it is not possible to chart clearly either the range within the normal at any age or the line of progress from one stage to the next. All that can be attempted is a description of the manner in which a child progresses and the series of experiences and satisfactions which naturally come his way.

The way a child progresses

59. As a child grows, he should increasingly become independent and at the same time capable of forming satisfactory and lasting relationships with other people. This is in essence an affair of the feelings, but the feelings do not mature in isolation and there is constant interplay between all the aspects of the child's growing self.

60. Each phase in development has its own appropriate emotional satisfactions. The normal course of development seems to be to experience these satisfactions in an unhurried, confident fashion, gaining something from them and either leaving them behind or building them into the next stage. Deprivation, curtailment or perversion of these natural satisfactions may lead to regression or to a general disinclination to go forward; and advance to the next stage is only possible if previous stages have been satisfactorily accomplished. Even on the physical plane this seems true: it may be said, for example, that an infant learns to walk from the neck downwards, progressively co-ordinating the muscles of the neck, back and limbs, as he learns first to hold up his head, then to heave a shoulder off the pillow, then to sit up, crawl, stand and finally stagger forwards.

61. Advance toward maturity is helped at each stage because the child's mind, body and feelings mature together. He is constantly discovering, often by accident, substitute satisfactions for those it is time to leave behind, and these new satisfactions in their turn help on the maturing of his feelings. When he begins to run about, for example, he can occupy himself better in

play and find new interests for himself, so that he has alternative pleasures to fall back on when his mother is too busy to give him her attention. Painful contacts with table corners or doorsteps help him to distinguish fact from fantasy, and to adapt his responses to it. He also plays his way into a dim realisation of what it will be like to be a grown-up person and may find it both possible and likeable. In this way he is helped by seeing older children, as well as his parents and other adults, obviously enjoying a more mature way of living which, because of its manifest controls and disciplines, may to the natural man in him seem impossibly difficult and distasteful. In this way he is led on towards maturity, finding at each step that he gains more than he loses and that he is equal to the increasingly complex demands which are made on him.

Infancy and early childhood

62. The first act of the drama in a child's struggle for independence is normally played out within the family, and in it the mother normally takes the leading rôle, since it is she who makes his first essay at independence possible and it is from her that he must first detach himself. But before the child becomes the man, the struggle has to be repeated more than once, each time on a more complex and conscious plane and accompanied at each repetition by the possibility of stress and breakdown. Roughly speaking, the first cycle takes seven years and may be described as the period of infancy and early childhood, in which the support and approval of adults are the most potent influences on a child's development.

63. To enjoy satisfactory relationships with people is always vital for a child's development, but his capacity for making them will largely depend on the quality of his emotional and physical experience in the first years of life. An infant has all his feeling in his body ; from the start he feels the attitudes of other people through their care of his body—for example, through the way in which his mother picks him up, holds him to her and feeds him. The world is presented to him right from the beginning as predominantly good or bad according to the quality of the mothering he receives. He needs one person constantly with him, not only to feed, care for and love him, but also to allow him to enjoy this relationship. In this way he builds up the sense of security which he needs if he is to reach out or respond to other people sufficiently to commit himself and run the risk of getting hurt ; and it is not until a person has the confidence to take this risk that he can fully give or receive affection. The same early experiences appear to affect a child's moral sensitiveness, his curiosity and liveliness of mind, and his ability to learn up to the limits of his native capacities.

64. Even for an infant who is loved and wanted, life soon presents problems. He quickly realises that the giver of good things can also refuse them. The first great crisis of separation occurs when he is weaned and has to learn to take solid food. Even at this early stage the principle of substitute satisfactions is at work, for by this time an infant is usually learning to sit up, curiosity is developing and he is beginning to play.

65. If a child is assured of his mother's love he can bear to be away from her, and by about the age of two has advanced sufficiently both in knowledge and bodily skill to want to do so, although at first only for short periods. The good mother, while maintaining a steady, secure intimacy with the child, is at the same time directing his interest away from herself, helping him to improve his speech and the use of his body and encouraging him to make friendly advances to other children. It is, however, during this period, somewhere between six months and three years, when a child is detaching himself from his mother through play and exploration, that he

needs her most and that maternal deprivation is most damaging. This is seen in the way he will sometimes not play with a new toy until his mother gives it to him; and in the way he rushes back to her for protection as soon as anything goes wrong with his attempts at friendliness with other children or with animals.

66. The question whether the world is fundamentally a friendly or a hostile place is continually before a child in his first years. Somewhere about the third year this uncertainty culminates in a period of conflict with authority, when he is often wilful, aggressive and difficult to control. On the handling he receives at this time will largely depend his ability to accept discipline and frustration in later years.

67. At this period, a child's relationship with his father becomes increasingly important. The father takes his place as the embodiment of authority in the family, not only protecting and supporting the mother but by firm though affectionate control buttressing the young child against his own aggressive feelings and designs. It is natural for a child to want to be grown up, and the father, by giving a satisfactory example of grown-up life and by allowing the child to watch and share some of his masculine activities, provides a further means of stimulating development. Through this second and significantly different relationship the child emerges out of a world centred on his mother into one of wider human relationships.

68. If the period of conflict with authority is brought to a satisfactory conclusion, a child normally enters on a much calmer phase, greatly helped in his progress towards independence by the development of a genuine desire for friendship with other children. This stage is often reached during the fifth year and makes the second great separation from the mother, when he goes to school, much easier to endure.

69. From this point the teacher takes over some of the functions of the mother, and it falls to the teacher to give the child in school the warmth of affection needed if he is to learn satisfactorily. The teacher also makes it possible for him to continue his emotional education. To this end she encourages the formation of small groups, both for play and work, and, while seeing that children do not harm each other, allows scope for feelings to be expressed naturally, including feelings of hostility and aggression. Like the good mother, the teacher has to accept a child's dependence and need for protection and at the same time encourage him in every way to become independent of her. In this, skilful teaching in the narrower sense is a great help; for the more a child knows, the more confidence he has in managing his own affairs. Growth in understanding the use of number, for example, may encourage him to lay out his pocket money for himself, and being able to read may make him less dependent on adults for his pleasures.

70. The young school-child will, however, transfer to his teachers the attitudes he has taken over from his parents; he will welcome the chance to learn new things if he has a mind "innocent and quiet" and has been encouraged at home to do things for himself. As he progresses through the school, he has gradually to forsake real things for symbols and learn to deal with the abstract; this will be a very difficult and painful process if growth is not continuing satisfactorily on the emotional side, as for example if he has been unable to tolerate the separation from his mother. Many children go through a period of nervous tension at about the time when the formal business of learning to read and write commonly begins, but this is normally quickly over; most children enjoy going to school and probably find membership of a large group a relief from the close-knit, intimate atmosphere of the family.

71. The fact that important steps forward are being made on the intellectual level at this stage also helps on emotional adjustments in other directions. The child of six or seven can usually distinguish between fact and fantasy, although the ability to do this is likely to break down under emotional stress (as when he is badgered to "own up"). Having a better understanding of the world around him, he can accept it more easily ; he realises, for instance, that if he wants parts for his meccano set he must wait until he has saved up enough for them. At the same time, he may still protest violently if he does not get his own way. He also begins to grasp that the rules and restrictions of life apply to other children as well as to himself. As he grows up physically he gains more confidence in his relationships with other children. Fortified in all these ways he enters, somewhere about the eighth year, on the period of later childhood.

Later childhood

72. It used to be held that the years between the ages of seven and twelve constituted a kind of golden age, when a child gave little trouble and lived happily and thoughtlessly, reaching an almost mature state of stability and reasonableness towards the end of the period. It has, however, recently been remarked that the eighth and ninth years constitute one of the peak periods for references to child guidance clinics, and educational backwardness also becomes a pressing problem at about the same age. There is some truth in both points of view. Whether a child is happy and stable in this period, or unhappy and out of step with society or with his lessons, largely depends on one thing—the adequacy of his early nurture.

73. The average child of eight has developed a capacity for stepping outside himself, as it were, and viewing himself as he appears to others. He needs the approval of other children and has become keenly aware of any differences between himself and them which are likely to diminish their approval. This may have either good or bad effects on the maturing process. For example, he may first begin to suffer consciously at this age from failure, whether at work or play. On the other hand, the result may be an improvement in his standards on both the social and the intellectual planes. He likes to look at the work of other children and compare it with his own, he considers their skill in relation to his own, he notices how they behave in the face of frustration, rebuke or victory. He wants to know as much as they do and to be as well thought of, and so he strives to emulate them. Above all, he wants to be accepted by them, and this often stimulates him to control his feelings and adapt his behaviour to the requirements of the group. If he is accepted, he can be very generous in his praise of others who are more successful than he is.

74. In this way he identifies himself with a larger group and can enjoy vicariously its success, so that the quality of his own individual performance matters less. As a result of his identification with the group, he thinks less about himself. Like the child of two or three years, he becomes absorbed in outside interests, and these are no longer confined to what is happening in his immediate environment. His actual world is likely to be rather restricted ; he does not travel much, does not meet many people and cannot exercise much control over the kind of experience which comes his way. But his imagination, though realistic and practical, is well developed and active, and in poetry and story or through the cinema and wireless he can enter into the lives and feelings of people still more remote and unfamiliar. He turns from one interest to another without much persistence, but all the while he is comparing, noting, and widening his experience. In this way he lives in a perpetually expanding universe, and his mind and feelings expand in harmony with it.

75. Although the influence of other children is very great at this stage, adults still play a most important part in his development. At school what some of his teachers say and do will have a lasting effect on him. The most formative influence in his life will, however, still be his home, and the security of a good home is vital for his sound growth.

76. One of the most important factors in fostering this sense of security is a harmonious relationship between the child's parents. Another is the existence, in the parents and the other adults with whom children come into contact, of firmly held moral principles and standards of conduct. These will not necessarily be based on religious beliefs; many parents without religious beliefs bring up their children satisfactorily, just as others with such beliefs fail to do so. But there are many people who feel that children who are brought up believing in a loving and merciful God are thereby helped to develop harmoniously and without constraint; and that a child can more readily get rid of a sense of guilt after wrong-doing, and can more readily forgive other people, if he knows that he himself is loved and forgiven.

77. In this period a child's life and interests are no longer entirely centred on his home and his school. He may join other groups where he will meet adults in a rather different guise, as leaders of co-operative enterprises in a freer and more friendly atmosphere than is usually possible in school. His passion for experimentation, his desire for independence or the influence of other children may occasionally lead him to lie, cheat or pilfer, but by the end of the period he has normally developed considerable resistance to temptation and is reliable, cheerful and co-operative.

Adolescence

78. Adolescence is often thought of as an unsettled period between two relatively settled ones. The junior school child should have adjusted himself to the world of childhood, and he can usually disregard the problems of the adult world. His body and mind serve him so well and his feelings trouble him so little that he is not tempted to introspection or self-mistrust. When maturity has been finally reached he will normally return to a like state of stability and serenity, and will feel himself confident to deal with the problems which in childhood he disregarded. Whether the transition from childhood to adult life is made easily or with difficulty will to a considerable extent depend on whether the early nurture of the child has been good or bad, and on the degree of strain and pressure which his environment is exercising at the time.

79. The far-reaching physical changes of puberty are matched by equally far-reaching emotional and intellectual changes. These may be described as the breaking down of an established pattern and its forming again on a more adult and complex level. The adolescent has to learn to manage a more adult body and to deal with unfamiliar and stronger feelings. This is made even more difficult, because the system of values which sufficed to control feeling during the previous period is itself being broken down and re-formed. The adolescent will have a wider interest in the world around him—in its day-to-day problems as they most immediately affect him, in broader political and social issues, and perhaps in the nature of the universe and the purpose and meaning of his and its existence. There will at this time often be an awakening or deepening of his religious feelings and a quickening of his aesthetic sensibility. He has to re-mould and make his own the principles and beliefs with which he has been growing up in infancy and childhood.

80. The period of adolescence is one of such instability that it is particularly difficult to determine what constitute the normal limits of behaviour and adjustment. An adolescent may, for example, give way to uncontrollable

bouts of temper or crying, may wander off, pilfer or romance, and may swing from exultation to depression, now flinging himself into society, now withdrawing into solitariness. All this may merely mean that, like the infant, he is adjusting himself to an unfamiliar and complex world by means of a personality which is itself unfamiliar and fluid, and that, also like the infant, he has to experiment in order to understand and control.

81. Adolescence has been described as having more in common with infancy than with the intervening period of childhood. The main need of the adolescent, as of the infant, is emancipation. Whereas however the infant has to emerge from a life centred on his mother into the family, the adolescent has to emerge from the family into the world at large. He has to free himself finally from dependence on adults, and to accept the responsibility of ordering his own life, even though he may go on living at home. In a way, therefore, he repeats the infant's struggle with authority and may experience again something of the infant's hostility and antagonism to his parents. But his struggle is more conscious, and is often accompanied by an ability to formulate and express criticism which may make it far more bitter and distressing both to himself and to the adults around him. Out of it, however, normally comes fuller understanding, an increased tolerance and a new relation of friendly equality. He may experience again something of the conflict which occupied him as an infant, in that he desires both protection and freedom, both fears independence and is irresistibly attracted to it. But between him and his infancy lies the period of childhood in which he has experienced the pleasure of comradeship with his peers, and the natural course of his maturing feelings is to drive him still further beyond the family, to form lasting friendships and to find new objects for his affections.

82. In the early part of adolescence there is generally a greater emotional interest in the same sex. This is a normal phase, which ordinarily gives place in the later teens to a greater emotional interest in the opposite sex. If a person has had ample opportunity to experience the progressive emotional stages of infancy, childhood and adolescence, he will as a young adult make a satisfactory adjustment more easily in the sphere of personal affections.

83. The adolescent needs also to come to terms with his work and to develop ambitions which are both possible of achievement and satisfying to his feelings of self-respect and self-interest. If he has to leave school at fifteen or sixteen he may not have much choice in what he does and may have to look elsewhere for his main interests, but at least he has the satisfaction of earning his own living and of having money to spend as he pleases. Absence of this obvious stage of independence may make the period more difficult for those who continue full-time education, but they have compensating opportunities for pursuing the career of their choice and for achieving intellectual emancipation, and have more leisure for reflecting on the world in general. In either event, the adolescent as he matures identifies himself to some extent with both his work and the community at large ; he is prepared to accept the requirements and restrictions of both and to contribute what he can to their successful functioning.

Summary

84. In reviewing this process of development from infancy to maturity one can pick out various pointers to normality or the reverse. At every stage the child who is progressing satisfactorily is able to profit from the experiences which can normally be assimilated by someone of his age and innate equipment. A child will, for example, learn to talk or to read at about the time when children of his intelligence commonly do. On the

emotional side also, he becomes increasingly sensitive to the feelings and wishes of others and is able to profit to the normal degree from the opportunities which life offers him of learning to control his feelings. One might even say that physically he profits in the same way ; his food does him good and he is built up by fresh air and exercise. The concept becomes clearer if one considers instances where something has gone wrong with the process of development: the child of average intelligence who, though present at all the lessons, does not learn to read ; the nervous child who may eat voraciously and who fails to thrive for no obvious physical reason ; the clever child who remains pig-headed and babyish in dealing with frustrations ; or the ten-year-old delinquent whose face still looks chubby and infantile, as if experience had washed over it without leaving its customary mark.

85. All through the process of development the normal child keeps in reasonable touch with the world around him (though with many sidesteps into fantasy and evasion), respects it and tries to adapt himself to it. In this way he gradually learns to control fantasy, accept discipline and persevere in the pursuit of more distant goals, and his prevailing mood is one of serenity and optimism. Year by year he is building up his own style of life, developing characteristic ways of meeting situations and dealing with problems. The older he gets, the more difficult it becomes to alter his life pattern and to modify a faulty style. His way through life from birth to maturity may be likened to the progress of a Channel swimmer, necessarily affected by waves and current and exulting in the resistance they offer him, but shaping a course to the opposite shore in spite of them.

CHAPTER IV

THE NATURE, SYMPTOMS AND CAUSES OF MALADJUSTMENT

A. The nature of maladjustment

86. "Maladjusted pupils" were defined in the Handicapped Pupils and School Health Service Regulations, 1945, as "pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social, or educational re-adjustment", and this definition has been repeated in the revised version of the regulations issued in 1953. Like the definitions of the other categories of handicapped pupils, it is not expressed in clinical terms, nor is it intended to provide exact criteria for identifying the handicap. It merely shows the limits within which maladjustment may be found: it is, for example, so worded as to include the withdrawn, introverted child, who may on the surface be quiet and well-behaved. The sole purpose of having a definition in these regulations is to make it legally possible for special educational treatment to be provided for maladjusted children, as for children suffering from other handicaps, and we do not wish to recommend any change in the definition adopted for this purpose.

87. This definition will not, however, suffice for our present investigation, for the following reasons:—

(*a*) It does not offer any help in the identification of maladjustment in particular children.

(*b*) It is not sufficiently widely conceived to ensure that maladjustment is dealt with at as early a stage as possible, before any disturbance has become deep-seated and difficult to eradicate.

(*c*) It is confined to children who can and should be treated within the educational system; it thus ignores very young children, and those older children who have to be treated outside the educational system, e.g. as in-patients of hospitals.

88. Maladjustment is not a medical term diagnosing a medical condition. It is not, as we have already mentioned, to be equated with bad behaviour, delinquency, oddness or educational subnormality. Nor is it the same as a deviation from the normal; while it is true that many deviations are signs of maladjustment, some may involve only one side of a child's development and may not affect his mental health.

89. We can perhaps best approach the nature of maladjustment by saying that it is a term describing an individual's relation at a particular time to the people and circumstances which make up his environment. In our view, a child may be regarded as maladjusted who is developing in ways that have a bad effect on himself or his fellows and cannot without help be remedied by his parents, teachers and the other adults in ordinary contact with him.

90. It is characteristic of maladjusted children that they are insecure and unhappy, and that they fail in their personal relationships. Receiving is difficult for them as well as giving, and they appear unable to respond to simple measures of love, comfort and reassurance. At the same time, they are not readily capable of improvement by ordinary discipline.

91. Maladjustment is an individual matter about which it is hard to generalise. In view of what has been said in previous chapters about the relative nature of adjustment and of normality, this is not surprising. A set of events or of hereditary factors may give rise to maladjustment in one child, whereas a similar set acting on another child may leave him unscathed. This can happen even if the two children have, so far as can be discovered, similar mental and physical characteristics. The age at which children go through the successive stages of development varies—and may vary considerably—from one child to another. There is also a wide range within the normal at any stage.

92. It is only possible to say tentatively that certain modes of behaviour or habits fall outside the limits of the normal or are incompatible with a state of adjustment. For example, temper tantrums may be a sign of maladjustment in a child aged 11, though they would be natural in a child of 3. Although most children achieve day and night dryness by the age of 2½, it is normal for some children to achieve it at a later age; but it would be abnormal if a child were not dry by the age of 5.

93. Maladjustment does not always show itself in aggressive or troublesome conduct; indeed, quiet and passive behaviour may overlay deep emotional disturbance. Maladjustment may, however, be linked with bad behaviour or delinquency. Children naturally like to have their own way, even at the cost of making their parents angry; but they will not be in disgrace for long and the matter will soon be forgotten by both sides. On the other hand, a continual state of friction between parents and children, in which each side becomes resentful, suspicious or cold towards the other, may result in the children becoming maladjusted.

94. Insecurity and anxiety are closely associated with maladjustment; and aggression provides one means of obtaining relief from the tension of anxiety. The aggression may lead to delinquency, which may thus be a symptom of maladjustment; and even if children are not detected when they do something which is an offence against the law, they may as a reaction have feelings of guilt leading to more anxiety. In this way a vicious circle of anxiety—aggression—guilt—anxiety is completed. On the other hand, as we shall see in Chapter XII, by no means all delinquents are maladjusted.

95. It is important not to forget that maladjustment may be present in some degree in pupils placed in any of the other categories of handicapped pupils. Under the School Health Service and Handicapped Pupils Regulations, 1953, there are nine of these: children who are educationally sub-normal, blind, partially sighted, deaf, partially deaf, epileptic, physically handicapped, delicate or who suffer from speech defects. In some cases, as we shall see later in this chapter, physical or mental disabilities may dispose children towards maladjustment. In others, children may suffer from a physical disability which is the result of maladjustment, e.g. bed-wetting. Some disabilities, e.g. asthma or speech defects, may be either the cause or the effect of maladjustment, and it is often hard to determine which they are.

B. Symptoms

96. Some system of classification, however inadequate, is necessary to make clear what are the characteristics of the children with whom we are concerned. All that can be attempted is a catalogue of the symptoms which children show. For those who wish to look at a detailed grouping of symptoms under different types of disorder, one will be found in Appendix B. We make however no claim that it is satisfactory, either from the scientific point of view or for comparing the work of different clinics; and we hope that

any professional body which may be set up to represent child psychiatrists will consider whether it is possible to work out a classification on sounder lines.

97. We group the symptoms, in the paragraphs which follow, under six heads:

(i) Nervous disorders (in this context we use the word "nervous" in its popular sense to describe a disorder which is primarily emotional),

(ii) Habit disorders,

(iii) Behaviour disorders,

(iv) Organic disorders,

(v) Psychotic behaviour,

(vi) Educational and vocational difficulties.

98. The various groups overlap and may be linked together in various ways: for example, habit and organic disorders both have a physical expression. The most helpful way of linking the first three groups is to say (though it can only be a very broad generalisation) that they each represent a different way of relief from fears: nervous disorders by a retreat into oneself, habit disorders by a shunt into a physical symptom and behaviour disorders by a revolt against authority.

99. When we come to the group of educational and vocational difficulties, it will be important to remember that the classification is based on the symptom which the child shows, as some of these difficulties will be far removed from the root of the trouble. Almost all children whose maladjustment shows itself at home and falls, for example, under the heading of nervous, habit or behaviour disorders, will be pupils in some school. Few of them will be able to do justice to their abilities in school work and they may also find it hard to adapt themselves to the school regime. Behind the school difficulty it will be necessary to look for the emotional trouble. Again, there will be some children who are found a problem in school, but who are well behaved at home. It will not be sufficient to regard all these as merely having educational difficulties. Sometimes there will be a deep-seated emotional trouble which only shows itself in school or at work, when demands of a new type are made.

(i) *Nervous disorders*

100. Many children are easily frightened, but the nervous child of whom we are thinking goes on being frightened when his fears are in no way justified by his real situation. At least that is so if his situation is judged by standards of external reality; many children however are more troubled by fears which relate to their internal security. A child may have temper tantrums or terrifying dreams in connection with some hostility between his parents. Anxiety may even arise over an event that is welcomed by his parents and in which he shares, for instance the birth of a brother. Perhaps this may make his jealousy and his sense of despair at being replaced all the more confusing to him, and turn into something which he cannot express and experience for what it is. In a family where no allowance was made for jealousy, symptoms of anxiety might well arise in this way.

101. In this group also belong the children who are excessively timid, who cannot face strangers, who are sick at parties, and who dread going to school because of fear of competition with others who seem to them to be more successful. Sometimes these children appear to be almost overwhelmed by their troubles. All children express a large part of their emotional

life in the form of fantasy, but these children have encountered so many situations which seem to them dangerous or damaging that their fantasy life has become highly elaborate and claims an undue amount of their attention. It has become more satisfying to them than the reality in which they get on so badly. They may thus give their parents or teachers an impression of being walled in or always on the defensive. Their symptoms may even be overlooked, for they will often be quiet, shy children who try to avoid trouble. But they mix poorly with others, and (as we saw in the last chapter*) the approval of other children is a special need at one period of a child's school life. They probably appear to their teachers apathetic and lacking in any capacity for effort. It is very common in such cases to find a multiplicity of symptoms. At home the child sleeps poorly, has bad dreams, eats little and is often faddy; as a result his physical health may deteriorate. This deflects a parent's anxiety to a physical cause, and understandably may lead to an attitude of over-protection. Outside his home the child makes few friends and is often regarded as a "sissie" and fair game for the others. All this combines to make his achievement in school disappointing in relation to his abilities. Such children are among those of whom school reports often say, "He could do better if he tried", without recognising how profound is the lack of confidence behind an apparent indifference.

102. An attempt may alternatively be made to deal with such unhappiness by a swing in the opposite direction, and it may be harder to see this in its true light. Restlessness, excitability and an effusive quality of over-friendliness may conceal a deep inability on the part of the child to forge for himself any kind of lasting relationship. Distrust of himself has passed into a denial to himself that there is anything to worry about. There are other nervous children whose nervousness is not so obvious, but who have developed unusual symptoms and so are unlikely to be overlooked. Their fears, becoming less generalized, have been attached to certain objects towards which they develop an obsession; or they may be aware of an unreasonable compulsion, such as an urge to smell everything they pick up or to touch every board in any fence they pass. The essence of the compulsion is that the child feels he must carry out a particular action, though he is unable to explain why. It appears as if the ritual or compulsion serves the purpose of deflecting anxiety from the real source of strain, and here will be found a link with habit disorders.

(ii) *Habit disorders*

103. There is no hard and fast division between this group and the last. The name brings out the fact that many children require help because they have failed to develop some habit regarded as normal and appropriate for their age, such as a regular rhythm of sleep or dryness at night, or because they have developed a habit which would be regarded as abnormal or at least undesirable at any time, such as stammering, twitching, sleep-walking or nervous vomiting. Compared with children feeling the compulsions considered under the last group, these children show less anxiety and even a degree of satisfaction in doing the forbidden thing. This is especially true of those children who develop habits of abnormal movement; their repetitive tic will increase with tension, but subside for a time after it has been performed. The element of habit lies in the fact that the body becomes accustomed to these unusual patterns and so finds difficulty in letting them cease. Most children suck their thumbs for a time in babyhood, but where the activity becomes a habit it is not uncommon to find older children who cannot get off to sleep without a period of thumb-sucking, of which they are really ashamed.

* See Chapter III, para. 73.

104. Where the disorder consists in the failure to develop a normal habit, it is important to link it with the child's general degree of maturity and then see it in terms of his relationship with his mother. A good relationship helps to establish habits smoothly and without much trouble at the appropriate stage. A mother's demands in the course of ordinary training are manifold: they will be made not only in relation to the control of excretions but also to eating and sleeping, and indeed to any function where complete dependence at first on a mother's help passes over gradually into complete independence. Small children will often seem to have mastered some step, only to go back to baby ways after a period of stress such as a physical illness, a separation from the mother, or some more lasting change such as the birth of a brother or sister.

105. There are also some disorders in which physical symptoms predominate but which are partly psychological in origin, though their exact cause is not clear. Of these the allergic conditions are a good example. No one knows precisely what causes certain individuals to react to particular substances with an uncommon violence, producing hay fever, asthma or skin rashes. In adults it is sometimes possible to discover which article of diet brings on an attack of this kind, but in children this type of sensitivity often follows a period of eczema in early infancy and they tend to react sensitively to many things ordinarily met with, such as dust, feathers, fish or eggs.

106. Since life becomes intolerable for such children it is dangerously easy to set up a vicious circle. The parents will naturally be over-anxious to prevent allergic reaction, which in turn increases the child's anxiety and so limits his activity. One sometimes meets asthmatic children who have never slept alone in case of an attack, who for the same reason have never been away from home and who rarely spend more than a few weeks of any term in school. Undoubtedly in many cases this background of anxiety plays a large part in bringing on an attack, which is then generally said to be due to excitement. These are the children who never succeed in getting to parties or to the pantomime. They tend to react excessively to any nervous stimulation, even without a full-blown attack, and readily become sleepless or faddy over food, as if the tendency to meet tension with a physical reaction were a general one.

(iii) *Behaviour disorders*

107. Behaviour disorders are shown by children who are in active conflict not only within themselves but with their environment, whether this is their immediate home setting or the conventions of the world at large. This group of disorders therefore includes minor disturbances such as temper tantrums, jealous behaviour and romancing, which are likely to occur for short periods in most normal lively families, as well as more serious disorders such as cruelty, incendiarism, stealing, persistent truancy and sexual troubles. Many of the children in this group come from homes where the personal relationships are abnormal and where the child is unable to count on loyalty and affection within his own family. Children who display some of these symptoms in an extreme form appear to be without the ability to form any relationship or to uphold any loyalty, going far on the way to becoming psychopathic persons.

108. It is important to realise that many of these children are primarily nervous and in conflict within themselves, but that a more assertive temperament has tended to bring the symptoms to the surface and into more open protest and revolt against authority as the child grows older. It may be possible to trace a behaviour difficulty back to early childhood, perhaps to

the rather difficult age between about 1½ and 4. For example, a child after some resistance to habit training in his second year may become generally difficult to manage. He not only refuses to use his pot, but lies down and screams or refuses his food or continually demands his mother. The fight is on; and if his mother is preoccupied with preparing for a second child, if she has to withdraw because of illness or if he is sent away to give her some peace, this early phase when children react negatively may well develop into something which probably both mother and child experience as a real estrangement. By the time he reaches school age, this child may be quite unready to leave his mother, control of himself and of his habits is still a matter of great concern, and he becomes a difficult child in school. It is only too easy to recognise the element of spoiling and mismanagement in all this and to overlook the anxiety which underlies his behaviour. It is not surprising if he bites and scratches other children since he looks on them as rivals to his position, and his powers of concentration will be undermined by his all-pervading insecurity. He does not learn so fast as the other children and is likely to be left out of things, with the result that he may begin to steal in order to have something to give away to attract a friend or to hug to himself as a bit of security. Perhaps by this time he often makes his father angry or frightens his mother into giving in for the sake of peace, and he may be heartily disliked all round for the trouble he brings.

(iv) *Organic disorders*

109. While in the group of habit disorders and in some nervous disorders it has been seen that tension produces a physical expression or symptom, in the organic group we are dealing with symptoms produced by physical changes, usually in the brain or spinal cord. Even here the association is not always as clear as one would expect; it is not known why some children after a head injury or an illness such as meningitis develop a change of character while others appear to recover completely. Other disorders in this small group include chorea, commonly known as St. Vitus' dance, and epilepsy, which is possibly the most likely organic disorder to be associated with maladjustment.

110. Only where attacks are severe or frequent need the epileptic child be kept apart from other children in his neighbourhood and sent to a boarding school. Otherwise, it will be possible for him to stay in an ordinary school and for his attacks to be managed as they occur; this in itself may minimize his feelings of strangeness. It may however not be in school so much as at home and with neighbours that he is made to feel different. Restrictions on cycling and swimming are inevitable; but if other children are told not to play with him and his mother hardly allows him out of her sight, he may become maladjusted as a rebellious protest against his limitations. Fortunately, the great majority of epileptic children are not maladjusted, and not all the children who have a convulsive attack will prove in the long run to be confirmed epileptics.

(v) *Psychotic behaviour*

111. This might be simply and comprehensively described as conduct which is so profoundly disturbed that disruption of the normal patterns of development takes place at all levels, intellectual, social and emotional. The parents of these children often describe them as "living in a world of their own", and perhaps the most characteristic thing about them is their inability to achieve normal relationships with either people or things. A psychotic child will often without asking take hold of his mother's hand as if to use it as an

instrument for getting him what he wants, doing it in a way which suggests that he does not recognise that his mother owns the hand. The psychotic child may also be unable to control the activities of his own body. He is thus often remote, solitary, incontinent, sleepless, unoccupied and ineducable.

112. These children are not always recognised as psychotic: they may be regarded by their parents as merely naughty. With girls especially, it may not be until adolescence, when their behaviour causes them to be brought before a juvenile court as in need of care and protection or as beyond control, that their real trouble is discovered. On the other hand, psychotic children may be taken to be mentally defective rather than mentally ill. There are however ways of distinguishing the two types. The seriously defective child often looks different from other children, while the psychotic, at least while young, is more likely to retain an alert and attractive appearance. The defective tries to copy other children, although he may be slow and clumsy in his efforts: the psychotic child shows no apparent interest and withdraws from others. He may become exclusively absorbed in some trivial and purposeless activity, such as swinging a bunch of keys, which is monotonously repeated as an end in itself.

113. Since one early symptom is often a failure to develop speech, parents usually learn to accept these odd ways, if only because they cannot do otherwise. Though the psychotic child can offer no explanation for his bizarre activities, he will sometimes throw himself into transports of distress if he is interrupted or opposed. Those who live with these children experience acute frustration at this lack of contact. The diagnosis of early psychosis is hardly justified unless there is a clear period of normal development followed by a failure to develop further or an actual regression, accompanied by the more positive features of withdrawal from all normal contacts. These children never play with another child or invent an intelligible game of imagination, and their activities as well as the range of their development tend to become more and more restricted, although in actual moving about they remain over-active, restlessly flitting from one queer performance to another.

(vi) *Educational and vocational difficulties*

114. The link between many educational and vocational difficulties and nervous, habit and behaviour disorders has been mentioned in paragraph 99. Here we are concerned with the ways in which a maladjusted child who is a failure at school or in employment expresses his maladjustment. At school this will primarily be shown by failure to learn, either in one or two subjects such as reading or arithmetic, or generally as when a bright child remains obstinately at the bottom of the class. The scholastic failure of these maladjusted children will frequently be accompanied by failure to get on with other children or with the staff. Sometimes these children are very contrary and tiresome. They may argue obstinately about obvious matters of fact, e.g., the spelling of a word, averring when confronted with the dictionary that it must be wrong. They may play the buffoon in class and irritate both the teacher and other pupils who want to get on with the lesson in hand. This gives them a justification for their unco-operative behaviour since they can excuse it on the grounds that " the others don't like me " or " the English master always picks on me ". Often they seem determined to get into trouble: for example, after a child has been rebuked for a misdemeanour and promised to behave better he will almost immediately commit it again. Other children have such a wild fantasy life that it distorts the knowledge they are trying to imbibe or even makes it impossible for them to learn a subject. In some cases this fear of learning goes so far that the child cannot face going to school at all.

115. Another type of educational difficulty shows itself in listlessness and lack of concentration. The child sits through the lessons with a glassy stare and never shows any feeling or animation. He appears not to be trying, but is in fact, like the stammerer, trying too hard and has built up a tension which prevents knowledge from penetrating. Alternatively, he may acquire a technique which prevents him from committing himself to the matter in hand and so excuses his failure : he mis-hears, insists that he has not been told, loses his books, forgets to take home his preparation or produces some physical symptom, e.g. a nose-bleed. As these children approach the end of their schooldays their maladjustment will often be shown in their inability to choose a career commensurate with their abilities: a very short-sighted boy may be obstinately determined to be a pilot in the R.A.F., or a clumsy unattractive 18-year-old girl will refuse to decide on any career because she wants to be a ballet dancer. Unless the difficulties of such children are resolved, they will repeat in employment the same pattern of failure and unco-operativeness.

C. Causes

116. The question of the extent to which heredity determines mental and emotional characteristics is important from the point of view of prevention ; and ideally from the point of view of treatment the causes of the child being as he now is should be known. But a knowledge of the relative influences of heredity and environment may not in a particular case be vital for treatment, since conditions arising from early environmental influences may become as intractable as hereditary conditions.

117. People dealing with a maladjusted child will often need to seek in his early childhood for the cause of his present trouble. Most authorities agree that by the time a child reaches school age serious maladjustment seldom results from the impact of recent attitudes, feelings and events unless he is predisposed to maladjustment by remote causes or hereditary factors. But even when the remoter origins of a child's trouble can be discovered, those who are trying to help him have to return from the past to the full complexity of the child as he now is and of his present environment before they can complete their diagnosis and undertake treatment ; and even when little or nothing can be discovered about the past, much can still be done to treat the child as he is found to be in the present. The growth of a child is like the growth of a plant which sends out curling tendrils feeling for support : something can be done at any time to provide support for the child and help on his normal development. Much will also be gained by removing certain symptoms of maladjustment, especially physical symptoms in the group of habit disorders. Further, in all cases, even the most complex and disheartening, there will still be much in the child that is sound and it should be possible to find this and build on it.

118. It is impossible to list all the factors which may play a part in producing maladjustment. They are as various as human life itself. Also, their mode of operation is various, as they may affect the child directly, or indirectly through other persons upon whom he is dependent, or in both ways in varying degrees. Nevertheless, some formulation in general terms of likely causes is necessary if preventive measures are to be taken and methods of treatment recommended. We indicate briefly, without any claim to completeness, some of the main factors which may be involved in maladjustment in children. These factors are grouped under five headings, as follows:—

(*a*) Personal relationships.
(*b*) Family environment.
(*c*) Community influences.
(*d*) Physical factors.
(*e*) Educational factors.

(*a*) *Personal relationships*

119. There is much evidence that failure in personal relationships is the most important factor in maladjustment. The relationship between mother and child in the early months of the child's life is, as we saw in the last chapter, of vital importance. If the infant is robbed of his mother through death, desertion, illness or any other cause, he needs some permanent mother substitute, able to satisfy his emotional as well as his physical wants. A succession of people is inadequate, however devoted and efficient each may be individually.

120. Loss of father or mother or both is most naturally repaired by blood relations stepping into their place. This natural method operates less easily in our present civilisation than possibly ever before, for two reasons. First, the family unit is now regarded primarily as father, mother and unmarried children ; grandparents, aunts and uncles and other relatives may be separated from the family emotionally as well as by distance. Secondly, families have tended to be smaller for the past two generations so that in any event the parents are likely to have fewer brothers and sisters. Loss of both parents may be repaired if suitable adoptive or foster parents are found, but this may take time or prove to be impossible. If the child goes into a children's home his relationship with parent substitutes is clearly of the utmost importance to his development.

121. There is also evidence that some children who are separated from their mothers in infancy for a prolonged period, as for example if they or their mothers are admitted to hospital, may as a result be disposed towards maladjustment. In this connection the implications of mothers of very young children going out to work and being away from them all day must be kept in mind.

122. It is of course possible for a child to suffer deeply when living with his parents if they are stern and undemonstrative. Terrible is the cry of Ruskin in his autobiography, "I had nothing to love". If the infant finds no one to love in his first years, there is a real danger that his capacity for coming to terms with people (or things like his work) will be seriously impaired ; he may even, in the way that we have seen, become incapable of giving or receiving affection. In other words, if a person is deprived of the normal experiences of babyhood, there will inevitably be times later on when the baby in him will take over and direct his behaviour.

123. The mother herself or the mother substitute may serve the child well or badly according to her character and circumstances. If she is herself psychologically ill or immature or overwhelmed by difficulties outside herself, she will be unable to give the infant the unremitting care which he needs, and neither he nor she will find the full satisfaction and joy which the relationship should naturally promote.

124. As the infant grows, the direct relation of the father to the child becomes more important. If his father is dead or has left the home or takes no interest in him, his chances of normal development will be reduced. At this period, parental disharmony begins to affect the child directly, instead of indirectly through his mother.

125. The nature of the relationship with the parents should change with the various stages of the child's development. A right relationship at one period may be harmful if prolonged beyond its proper term: the dependence on the mother which is proper for the infant is harmful to the schoolboy. Equally a relationship that would be right later may be initiated prematurely : the responsibility and freedom rightly given to the youth may be too heavy a burden for the seven-year-old. A child's development may be hindered by

fussiness, expressed in the early years in rigid habit training and later in curbing adventurousness ; or it may be hindered if a child is deprived of the chance of close companionship with other children. Jealousy of brothers and sisters, if handled unwisely, may predispose to maladjustment.

(b) *Family environment*

126. Adverse social conditions may be a factor in producing maladjustment. Bad physical conditions in the home are in the main secondary in nature, in that the effect on the child is normally produced indirectly through other members of the family. Conditions of discomfort or squalor need not have any bad psychological effect on the healthy child, but, whether caused by domestic inefficiency or bad housing, they may constitute such a serious strain on the parents that they fail to give the child the affection and care which he needs. It has to be remembered too that some of the characteristics which make people inadequate in managing households may make them inadequate as parents.

127. The most severe strain however imposed on parents and children by housing conditions is due, not to dirt, but to overcrowding and the sharing of houses by a number of families who are not related or friends. Mothers may, for example, be subjected to constant complaints by people living on the floor above or below them or may be threatened with eviction by the landlady, merely because a tiny baby cries or a high-spirited three-year-old makes a noise.

128. Poverty may operate in the same way as bad or overcrowded housing, and it too may have a further effect if it leads to any ostracism of the family by neighbours. Yet many fine men and women have been reared in slum dwellings or in rural homes at bare subsistence level, and there is no reason to suppose that such conditions produce maladjustment if the child has received the right kind of care and affection from his parents.

(c) *Community influences*

129. Harm may be caused to the child if his family's cultural or class standards are radically different from those of the families with whom they are thrown into daily contact. Such conditions can give rise to feelings of hatred or rejection in the child and cause maladjustment. We suspect that equally severe strains may be imposed on children whose parents have social aspirations and are trying to keep up with a set of people possessing more money, or abilities or tastes different from their own ; more knowledge is needed about the effect of this on children. It may also be that the standards of conduct accepted and followed in the child's home and in his immediate environment are lower than the minimum necessary to secure a sound society and right living in its members. The result may be that the child has so much difficulty in controlling himself or forming relationships with others that maladjustment is caused.

130. Major upheavals and changes in the life of the whole community or nation, such as war, mass unemployment or a lowering of moral standards, are likely to increase the incidence of maladjustment in children, owing to the increased stress placed on the individual living in the community and to the disturbance caused in family life and personal relationships. The reserve troops of juvenile delinquency are said to be called out in periods of social disturbance and change, and the same is no doubt true in some degree of maladjustment.

(d) *Physical factors*

131. We said earlier on in this chapter that physical condition may be related to maladjustment. The experience of suffering from disabilities, such as blindness, deafness, crippling and congenital malformation, in some cases

gives rise to maladjustment, since these limit a child's opportunities of achievement and embarrass him in his relations with others. It is bad enough for a child to have a sense of disability, but if it is incorrectly diagnosed, for example when high-frequency deafness is mistaken for dullness, the child is likely to feel that everybody's hand is against him and, if he is intelligent, to feel thwarted as well. Again, serious accidents and illness in childhood may have a bad effect on the mental balance of the child: they may, for example, have prevented him from exploring the physical world and enjoying the satisfactions of conquest over it, so that he remains for too long dependent on his parents for his interests and pleasures.

(e) *Educational factors*

132. The school is probably seldom the direct or chief cause of maladjustment, but it may quite often be a precipitating or contributory factor. Any major change in the circumstances of a child requires him to make fresh adjustments and, if he is already disposed to maladjustment or suffering from it to a mild degree, such changes may add sufficient extra strain to induce an open breakdown. Going to school for the first time will be a severe ordeal for some nervous or backward children who are still completely dependent on their mothers. Every teacher of a reception class in an infants' school is familiar with the child who has to be brought screaming to school for the first few days and who cries or sulks throughout the day. If this situation is not handled successfully, it may lead to other symptoms such as aggressiveness or soiling, and may perpetuate an attitude to school and learning which will result in further breakdowns at other periods of nervous tension. One of these, as we saw in the last chapter, may occur when the formal business of learning to read and write begins. A number of children show symptoms at this stage such as restlessness, nail-biting and grimacing, and their sleep may be disturbed.

133. Another of these periods of increased strain occurs at the age of transfer to a secondary school. The admission examination in itself is often a cause of anxiety and nervous tension, particularly if children are being pressed beyond their natural capacity by ambitious parents or teachers. If a child obtains a place in a secondary grammar or technical school as a result of special coaching, he may suffer from discouragement and strain when he finds the work there beyond his powers. Some children who are bright but not bookish may, as the work in such schools becomes more abstract and formal, find that it does not suit them. They cannot cope with the variety of subjects and with the many changes of teacher which they meet with during a school day. This is particularly likely to happen with clever children who are emotionally young for their age.

134. The exceptionally bright child can present problems of his own. He may suffer from boredom and frustration; and because of his intellectual superiority, he may give his teachers the impression that he is deliberately pert and provocative. Particularly as he gets into his teens, he may become intolerant of the inevitable discipline and restrictions of school.

135. Social factors play a part in causing strain when children move from one school to another. When families are uprooted from their old neighbourhoods and move to new towns or new housing estates, their children may find that many of the children at the school in the new area are of a different social class. Remarks such as "too posh" or "they don't talk the same as me" may reveal a deep rejection of the new school which is likely to have far-reaching effects on a child's happiness or stability. Children from a small village school may find it difficult to fit into a large central secondary school, particularly if they have no friends at their new school or have to travel a long way to reach it. Children from broken or unhappy

homes are especially likely to suffer from a change of school. They often, for example, manage to keep going fairly well in their familiar primary school and may even achieve a place in a grammar or technical school; but within a short time after the transfer they start pilfering or become rebellious, or they may truant or even refuse to go to school at all.

136. The onset of physical puberty is another time of strain. Instability is characteristic of this period, as we saw in the last chapter, and if this is not correctly handled it may lead to maladjustment as a defence against too great scholastic pressure.

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137. As we have indicated in paragraph 91, it is not suggested that the causal factors we have mentioned inevitably produce maladjustment whenever they operate strongly. All are likely to have an effect on personality and all seem to be sufficiently clearly associated with maladjustment to be regarded as causes of it, but only some of the children affected by them become maladjusted to any significant degree. The reasons why one child succumbs rather than another seem to be deep and, at present, obscure.

CHAPTER V

STATUTORY AUTHORITY FOR TREATMENT OF MALADJUSTED CHILDREN

138. Before we go on in the following chapters to discuss the different methods of treating maladjusted children, it will be convenient to deal briefly in a single chapter, with the various statutory provisions concerning the treatment of maladjusted children within the educational system. These provisions may best be described if we consider the powers and duties of local education authorities in regard to the four following functions or services:

A. Discovery of maladjusted children (" ascertainment ").

B. Provision of special educational treatment for maladjusted children.

C. The school health service.

D. Child guidance.

Since child guidance clinics can be provided by the hospital service as well as by local education authorities, and since local health authorities are concerned in the prevention and treatment of maladjustment, we shall also deal briefly with the relevant provisions of the National Health Service Act, 1946:

E. Child guidance clinics under the national health service.

F. The powers of local health authorities.

A. Discovery of maladjusted children (" ascertainment ")

139. Section 8 of the Education Act, 1944, lays upon every local education authority the duty to secure that there shall be available for their area sufficient primary and secondary schools to meet the varying ages, abilities and aptitudes of the children there. It goes on to mention particular considerations to which authorities must have regard in fulfilling this duty. One of these is that they must make provision for pupils suffering from any disability of mind or body by providing, either in special schools or otherwise, special educational treatment, which is defined as education by special methods appropriate to the particular disability from which a child is suffering. The duties laid upon authorities by Section 8 carry with them the duty to assess the abilities and aptitudes of the children for whom they have to provide education. This is a process which goes on throughout a child's school career. Probably the most widely known example of it is the selection of boys and girls for different kinds of secondary education at about the age of 11 which is carried out annually by nearly every authority.

140. The discovery of handicapped pupils by local education authorities, and the selection of the most severely handicapped for special schools, are other examples of the way in which authorities have to measure the varying abilities and aptitudes of the children in their area in order to provide them with the primary or secondary education suited to their particular

needs. Owing to the highly specialised nature of this particular kind of measurement, there are more elaborate provisions about it in Section 34 of the Education Act. Because the opening words of this Section of the Act specify that it shall be the duty of every local education authority to "ascertain" what children in their area require special educational treatment, the process of discovering handicapped children is very often described as "ascertainment". This word is widely and loosely used as though it had some special technical significance (similar to the significance of "certification" in the Education Act, 1921) which it has not; we have therefore endeavoured throughout this report to use the words "discover" or "find out" rather than "ascertain".

141. If they find it necessary in carrying out their duty to discover what children need special treatment, authorities are empowered under Section 34 to require a child in their area over the age of two to be submitted for medical examination, to see whether he is suffering from any disability of mind or body and what are the nature and extent of any such disability. Similarly, the parent of any child over the age of two may ask the authority to cause him to be medically examined for this purpose, and the authority must comply with such a request unless they consider it to be unreasonable. When a medical examination has been held, the medical officer gives advice to the authority, who also have a duty to obtain what information they can from teachers and others* about the ability and aptitude of the child. The authority then have to decide whether or not in their opinion the child needs special educational treatment and, if so, to provide it, unless the parent makes suitable arrangements.

142. The medical officer, if so required by the parent or the authority, must, after examining the child, issue to the authority and to the parent a certificate in prescribed form showing whether the child is suffering from any disability and, if he is, the nature and extent of it†. The authority can only require the issue of such a certificate if it is, in their opinion, necessary for the purpose of securing the attendance of the child at a special school, i.e. if parental opposition is expected. The parent may appeal to the Minister of Education for the cancellation of the certificate.

B. Provision of special educational treatment for maladjusted children

143. Having discovered that a child is maladjusted, the authority have a duty to provide him with special educational treatment. This duty derives from the general duty laid upon authorities by Section 8 of the Education Act, 1944, to which we have already referred above, in paragraph 139. It is further amplified and explained in Section 33 (2) which, as amended by the Education (Miscellaneous Provisions) Act, 1953, reads as follows:

> "The arrangements made by a local education authority for the special educational treatment of pupils of any such category shall, so far as is practicable, provide for the education of pupils in whose case the disability is serious in special schools appropriate for that category, but where that is impracticable, or where the disability is not serious, the arrangements may provide for the giving of such education in any school maintained by a local education authority or in any school not so maintained, other than one notified by the Minister to the local education authority to be, in his opinion, unsuitable for the purpose."

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* In dealing with a maladjusted child, reports from a child guidance clinic (see Chapter VI) would be appropriate.

† The prescribed form of the certificate is given in Appendix C.

As we shall suggest when we come to deal more fully with treatment in subsequent chapters, maladjusted children can often be best treated if they are educated in an ordinary school while attending a child guidance clinic and, in some cases, while boarded in a boarding home or with foster-parents. It is open to question whether these arrangements, although highly desirable, are in all cases covered by the Education Act, since, according to the wording of Section 33 (2) quoted above, they are legally possible only where it is "impracticable" to educate the child in a special school or where "the disability is not serious". These criteria do not always apply and we recommend that consideration should be given to the need for amending this section of the Act to ensure that every kind of special educational treatment suitable for maladjusted children is fully covered.

Special schools

144. Special schools are defined in Section 9 (5) of the Education Act, 1944, which reads as follows:

> "Schools which are especially organised for the purpose of providing special educational treatment for pupils requiring such treatment and are approved by the Minister for that purpose shall be known as special schools."

Special schools may be provided and maintained either by a local education authority ("maintained special schools") or by a voluntary body ("non-maintained special schools", often incorrectly described as "voluntary special schools"). The Minister has power, under Section 33 (3) of the Act, to make regulations specifying the requirements to be complied with by any school as a condition of its approval by him as a special school. These requirements are at present set out in Parts V and VI of the School Health Service and Handicapped Pupils Regulations, 1953*. There are both day and boarding special schools; the statutory provisions in regard to boarding education, at all kinds of school and otherwise than at school, are dealt with in paragraphs 151-3 below.

145. Authorities have a power to make a school attendance order directing that a child of compulsory school age shall attend a named special school, just as they have power to make such orders in respect of other primary and secondary schools. The procedure for dealing with school attendance orders is set out in Section 37 of the Education Act, 1944†, and provides for appeal to the Minister if the authority and the parents differ about the school to be named. If parents refuse to comply with a school attendance order, they can under Section 40 of the Act only be fined (or in the last resort sent to prison for not more than one month). Local education authorities have, so far as we are aware, never used their powers of enforcement under the Education Act to secure the attendance of maladjusted children at special schools, presumably because the co-operation both of the parents and the child is ordinarily regarded as an essential prerequisite of success in treatment. Authorities also, however, have power to bring a child before a juvenile court. As will be seen from Appendix G, a child brought before a juvenile court for any reason can be committed to a Fit Person, usually the local authority, and this is the only certain means of securing his attendance at school.

146. A general provision in Section 61 (1) of the Education Act, 1944, prohibits the charging of any tuition fee at any school maintained by a local education authority, including maintained special schools. Non-maintained

* Extracts from these regulations are given in Appendix D.

† As amended by Section 10 of the Education (Miscellaneous Provisions) Act, 1953.

special schools charge fees, which have to be approved by the Minister. Almost invariably the pupils in these schools are sent there by local education authorities who pay their fees in full, in accordance with the duty laid upon authorities by Section 6 (2) (*a*) (iii) of the Education (Miscellaneous Provisions) Act, 1953, which provides that an authority shall pay the fees in full where they are satisfied that a pupil "requires special educational treatment and that it is expedient in his interests that such treatment should be provided for him at a special school not maintained by them or another local education authority".

Primary and secondary schools (other than special schools)

147. *Maintained and other grant-aided schools.* The general statutory provisions in regard to maintained primary and secondary schools are sufficiently familiar to make any description here unnecessary. There are, in addition, a number of schools directly grant-aided by the Ministry, mostly grammar schools*. All these schools have to conform with requirements prescribed by the Minister in regulations.

148. *Independent schools.* Many maladjusted pupils are sent by local education authorities to independent schools. These are schools which are not maintained by local education authorities or in receipt of grants from the Minister† ; they are not subject to any regulations made by him‡, but are open to inspection on his behalf under Section 77 of the Education Act, 1944. Some independent schools apply for recognition by the Minister as "efficient" primary and/or secondary schools. The conditions with which independent schools have to comply in order to secure recognition as efficient are set out in a body of rules made by the Minister§. Recognition as efficient is granted on the recommendation of H.M. Inspectors of Schools. Some, but by no means all, of the independent schools used by local education authorities for the education of maladjusted pupils are recognised as efficient‖ ; this is a matter to which we shall return in Chapter X.

149. In making payment to independent schools for the education of maladjusted children, local education authorities rely in the main on their powers under Section 6 of the Education (Miscellaneous Provisions) Act, 1953. If, in the words of Section 6 (2) (*a*) (ii), the authority "are satisfied that, by reason of a shortage of places in schools maintained by them and schools maintained by other local education authorities, being schools to which pupils could be sent with reasonable convenience, education suitable to the age, ability and aptitude of the pupil cannot be provided by them for him except at a school not maintained by them or another local education authority", they must pay the full tuition fee. Where this condition does not apply, there are provisions elsewhere in the Education Acts¶ which enable an authority to assist with the fees to avoid hardship.

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* There were in December, 1954, 193 direct grant schools, of which 164 were grammar schools.

† Non-maintained special schools are not independent schools.

‡ Except the Pupils' Registration Regulations made under Section 80 of the Education Act, 1944.

§ Rules 16, the current version of which is given in full in Appendix E. A list of schools recognised as efficient is published by H.M. Stationery Office (List 70).

‖ In December, 1954, of some 4,000 independent schools 1,343 were recognised as efficient. At the same date, of the 153 schools being used by local education authorities for the education of maladjusted pupils, 63 were recognised as efficient.

¶ Section 81 of the Education Act, 1944, and the regulations made thereunder.

Home tuition

150. As will be seen in Chapter VII, a few maladjusted children are given tuition at home by a visiting teacher. Authorities have power under Section 56 of the Education Act, 1944*, to make, with the approval of the Minister, special arrangements for children to receive education otherwise than at school, if they "are satisfied that by reason of any extraordinary circumstances a child or young person is unable to attend a suitable school for the purpose of receiving primary or secondary education".

Boarding Education

151. *Boarding at school.* If the authority provide education at a boarding school, they must make no charge for the boarding if the pupil could not receive the appropriate education unless he were boarded. This is required, in the case of maintained schools, by proviso (*a*) to Section 61 (2) of the Education Act, 1944:

> "Where the board and lodging provided for the pupil are so provided under arrangements made by the local education authority on the ground that, in their opinion, education suitable to his age, ability and aptitude cannot otherwise be provided by the authority for him, the authority shall remit the whole of the fees payable under this subsection";

and, in the case of non-maintained schools (including independent schools as well as non-maintained special schools), by Section 6 (2) (*b*) of the Education (Miscellaneous Provisions) Act, 1953:

> "[the local education authority] shall, where board and lodging are provided for the pupil at the school and the authority are satisfied that education suitable to his age, ability and aptitude cannot be provided by them for him at any school unless board and lodging are also provided for him (either at school or elsewhere), pay the whole of the fees payable in respect of the board and lodging."

152. *Boarding otherwise than at school.* Under Section 50 (1) of the Education Act, 1944, as amended by the Education (Miscellaneous Provisions) Act, 1948, a local education authority have power to provide boarding accommodation otherwise than at school for any pupil requiring special educational treatment if they are satisfied "that provision for him of board and lodging is necessary for enabling him to receive the required special educational treatment". Boarding arrangements for maladjusted pupils under this section may take the form of boarding in boarding homes†, or with foster-parents. Most hostels used for maladjusted pupils are approved by the Minister under Part IV of the School Health Service and Handicapped Pupils Regulations, 1953‡; they include some run by voluntary bodies, but most are provided and maintained by local education authorities. Hostels which have been approved are inspected regularly on the Minister's behalf and must conform to the regulations. Authorities also have power to use hostels not approved by the Minister or to board children in foster-homes.

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* As amended by the First Schedule to the Education (Miscellaneous Provisions) Act, 1948.

† Or "hostels" as they are often called; in order to avoid confusion with a child's own home and with homes provided by a local authority under the Children Act, "hostels" will be used henceforward in this report.

‡ See Appendix D.

153. Where a pupil is boarded otherwise than at school, the local education authority must meet the full cost if the appropriate education could not otherwise be given him, as stipulated in proviso (*a*) to Section 52 (1) of the Education Act, 1944:—

> " Where the board and lodging provided for the pupil were so provided under arrangements made by the local education authority on the ground that in their opinion education suitable to his age ability and aptitude could not otherwise be provided by the authority for him, no sum shall be recoverable [from the parents] in respect thereof under this section."

C. The school health service

154. Under Section 48 of the Education Act, 1944, local education authorities have the duty to provide, at appropriate intervals, for the medical inspection of all pupils in schools maintained by them; and to make such arrangements for securing the provision of free medical treatment for pupils in maintained schools " as are necessary for securing that comprehensive facilities for free medical treatment are available either under [the Education] Act or otherwise ". In Part II of the School Health Service and Handicapped Pupils Regulations, 1953*, local education authorities are required to establish a school health service through which they are to perform their functions with respect to the medical examination, inspection and treatment of pupils. The regulations also provide that the authority shall appoint a Principal School Medical Officer, to be responsible to them for the efficient conduct of the school health service, and such other medical officers, nurses and other persons as may be necessary; nurses, with certain exceptions, have to possess the additional qualification of health visitor. In making their arrangements for the school health service, local education authorities are required " to have regard to other services in their area relating to health and education and [to] secure that their School Health Service is in harmony with such other services ".

155. Local education authorities have power, under Section 78 (2) of the Education Act, 1944, to extend their arrangements for medical inspection and treatment to pupils in schools not maintained by them, by agreement with the proprietor or governors of the school. Authorities also have power under Section 78 (1) to extend their arrangements to children or young persons receiving primary or secondary education " otherwise than at school " under Section 56. They have no power, however, to provide medical inspection and treatment for children or young persons who are neither at school nor receiving primary or secondary education otherwise than at school. Their power under Section 34 of the Act, to examine children medically with a view of finding out whether they need special educational treatment (to which reference has already been made in paragraphs 141 and 142 above) relates to children in their area over two years old, whether they are at school or not.

D. Child guidance

156. Child guidance is not specifically mentioned in the Education Acts of England and Wales. It will be seen from Chapter VI that the child guidance service, as we envisage it, involves a school psychological service and child guidance clinics, with the school health service co-operating closely with both. The power of local education authorities to provide a school psychological service derives from their general duty to assess the ability and aptitude of children and to provide sufficient variety of primary and secondary education, as stipulated in Section 8 of the Education Act, 1944

* See Appendix D.

(cf. paragraphs 139 and 140 above): their power to provide child guidance clinics derives from their duty, under Section 48 of the Act, to secure the provision of medical treatment and can be extended, by virtue of Section 78 (2) of the Act, to pupils not in maintained schools (cf. paragraphs 154 and 155 above).

E. Child guidance clinics under the national health service

157. In Section 1 of the National Health Service Act, 1946, it is made clear that the national health service is intended to secure improvement in people's mental as well as physical health, and the prevention of illness as well as its diagnosis and treatment. Under Section 3 it is the duty of the Minister of Health to provide, " to such extent as he considers necessary to meet all reasonable requirements ", " hospital and specialist services ", i.e. " (*a*) hospital accommodation ; (*b*) medical, nursing and other services required at or for the purposes of hospitals ; (*c*) the services of specialists ", e.g. at a hospital, health centre or clinic. From the definition of " hospital " in Section 79 (1), hospital accommodation is to be construed as including clinics and out-patient departments maintained in connection with a hospital. Under Section 12 it is made the duty of regional hospital boards " generally to administer on behalf of the Minister the hospital and specialist services provided in their area ". The child guidance clinics forming part of the national health service have to be available to children in England and Wales, irrespective of whether they are yet of an age to attend school and where they live, and the service provided has to be free of charge.

F. The powers of local health authorities

158. Local health authorities have a duty, under Section 22 (1) of the National Health Service Act, 1946, " to make arrangements for the care . . . of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority ". Local health authorities have a power, under Section 28 of the National Health Service Act, to " make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons ". Maternity and child welfare services are provided under Section 22, and the two Sections would enable local health authorities to provide child guidance for children of pre-school age and for boys and girls not at school.

Recommendation

We recommend that consideration should be given to the question whether Section 33 (2) of the Education Act, 1944, covers all forms of special educational treatment suitable for maladjusted pupils which can be combined with attendance at an ordinary school ; and that, if necessary, the law should be amended.

CHAPTER VI

CHILD GUIDANCE

(i) General considerations

159. In this chapter we consider what is in our view the principal means of attacking the problem of maladjustment in children. The term "child guidance" is frequently used in a narrow sense to describe the clinical treatment of maladjusted children, but in the broadest sense child guidance is synonymous with the whole process of nurturing and bringing up children —in fact with education itself; and in this sense both parents and teachers are constantly engaged in the process of child guidance. Our use of the term lies between these two extremes.

160. To be effective, child guidance arrangements, as we envisage them, should be designed not only to treat maladjusted children but also to prevent maladjustment arising. Mother and child interact emotionally to such an extent that, if the mother can be reassured and helped to handle her children more confidently and wisely, this may prevent troubles arising or becoming more serious which after a time would, if unremedied, lead to maladjustment.

161. The two places where children in general spend most of their time are their home and school; in one or the other, if not both, they will show their difficulties. If arrangements for child guidance are to be successful, they must:

(*a*) deal with children, not in isolation, but in and with their families;

(*b*) prevent maladjustment by dealing with minor troubles at as early a stage as possible;

(*c*) have roots in the schools;

(*d*) be closely connected with the school health service and other health services; and

(*e*) inspire confidence in parents, teachers and other adults in contact with children.

162. In our view, these conditions can best be met where there is a school psychological service working in association with a child guidance clinic or clinics, and where the school health service co-operates closely with both. Local education authorities have a statutory duty to provide this latter service, but not all authorities operate a school psychological service or child guidance clinics.

163. A school psychological service performs many functions which are not directly concerned with maladjusted children; it is primarily non-medical, and responsibility to the local education authority for its general functioning naturally rests with the Chief Education Officer. Child guidance clinics may be provided either by the regional hospital board or by the local education authority*. Those provided by the local education authority, like other types of clinic, form part of the school health service, and responsibility to the authority for their general functioning naturally rests with the Principal School Medical Officer.

164. Although, for the reasons given in the preceding paragraph, these various components do not form a single administrative unit and may even be provided by separate bodies, their closest co-operation is essential and there

* See Chapter V, paras. 156 and 157.

should normally be some sharing of staff between them. Where these conditions are fulfilled, these components form a comprehensive child guidance service. We recommend that such a service should be available for the area of every local education authority.

165. In the remainder of this chapter we first discuss the functions of the school psychological service, the school health service and the child guidance clinic in relation to the child guidance service ; and in the concluding section we consider the pattern of provision most likely to ensure that the child guidance service is fully effective and the work of its components completely integrated.

(ii) The school psychological service

166. Many of the functions of the school psychological service which are not directly concerned with maladjusted children stem from the duty imposed on local education authorities under the Education Act of 1944 to assess the abilities and aptitudes of the children for whom they have to provide education, and to ensure that, throughout their school career, the education provided continues to meet their needs. Educational psychologists in a school psychological service may, for example, be asked to advise on the way in which children should be allocated at the age of 11+ to the various types of secondary school, and may be asked to give vocational guidance when children are about to leave school. They may organise remedial classes for backward children or carry out research into educational problems, such as the incidence of reading difficulties ; they may test the capacities and advise on the educational needs of handicapped children, e.g. the educationally sub-normal and those with defects of sight or hearing or other physical handicaps. The existing school psychological services have grown up in different ways, often with an emphasis either on work with individual children or on work with groups. Few services carry out all the functions named, but all perform some of them—and doubtless others which have not been referred to here. By what staff and means and under whose direction these functions should be carried out is not our concern. We have mentioned them only in order to indicate the scope of the work which may fall to a school psychological service.

167. The work of the school psychological service with which we are particularly concerned falls roughly into three divisions. First, the educational psychologist is called upon to give advice on individual children with learning difficulties ; behind these often lies an emotional trouble. Secondly, individual children are referred because their behaviour is causing annoyance or anxiety in ways which baffle teachers. For example, they may be truants for no obvious reason, they may be cruel to younger children, or they may be so nervous and timid that it interferes with their happiness and development. Teachers may refer children whose behaviour at home parents have come to discuss with them ; or parents may come to the school themselves to consult the psychologist. Thirdly, the psychologist gives talks to parents, teachers and others concerned with the care of children on subjects such as normal development, the management of children and their behaviour problems. The general object of these talks is to help those concerned to understand children better, and to distinguish between the minor difficulties which are incidental to growth and those for which outside help may be needed.

168. The psychologist working in conjunction with the teachers can help many children in the context of their school. If a child is helped to overcome a learning difficulty, such as inability to read, about which he is sensitive, the resulting access of satisfaction and self-confidence may cause his emotional troubles to disappear. In seeing children with learning or behaviour difficulties, however, the psychologist must know the limitations

of what he can do unaided and the contribution which each of the other members of the child guidance team can make. The only satisfactory way of securing this is for the psychologist to work part-time in the child guidance clinic as a member of the clinic team.

169. It is important that troubles which require investigation by the whole team should be recognised and that children who need to be dealt with at the clinic should be referred there as soon as possible. Discussion has sometimes ranged round the question whether it is right for somebody who is not medically qualified to select children for reference to a clinic. If the child guidance service is a broadly-based and comprehensive service such as we recommend, this question should not need to be asked or answered. Everybody who has contact with children—not least the parents—inevitably carries out some child guidance in the wider sense and some selection; and, if the dual rôle of the educational psychologist in schools and clinics is accepted, we can see no objection to his taking the responsibility for deciding for many of the children whose troubles come to light in and through schools whether they need to be investigated by the whole clinic team.

170. School psychological services organised in the way recommended can, in addition to treating a number of learning and other difficulties on the spot, help to improve the ability of parents and teachers themselves to handle the minor troubles of children and to prevent them developing into maladjustment. In these ways a school psychological service should in course of time reduce the number of children referred for investigation by the whole child guidance team, and should also ensure that those who do require this are referred without delay.

(iii) **The school health service**

171. It has always been a fundamental part of the duties of the school health service to care for the emotional as well as the physical well-being of children. In its early days the service had to concentrate mainly on physical defects, but as the physical health of children has improved school medical officers and school nurses have been able to devote more attention to emotional and behaviour difficulties.

172. School medical officers do not visit schools solely for the purpose of conducting the statutory general medical inspections*. In urban areas at least they can usually pay frequent visits to schools to see and discuss with the teachers and school nurses any children whose physical or mental health is causing concern. School nurses are often health visitors as well and so have an intimate knowledge of the family circumstances of many children. The school medical officer also holds consultation clinics, to which he or other school doctors, or school nurses, teachers or parents can refer children for investigation. At these clinics he has to decide, with the aid of any information emanating from the school or the parents, whether he can deal satisfactorily with the children there or whether they require to be sent to a child guidance clinic.

173. There is no doubt that the staff of the school health service can, like the school psychological service, do much to lessen the number of children who have to be referred to child guidance clinics, and to ensure that those who require this are referred as early as possible. The staff of both services work in the schools in association with the teachers, and they can achieve much more for maladjusted children and their parents by working together than in isolation.

* More will be said about the system of periodic and special inspections in Chapter XVI, where we discuss the preventive work of the school health service.

(iv) **The child guidance clinic***

Powers of the local education authority and of the regional hospital board

174. In our account in Chapter V of the statutory basis for the provision of child guidance, we showed that neither local education authorities nor regional hospital boards have an explicit duty to provide clinics or even to see that clinics are provided. The general duties however laid on regional hospital boards, acting for the Minister of Health, and upon local education authorities are such as to imply that they both have an obligation to arrange for the provision of a clinic service in their area, and the hospital boards must see that the service is available to all children irrespective of age and type of school attended.

175. In these circumstances, it would not be in the interests of the children, nor conducive to efficiency or economy, for either the local education authority or the regional hospital board to plan its child guidance arrangements in isolation. Whether a child guidance clinic in a particular area is provided by the local education authority or the regional hospital board, it should have close links both with the education service and with various branches of the health service—more especially if it is the only clinic serving the area. Otherwise, it is likely that a number of children who need help by a child guidance team will never find their way to the clinic. In an area served by a clinic which had few links with the education service, many children who might have been discovered through teachers and the school psychological service would not be referred: in an area where links with the health service were inadequate, children would be missed who might have been referred by child welfare centres, family doctors or hospitals.

176. Irrespective of whether a child guidance clinic is provided by a local education authority or a regional hospital board, it should be available to all boys and girls, including children under five and pupils at independent schools†. It is desirable that up to the age of 18 young people who have left school should have access to child guidance clinics if there is no more suitable service providing the help they need‡.

177. As we have already mentioned in Chapter V, paragraph 158, the powers of local health authorities are sufficient to enable them to provide child guidance for children under five and for young people no longer at school. It is possible for an authority in its capacity as local health authority to arrange for the use of child guidance clinics provided in its capacity as local education authority; this is already a common practice in relation to other types of clinic forming part of the school health service. There is, however, some doubt whether the powers of local education authorities to treat children attending independent schools and other schools not maintained by a local education authority are sufficiently comprehensive or flexible. Their powers can only be exercised if arrangements have been made between the authority and the proprietor or governors of the school§, which may make it difficult for parents to take their children direct to a child guidance clinic. We hope that further attention will be given to this point when the question of amending the law is considered.

178. In making our suggestions and recommendations in the following paragraphs, we are thinking primarily of child guidance clinics provided

* For the benefit of those unfamiliar, even at second hand, with the workings of a child guidance clinic, we have included a brief description in Appendix F.

† Child guidance clinics in children's hospitals may, of course, be bound by the age limits applying to the hospital.

‡ We shall say more about this in Chapter XI, para. 344.

§ See Chapter V, para. 155.

by local education authorities, since our terms of reference do not extend to clinics outside the education service. But similar considerations would apply in any area where the clinics in the child guidance service were provided by the regional hospital board.

The clinic team

179. The requirements mentioned in paragraph 175 can be adequately met if a clinic is staffed by the usual threefold team of psychiatrist, educational psychologist and psychiatric social worker, working under the clinical direction of the psychiatrist. The psychiatrist himself usually only works part-time in the child guidance clinic, and spends the remainder of his time in the hospital service or in private practice or both. He is thus the main link between the clinic and the hospital and general practitioner services in the area.

180. The educational psychologist should be the clinic's main link with the schools and the teachers. As we have already mentioned in paragraph 168, he should work part-time in the clinic and part-time in the school psychological service. Wherever possible a child should be seen in the clinic by the psychologist who is familiar, through the school psychological service, with the school from which the child comes.

181. The psychiatric social worker should deal, as necessary, with the parents both of the children being treated at the clinic, under the direction of the psychiatrist, and of those receiving special help in the schools, on the advice of the psychologist. It is assumed that all three members of the clinic team will be in close touch, through the Principal School Medical Officer and (where he is not the same individual) the Medical Officer of Health, with the school health and child welfare services.

182. In addition to workers from the three professions which form the basis of the child guidance clinic team and in addition to the help to be obtained from school medical officers, there are others who may be usefully associated with the team in its work. We have in mind particularly the following:

(a) *Consultant paediatrician.* The paediatrician's special contribution to the work of the clinic is to provide an additional safeguard against the risk of making a false diagnosis of a child's trouble through overlooking some physical factor; and it is essential that a paediatrician should be available for consultation by the school medical officer or psychiatrist. In some areas there will be no hospital near with a paediatrician on the staff or, if there is, he may not be able to visit the clinic regularly, but there should always be a working arrangement with a paediatrician for consultation when needed.

(b) *Non-medical child psychotherapist.* Some psychiatrists prefer to give all their treatment themselves, but others are willing to delegate this to a child psychotherapist. A psychotherapist should work only under the direction of a psychiatrist and should not be appointed to a clinic unless the psychiatrist there wishes to work with one. It is very important for child psychotherapists to have suitable training; three training courses are in existence in this country, and we understand that the Association of Child Psychotherapists (non-medical), which at present has about 40 members, is giving close attention to training.

(c) *Speech therapist.* Stammering and other defects of speech are listed under habit disorders in the grouping of symptoms given in Appendix B. It was also stated in Chapter IV, paragraph 95, that speech

defects might be either the cause or the effect of maladjustment, and that it was often hard to determine which they were. From this the importance of having a speech therapist available can readily be seen. Many local education authorities employ one or more in their school health service, so that this should usually not be difficult to arrange; indeed, it is the policy in a few areas that a speech therapist should work in the same premises as a child guidance clinic.

There should also be a working arrangement with a hospital for the use of specialist services, such as X-rays and electro-encephalography.

183. It is essential that the professional staff in a clinic should have adequate secretarial and clerical assistance. There should be a secretary who is competent to handle the office routine of the clinic, and who has the right personality to enable her to act as receptionist to parents and other visitors to it. Often there has been little or no clerical or secretarial assistance or it has been of poor quality, with the result that psychiatric social workers have had to carry out the bulk of the clerical and secretarial work. In view of the careful way in which they are selected and the elaborate nature of their specialised training, this represents a waste of skilled man-power which could not be justified even if there were not a serious shortage of psychiatric social workers.

Numbers and time-ratio of staff

184. In the past ½:1:2 was frequently taken as the ratio for the time of psychiatrists, educational psychologists and psychiatric social workers required*, and this ratio is still often recommended. This seems to be a suitable ratio for work in clinics where only a minority of the cases seen are given prolonged treatment. Where the aim is to provide prolonged treatment for those who need it, including some of the parents, the ratio may need to be altered to 1:1:2, with a non-medical child psychotherapist coming part-time as an alternative to having a psychiatrist full-time instead of half-time†. Since in the next few years an increase is likely in the proportion of children seen who are given treatment and in the average time devoted to the treatment of each child, it seems prudent to take 1:1:2 rather than ½:1:2 as a general guide. Where analytical methods are used in treatment, a further increase will be necessary in the time given by the psychiatrist.

185. A ratio of 1:1:2, however, makes no allowance for the work which the child guidance service does in the schools. Experience in a county area, which has a school psychological service working closely with child guidance clinics, suggests that for a child guidance team with one full-time psychiatrist two educational psychologists are needed, each of the latter working roughly half-time in the clinic and half-time on the work of the child guidance service in the schools. The psychiatric social workers will also probably visit the parents of some of the children about whom the educational psychologists are consulted in the schools (see para. 181 above), and will give talks and run discussion groups for parents and teachers. For this additional work another psychiatric social worker will be required; all three psychiatric social workers should preferably share their time between clinic, schools and homes. Accordingly, for the work of a child guidance team in which the

* This ratio is based on a type of clinic which was usual in the pre-war period, where there was a full-time psychiatric social worker, a half-time psychologist and a psychiatrist working on a sessional basis for roughly one quarter of his time.

† Different approaches to treatment are discussed in the next section, paras. 187–191.

educational psychologists and other members of the basic team work part-time in the school psychological service, we recommend a ratio of 1:2:3 for the psychiatrists, educational psychologists and psychiatric social workers required.

186. A ratio of 1:2:3 should cover the essential child guidance work of the clinic and the school psychological service, but it might need to be altered if some of the desirable work could be fitted in which often cannot at present even be attempted. We are in particular thinking of more thorough treatment of parents and the training of intending child guidance workers. Practical experience of work in a clinic is an essential part of training; we shall return to this subject in Chapter XIV, in which we deal with the supply and training of child guidance workers. In addition, it is desirable that clinics should have the staff to enable them to follow up their cases and carry out research into the efficacy of different methods of treatment.

Policy over providing treatment

187. Before treatment of any kind can be given to a maladjusted child, his trouble has to be investigated and diagnosed. This is likely to involve both the educational psychologist and the psychiatrist seeing the child, and the psychiatric social worker visiting the home or seeing one or both parents at the clinic*. After investigation and diagnosis, there are a number of possible approaches to treatment. At one extreme, the clinic provides all the treatment a child needs, however complicated and prolonged: at the other, the clinic offers the parents reassurance and simple advice about how to deal with his trouble.

188. The advantages of the first approach are clear. It gives parents and authorities the confidence that, whatever emotional or psychological trouble a child is found to suffer from, the clinic will provide all the treatment needed or will recommend where it should be obtained; in other words the clinic will "see them through". This approach also ensures that no time spent on investigation is wasted, since it will always be possible to provide the treatment found to be needed. Sometimes, of course, no treatment of any kind or treatment only for a short period is required. Nevertheless, the fact has to be faced that some maladjusted children require lengthy, complicated and time-consuming treatment; a large number of visits to the clinic may be necessary before there is much impact on a child. In consequence, the number of children who can under this system receive any attention from the clinic is very restricted.

189. The most obvious advantage of the second approach is that many more children can be seen. This approach also has other advantages. Investigation, diagnosis and an interview with the parents are themselves part of treatment. It is remarkable how some children, after the preliminary diagnosis and interview with parents have taken place, get over their difficulties while awaiting treatment. The idea of giving parents reassurance and advice about how to deal with their child's trouble is also consistent with a fundamental principle which underlies all child guidance. The clinic's function is not to take responsibility for their child away from the parents, but to help them to cope better with him. Where treatment is given, the object is not to cure the child's trouble in the sense that treatment is given to cure a child of pneumonia; it is rather to help him and his parents to cure themselves through gaining renewed confidence and an understanding of the reasons why they and the people round them behave as they do.

190. Both these approaches can be found among existing clinics, and many intermediate variations. For example, a clinic may provide for all the children in attendance who need it a course of treatment of limited duration; or it

* See Appendix F.

may select for treatment a number of the children most likely to benefit, and devote the rest of its time to a service with a quick turn-over for investigation and diagnosis followed by an interview with the parents. There is room for plenty of experiment; and as it becomes easier to devote time to following up cases, it should be possible, from a comparison between the results of the various methods, to draw important conclusions about the lines on which child guidance can most fruitfully develop.

191. Whatever the method of approach, there are two points of particular importance. In the first place, in an area where there is only one clinic and a long waiting list, it would be unwise to limit the number of children seen to those for whom it would be possible to provide all the treatment found to be needed. In the second place, whatever approach is adopted in a clinic, the staff should be clear about the objectives and should not take on more work than they can do well. Many clinics are under constant pressure to take on more work, and they must resist this if it would mean sacrificing their standards.

Case-load

192. One of the bodies giving written evidence quoted 300 new cases as the number which it was accepted that a full-time clinic with one full-time psychiatrist and full complementary staff could deal with in a year. At the same time, two of their representatives in giving oral evidence admitted that many people considered this figure to be too optimistic; and it seems likely that 300 is the largest number of new cases which can be taken on in a year, even where only a minority receive prolonged treatment*. Where the number seen is restricted to those who can be given prolonged treatment if it is needed, the yearly total of new cases will naturally be very much less.

Premises and equipment

193. A clinic needs to be adequately housed; if it is in poor or makeshift premises, it puts off parents and is tiring and distracting for the staff. It is also important for parents that a clinic should be easily accessible, preferably on a bus route. There is no reason why a new building should be needed. Indeed in some ways an old house makes a better setting, as it is easier to create there a friendly atmosphere, and it is often an advantage for a child guidance clinic to strike a different note from the other kinds of clinic and hospital departments which children may have attended previously. The headquarters of the school psychological service may be associated with the central clinic in an area, but use of rooms for more than one purpose is to be avoided, and even the sharing of the building with another service must be done with circumspection: for example, it should cause no difficulty if a speech therapist works in the same premises†, but it might, for different reasons, be inconvenient to have there either a dental clinic or work connected with mental deficiency. On the other hand, there is much to be said for proximity to other services; and in an area where the idea of a child guidance clinic is still unfamiliar, a clinic would be accepted more readily if it were situated close to a known institution such as a child welfare centre or a school clinic.

194. The number of consulting rooms required and the size of rooms generally will depend on the ideas of the people using them. There should be sufficient accommodation to make it possible for every member of the

* One London clinic (not provided by a local education authority) with a full-time psychiatrist sees 450 new cases a year; in making our estimate, however, we have assumed that many of the simpler cases at present referred to clinics will have been dealt with in the schools by the school psychological service.

† cf. para. 182 (*c*).

clinic staff, full- or part-time, to work undisturbed and have his possessions about him in safety. Other needs to be remembered are: a waiting room with space for children to play under their parents' eye; two playrooms, one with water laid on and suitable for messy play; a work office, where copy-typing and other noisy work can be done, separate from the reception office; and storage space for records.

195. All rooms into which children or parents will come should be as comfortable and homely as possible. The room of every psychiatrist, educational psychologist and, where one is employed, child psychotherapist, should be provided with the kind of furniture, including a kindergarten table and chairs, which will enable children to feel at home, especially small children. Adequate testing materials are needed for assessing a child's abilities, attainments and personality, with books and other equipment necessary for remedial education. A wide variety of materials for play are required: usually these include stuffed and miniature toys, bricks, plasticine, drawing and painting materials, and sand trays. A full range should be supplied of the equipment needed to run an office efficiently, including filing and card index cabinets.

Access to clinics

196. Maladjustment in children may come to light in a variety of ways—a matter which we shall discuss in more detail in Chapter XVI, in which we deal with the discovery as well as the prevention of maladjustment, A variety of people may therefore be instrumental in bringing children to a child guidance clinic, such as health visitors, teachers, family doctors or social workers, in addition to educational psychologists and the staff of the school health service whose rôle has been discussed earlier in this chapter. Probably the majority of children who reach the clinic will have been sent there on expert advice.

197. We regard it as of fundamental importance, however, that parents should themselves have direct access to the clinic, without their children having first been seen and recommended by some intermediary. A child guidance clinic depends for its successful working on the co-operation and confidence of parents; and it must therefore be something to which parents can feel that they have access, not something which seems remote, alien and occult. We are glad to know that most clinics do offer parents the right of direct access.

Problem case conferences

198. In passing, we should mention a special system which has grown up in London and which has attracted considerable attention. In the London County Council's area cases are usually reviewed by problem case conferences before they are sent by the authority to a child guidance clinic. The first clinics in London were established by voluntary hospitals and other private organisations, and these conferences were set up primarily to control the expenditure incurred by the Council in paying for the treatment of school children at the various clinics; payment was made only if the child had been recommended for treatment by a case conference. The establishment of the national health service in 1948 removed this reason for the existence of the conferences, but they have remained in being because they are thought to be of value for the collection of information about difficult children and for advising the authority about their treatment. Conferences are held once, or sometimes twice, a month in each of the nine divisions of the London area and are attended by officers representing the divisional education, medical and care services and sometimes by other experts.

199. We do not recommend that the system should be introduced in other areas. To bring together at regular intervals a large number of people to discuss the case-papers of children, who will not be known personally to many of those present, seems to us a procedure that ordinarily would be both cumbersome and likely to lead to delay in providing the treatment required. At the same time, we appreciate the fact that in London the problem case conferences reflect the pioneer work done there by voluntary care workers and clinics; and we do not wish to disparage a system which has been found useful in the special circumstances of London, even if we do not suggest that it should be adopted elsewhere.

(v) **Patterns of provision**

200. A pattern of provision has developed in a number of areas since the inception of the national health service which seems most likely to lead to the fulfilment of the various conditions which we have set out in this chapter as essential to a satisfactory child guidance service. We should therefore like to recommend this pattern for favourable consideration. Under it, the local education authority provide the clinic, and employ the educational psychologists (who also work in the school psychological service) and the psychiatric social workers, while the regional hospital board provide and pay for the psychiatrist. It is important, in the case of arrangements of this kind, that there should be full consultation between the regional hospital board and the local education authority about appointments to the clinic staff by either party.

201. Where this particular pattern is not followed, other arrangements need to be made for securing proper co-operation. If the psychiatrist is employed (as he may be) by the local education authority in their school health service, it is important that he should establish and maintain contact with the hospital and general practitioner services, and with the local authority's other health services. If, on the other hand, the clinic is provided by the hospital service, it is obviously desirable that the psychologist should have contact with the schools, possibly by being employed part-time by the local education authority in the school psychological service.

202. There are some children (though they are comparatively few) who cannot be treated in any clinic, whether one provided by the local education authority or a hospital board. Children who are psychotic or severely disturbed in other ways require investigation and treatment for a period in an establishment outside the educational system, possible in a children's department or unit attached to a hospital. We shall say a little more about the needs of these children in Chapter X (paragraph 322).

203. We understand that in Circular 179*, which was issued in 1948, it was the intention of the Ministry of Education to distinguish these children

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* "The School Health Service and Handicapped Pupils: Effect of the Establishment of the National Health Service". Part of this reads:—

"*Child Guidance*

18. Child Guidance work of the type at present undertaken by Local Education Authorities is in the main an educational service closely linked with the school and home. Thus the needs of most of the children who are maladjusted, whether to a degree which calls for their ascertainment as handicapped pupils or to a lesser degree, can be met by social and educational adjustments. Much of the work is carried out at the schools in co-operation with the parents and teachers by the educational psychologists and specially qualified social workers appointed by Authorities. The educational, physical and psychiatric aspects of the work are, however, inseparable and at the Child Guidance Centres established by Authorities the team of workers includes a psychiatrist and also, as a rule, a paediatrician. Some of the children may be found to need psychiatric treatment; the Minister, in agreement with the Minister of Health, considers that these children should normally be referred by the Authority to the clinics which will be provided in due course by the Regional Hospital Boards and which in some instances are already available; similarly, these clinics will refer appropriate cases to the Child Guidance Centres."

from others who require to attend a child guidance clinic. Unfortunately, although the Circular emphasised that the educational, physical and psychiatric aspects of the work were inseparable, it caused confusion by proposing that any children needing psychiatric treatment should normally be referred from local education authorities' clinics to hospital board clinics. The impression was given that the establishment everywhere of two separate sets of clinics was advocated, each type having a different bias and referring some children to the other. Whether or not this was intended, the clinic service in this country has not in fact developed along these lines since 1948 and, for the reasons already given, it is not the pattern we recommend for the future.

Recommendations

We recommend that

(1) there should be a comprehensive child guidance service available for the area of every local education authority, involving a school psychological service, the school health service and child guidance clinic(s), all of which should work in close co-operation.

(2) the educational psychologist in the school psychological service should, when possible, try to help within the setting of their school individual children who have learning or behaviour difficulties; when this is not possible, he should refer children without delay to the clinic for investigation by the whole team.

(3) the educational psychologist in the child guidance service should work part-time in the child guidance clinic and part-time in the school psychological service, and should be the main link between the schools and the clinic.

(4) local education authorities and regional hospital boards should plan their provision of child guidance clinics in consultation.

(5) all child guidance clinics, whether provided by local education authorities or regional hospital boards, should have close links with both the education and health services.

(6) all child guidance clinics, whether provided by local education authorities or by regional hospital boards, should normally be open to all boys and girls in the area up to the age of 18, whether they are at school or not; and the law should, if necessary, be amended to allow direct access to clinics for children attending schools not maintained by a local education authority.

(7) the basic child guidance team, consisting of a psychiatrist, educational psychologist(s) and psychiatric social worker(s), should be able to call on a consultant paediatrician and other workers and specialist services as required.

(8) the staffing of a child guidance service should provide for adequate secretarial and clerical assistance.

(9) a reasonable ratio between psychiatrists, educational psychologists and psychiatric social workers in a team working in a child guidance service is 1:2:3.

(10) all clinics should have a clear policy over treatment.

(11) all clinics should have premises which are suitable and easily reached.

(12) parents should have direct access to clinics.

(13) the pattern of provision most likely to lead to an effective and well-integrated child guidance service is for the local education authority to provide the clinic and to employ the educational psychologist(s) and psychiatric social worker(s), and for the regional hospital board to provide and pay for the psychiatrist.

(14) where the services of the psychiatrist are provided by the regional hospital board and the local education authority employ the rest of the clinic staff, there should be full consultation between the two employing bodies about appointments to the clinic staff by either of them.

(15) paragraph 18 of Ministry of Education Circular 179 should be withdrawn.

CHAPTER VII

DAY SPECIAL SCHOOLS AND CLASSES

204. The child guidance service, which we have discussed in the last chapter, can treat most maladjusted children referred to it without the necessity of removing them from their normal environment of school or home. We now turn to other types of treatment within the educational system which entail a change of environment—whether of school, of home or of both. We consider the various forms of day treatment in this chapter, and of residential treatment in Chapters VIII-X.

205. At present there are day special schools or classes* specifically for maladjusted children in the areas of only three local education authorities. Elsewhere, some maladjusted children have been sent to day open-air schools†, some have been placed in special classes for retarded children and a few have been given home tuition, but over the country as a whole little day provision has been made. This suggests that few people have so far been convinced that there is a place for any form of treatment short of removal from home, once the stage has been reached when clinic treatment by itself is insufficient.

206. There are obvious advantages in leaving a child in his own home during treatment. One consideration is that it costs far less; and there are other no less practical advantages. Since the restoration of harmony and understanding between parents and children must be one of the main purposes of treatment, it is most satisfactory to treat a child, if possible, while he remains in the natural environment of his own home. Treatment of him and of his parents can then go hand in hand; and there is no danger of a conflict being set up in his mind between the different standards of two environments. The co-operation of parents may be much easier to secure if their child can stay at home than if he is sent to a boarding establishment. Boarding is not part of the traditions of a large section of the population: indeed some regard a boarding establishment as a place to which children are sent only if they are mentally defective or have committed some crime.

207. We were told in evidence that day special schools and classes can help many maladjusted children who are making no progress in their ordinary schools or who are manifesting behaviour difficulties there or at home. Most maladjusted children fail to do justice to their abilities, and consequently may suffer from intense frustration in their school work. As the London County Council said in giving evidence about their special classes, "if this frustration can be removed by giving the children a feeling of progress in mastering the three R.s, the resultant satisfaction and release may flow over and help to overcome their more fundamental troubles."

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* The meaning of the term "special school" was explained in Chapter V, paragraph 144. The term "special class" has no statutory definition: a special class may be part of an ordinary primary or secondary school or it may be unattached to any school, as in the case of the London day classes for maladjusted children which we describe in paragraphs 214–220. Whereas a special school requires the Minister's specific approval, special classes do not.

† i.e. special schools for delicate children. Delicate children are defined in Regulation 14 (*j*) of the School Health Service and Handicapped Pupils Regulations, 1953—see Appendix D.

208. It is, however, not easy to help these children to make progress. Not only is the quality of their work usually poor, but interest in it and the urge to learn have been lost, if they ever existed. The teacher's prime function in a day special school or class is not to teach but to help each child to release the emotional tension which prevents him from learning. He has to create an atmosphere in the classroom, based on a personal relationship between teacher and child, in which the child's interest is awakened and he is encouraged to learn by gaining a sense of achievement. A different approach may be needed for every child and, when children are ready to learn, different methods of teaching basic skills such as reading.

209. A special school or class for maladjusted children has a wider therapeutic purpose than to help children progress with their school work, important though that is. It provides treatment, usually in co-operation with a child guidance clinic, with the object of helping the child to become more adjusted and of restoring his family relationships. At the start it is essential that a child should feel safe to express his maladjustment and should know the bounds within which he can do this; as he gains a greater sense of security and develops fresh interests, the need for this expression will disappear. In the classroom this means that odd or aggressive behaviour must be tolerated in the early stages: for example, a child may sing continually or sit on a cupboard, or may throw things about.

210. The teacher requires great skill to allow children initial scope to express their maladjustment without disturbing the rest of the class too much or disorganising their work; to know when more orthodox or restrained behaviour can be demanded of each child; and to know when each is ready to start learning. He cannot foresee the course which any lesson will take; he must always be ready to change what has been planned or to take the children outside for a break in order to allow tension to disperse.

211. In dealing with a child teachers have to bear in mind his home background. They regard it as a normal obligation to keep in touch with parents, to give them support and to help them to a better understanding of their children's needs. One witness remarked that often the teacher of a special class was the first person from the educational world to go into a child's home and make the parents feel that, with them, he was on the child's side.

212. Even if it is conceded that to stay at home is a great advantage and that a day special school or class can often help a maladjusted child who cannot get on in an ordinary school, it is sometimes argued that where a child's home is unsatisfactory there is no alternative to treatment away from it. Where a child appears to be deeply and permanently rejected by his parents, there may be no alternative to treating him away from home; but there are many unsatisfactory homes where the children are not rejected and where parents have real affection for them. We shall consider in the next chapter what kind of circumstances justify boarding: we are concerned here to emphasise that some maladjusted children with unsatisfactory homes can be treated successfully through day classes and schools.

213. The possible forms of special day provision appear to be as follows:

(*a*) Part-time special classes
(*b*) Full-time special classes } for maladjusted pupils.
(*c*) Day special schools
(*d*) Home tuition.
(*e*) Special classes for backward pupils.
(*f*) Day open-air schools.
(*g*) Independent day schools.

(a) *Part-time special classes for maladjusted pupils*

214. So far only the London County Council have provided part-time day classes for maladjusted pupils, and the description which follows is based on evidence from the L.C.C. or from teachers in charge of special classes. The particular feature of these classes, which at present number 17, is that the child stays on the roll of his ordinary school and only leaves it to attend the class for a number of half-days a week. Admission of a child to a class, alteration in the number of sessions he spends there and his return to a full-time attendance at his ordinary school can thus all very easily be arranged. The classes are held on four days a week only ; this leaves the teacher one day free for visiting the homes of the children, the ordinary schools from which they come, child guidance clinics and other agencies.

215. Children reach classes through the problem case conferences*, which have child guidance and other reports to assist them. The majority of children in the classes are of low average ability, but little difficulty has been experienced in fitting in children a little above or below this level.

216. Most children attend for between two and five half-day sessions per week. It is often desirable to try to avoid taking older pupils from their ordinary schools for periods when practical work, physical education and games are on the time-table. If a child has developed a strong aversion to attendance at an ordinary school he may at the beginning go to the class for all the days it operates ; contrary to what might be expected, habitual truants have benefited from attending a part-time class. The groups are as small as can be arranged without focussing too much attention on the individual child ; from 4 to 6 children has been found to be the best size. The number of children attending a class in a week is ordinarily between 14 and 22.

217. Where possible the teacher has a free hand in making up groups. An important factor is the personalities of the children ; a mixture of aggressive and quieter children is usually arranged. It is occasionally useful to have a group consisting entirely of boys or girls, but otherwise children of different ages and sexes can be satisfactorily combined. The length of time which children require to attend a class may be anything from three months to three years.

218. It has often been found better to have the premises of a class quite separate from a school, since school may have unhappy associations for many maladjusted children, and since an independent class run on free lines is not likely to fit in with the routine of an ordinary school unless the head is able to make special arrangements. Sometimes it has been possible to find rooms in a building used for social work of some kind or in a large private house. Whatever premises are obtained, experience shows that they should be conveniently placed for the contributory schools, that it should be possible to create a friendly atmosphere and that the rooms should not be used for any other purpose ; it helps to give maladjusted children a feeling of security to know that the room they work in is theirs, and that they can leave about their belongings and work material without risk of losing them. Storage space for a wide variety of apparatus is needed. Where they can be provided, a small space for play outside and an extra room are of great value ; one room can then be set aside for simple art and craftwork and messy play.

219. We were told that in London about one quarter of the children attending part-time classes were also visiting a child guidance clinic regularly for treatment, and nearly half were going for an occasional interview. It might be thought that children would be upset by having to divide their time between the clinic, their school and the special class, but a witness from the London

* See Chapter VI, paragraph 198.

County Council said that this effect had not been noticed. The closest co-operation has, of course, to be maintained between the clinic, the teacher in charge of the class and the child's ordinary school, so that each knows what the others are trying to do ; in this way it is easier to ensure that the treatment which the child receives is consistent.

220. It might be thought preferable for a teacher in charge of a special class to serve under a head teacher. The work however demands a high degree of initiative and resourcefulness, and the independence which the teachers of London's classes enjoy is a powerful means of attracting to the work teachers with the right qualities. When a teacher requires advice or guidance, she can obtain it from the authority's educational psychologist or from members of the staff of a child guidance clinic.

221. We have been much impressed by the evidence of what part-time classes can achieve through treating children in very small groups in an atmosphere completely different from that of their ordinary school, while at the same time keeping them members of it ; and through giving support and help to parents. There are clearly difficulties to be overcome in fitting any part-time classes into the educational system of an area, and we should not expect that other authorities which decide to set up classes will necessarily find the pattern worked out by London the most appropriate to their needs and circumstances. In one respect, a difference is inevitable, since the system of problem case conferences exists only in London ; a suitable arrangement might be for decisions about admission and discharge to be made on the recommendation of the child guidance service and in close consultation with the teacher in charge of the class and the head-teacher of the child's ordinary school. Authorities may also wish to experiment with extensions of the work: it has, for example, been suggested to us that class premises might be used on some evenings for club work with the children and their parents.

222. It seems important, however, to retain certain features. As we shall see later, a group in a day special school should ordinarily not consist of more than ten children. In a special class which children attend part-time, it is difficult for the teacher to find out the best way to help each child and establish a good personal relationship with him unless the number in a class is considerably less than ten. The teacher of a special class should be allowed as much freedom as possible in running his class and plenty of time for visiting.

(b) *Full-time special classes for maladjusted pupils*

223. Full-time special classes are used with success in the treatment of children suffering from certain other handicaps, but we have no record of any having been set up for maladjusted children. A full-time class would necessarily be part of an ordinary school, so that it would not have some of the features which make part-time classes and day special schools so successful in dealing with many maladjusted children. Without experience of full-time classes for such children it is impossible to say whether they are likely to be a success ; and we hope that they will be tried where conditions seem suitable.

(c) *Day special schools*

224. The three existing day special schools for maladjusted children in Leicester, Oxford and London have grown up in different ways. Leicester's school began as an experimental school which was opened in 1932 for children of good intelligence who were below standard in school work or who were misfits in other ways. Of recent years few children have been taken merely because they were behind in their work, though almost all the children are retarded as well as having behaviour difficulties or showing other signs

of maladjustment. Admission, we were told, is usually limited to children, with I.Q.s of not less than 90, and the average length of stay is two years. The Oxford school developed from "observational" classes established in 1930 for children presenting difficulties of behaviour. It was recognised as a separate school in 1939, and during the war other types of maladjusted children came to be admitted as well. The school is now housed in the same premises as the authority's child guidance clinic. Finally, London opened the Lilian Baylis School in Southwark in January, 1954. We understand that one of the reasons which led the London County Council to make this provision, in addition to their part-time day special classes, was that teachers of these classes sometimes expressed a wish that certain children could come to their class for a bigger proportion of their time; it was also desired to provide for those children whose behaviour difficulties make it necessary for them to be completely detached for a time from their ordinary school, though they do not need to leave home.

225. We have been impressed by the evidence of the success of the two older day special schools, and there is no reason to doubt that the London school will be equally successful. As might be expected, there are differences between the three schools, e.g. in size (ranging from 45 to 70), in the proportion of pupils attending a child guidance clinic and in the ways in which work with parents is carried out*.

226. Other authorities which decide to establish day schools will doubtless introduce new features not to be found in the three existing schools. There is plenty of scope for experiment in this field, but there seem to us to be certain basic requirements which will need to be observed. These are:—

(i) children should be admitted or discharged on the recommendation of the child guidance service and in consultation with the head of the school;

(ii) adequate arrangements need to be made for keeping in close touch with the parents;

(iii) the size of the school should fall within certain limits, which are discussed in the two following paragraphs;

(iv) groups of children should be fairly small and the school needs to be generously staffed (see paragraph 229).

227. A day school for maladjusted children needs to be large enough to allow of variety of aptitude and personality among the staff. It is an important contributory factor to a child's readjustment that he should find an adult to whom he takes a liking. It is also important that he should find an activity which he can enjoy; the staff, between them, must be able to cover a wide range of activities—such as craftwork, art, music, physical education and gardening—in addition to the more formal subjects. These needs are unlikely to be satisfactorily met unless there is a teaching staff of at least three. Another reason for having a staff of at least this size is that difficulties may arise at any time with a particular child which call for the undivided attention of one of the staff. Children need to belong to a school community of at least 20, and a school with three teachers would not be economical to run if it had less than this number of children.

228. On the other hand, if the school is too large, a child will not feel certain that he has an assured place in it. He may feel that he is losing his individuality or may be afraid of the consequences of giving vent to his feelings. From the point of view of the staff, it is equally important that

* An interesting development in the London school is the appointment of a psychiatric social worker to work half-time on its staff.

a school should be moderate in size. The head of the school must know al about his pupils, including their relationship with their homes and thei treatment by child guidance clinics. He must also find time to help, whe required, children who have left his school, or to help their parents, s that his case-load may be nearly double the number of children in th school. Further, if numbers are great, it is very difficult to maintain th ordered, but not restrictive, framework which maladjusted children nee to their lives. We consider, therefore, that a school for maladjusted childre should ordinarily not have more than about 50 pupils.

229. The work of a class of maladjusted children is, as we saw earlier i this chapter, highly individual and very exacting. The teacher requires grea patience and judgment, and needs to have to hand a multiplicity of teachin methods and techniques. Groups for different purposes will vary in size, bu ordinarily a teacher cannot in our opinion satisfactorily meet the needs o more than ten children ; and for activities where there is any risk of childre injuring each other if inadequately supervised, a group may need to b considerably smaller. Even when specialist teachers are available part-tim to take some of the practical work, it is not sufficient to have a ratio o one full-time teacher to ten children ; the head has responsibilities both insid and outside the school which will prevent him from taking charge of childre for part of the school day. We suggest that the staffing ratio for school within the recommended limits of size should be as follows:

20 to 25 children—a head and 2 other teachers,

26 to 35 children—a head and 3 other teachers,

36 to 45 children—a head and 4 other teachers,

46 to 50 children—a head and 5 other teachers.

(d) *Home tuition*

230. In December, 1954, only about 60 maladjusted children in England and Wales were receiving home tuition from a visiting teacher. This has been found useful where a child has an acute phobia for school, and has been so shaken by some experience that he would suffer agony in leaving home and going to a strange environment even for a few hours a day. Home tuition has been tried for psychotic and pre-psychotic children ; it may be a means of keeping some of them in touch with reality. It has also been provided in a few areas for children awaiting places in special schools who have proved unmanageable in ordinary schools. Two or three half-days a week is the proportion of the time for which home tuition is often given ; sometimes it is possible to arrange for three or four children to be taken together.

231. Experience suggests that home tuition should be regarded as a temporary expedient only to be adopted in exceptional circumstances, a means of steadying a child and preparing for his return to school ; it should never be thought of as a permanent arrangement and an end in itself. It will not cure children who have been very troublesome in school ; their problem is to adjust themselves to a group, and they often behave well when they are alone with one adult. Further, where a child's difficulties arise from relationships within the family, it may only make matters worse to give him tuition for long at home. There is much to be said for the view that a child will not make a good adjustment to society unless he has first made a good adjustment to his school as well as to his family. Nevertheless, occasions do arise where a child, for a period at least, cannot attend school, and it is much better that he should have some tuition while he is at home rather than stay there throughout the week with little or nothing to do.

(e) *Special classes for backward pupils*

232. A wide variety of adjectives, e.g. coaching, opportunity, progress, remedial and special, has been used to describe the classes and groups formed within ordinary schools for backward children. Some of these classes are for the dull, some for those retarded for other reasons, others are for both; some are full-time, others part-time. The evidence presented to us indicates that classes for retarded, but not exclusively for dull, children help some children whose maladjustment is not very severe. The main reason for this is that, as we saw earlier, where a child meets with success in his school work for perhaps the first time in his life, it can have an effect on his whole emotional development.

(f) *Day open-air schools*

233. In an earlier chapter we spoke of disorders such as asthma in which physical symptoms predominate but which are partly psychological in origin*. All open-air schools are thus likely to contain some children who may be regarded as maladjusted as well as delicate. In addition some open-air schools accept a few maladjusted children who are not delicate, but who may respond well to a régime devised for delicate children. Careful selection is necessary to ensure that only those maladjusted children are admitted who will both benefit from the régime and fit into the group, i.e. as a general rule those suffering from nervous or habit rather than behaviour disorders.

234. An interesting experiment has been tried in Chesterfield, where a school and a children's centre (including a child guidance clinic) were set up in 1939 with the aim of combining the physical, intellectual and psychological approaches to children's problems. The school is primarily an open-air school for delicate children, but it caters also for two other groups, children "in poor emotional health", and the educationally retarded. In December, 1954, 48 of the total roll of 157 were maladjusted pupils, and of these 14 lived in a hostel in the vicinity.

(g) *Independent day schools*

235. Occasionally small independent day schools have been used for maladjusted pupils, where a child having child guidance treatment is not yet fit for an ordinary primary or secondary school and no other special facilities are available. There is provision† to enable authorities to pay the fees in suitable cases.

Conclusions

236. A variety of forms of day treatment is possible, but the number of maladjusted children to whom day treatment has been given is very few. In December, 1954, for example, the number of maladjusted children receiving some form of day treatment (apart from child guidance) in proportion to the number attending boarding schools or hostels was only 1 in 7. We hope that day provision will be much further developed. The broad lines on which the existing classes and schools are run seem to us sound, but little, for example, is known as yet about the types of maladjusted child who will respond to the various forms of treatment, and more attention has so far been paid to children who are a nuisance at home or school than to those who are quiet and withdrawn.

237. In particular, we suggest that local education authorities should consider whether it would be possible to establish in urban areas part-time classes and/or day special schools for maladjusted children. A part-time

* See Chapter IV, paragraph 105.

† In Section 6 (2) (*a*) (ii) of the Education (Miscellaneous Provisions) Act, 1953 (see Chapter V, paragraph 149).

class holding sessions for four days a week could be run for as few as 12-1 children ; and so a class could be formed in many towns where there woul not be enough children within range to justify a school. A class also ha the advantages that its smaller size makes for an even freer and mor personal atmosphere, and that the children in attendance are still in touc with their ordinary schools. On the other hand, at least 20-25 children will b needed to form a school. The special advantages of a school are that, havin at least three teachers on the staff, it can provide a wider range of activitie and can deal with a wider variety of types of maladjusted children. Wher either a class or a school is practicable, it is best that authorities shoul themselves weigh up the merits of the two forms of provision ; in man urban areas it will be possible to provide both, if authorities so wish.

238. There is very little evidence to go on but, if the experience of Oxfor and Leicester is compared and it is assumed that the great majority o children in these day special schools would also have derived benefit fron attending a part-time special class, the indications are that urban areas wit a school population of 6,000 would be large enough to support a part-tim class and those with 10,000 a small school. These figures are, of course tentative. What seems certain is that the establishment of more part-tim classes and day special schools should enable more maladjusted childre to be dealt with in their home environment, and should save a large amoun of expenditure. We have been told that, if no day special school had bee available, at least one third of the children attending Oxford's school i 1953 would have been recommended for residential treatment, and tha over a period of three years the corresponding figure for Leicester's schoo lay between one third and one half. These are striking figures. We believ that the most rapid and effective advance possible at the present time ca be made through the development of day special schools and classes whic will treat children in and with their families.

Recommendations

We recommend that

(1) local education authorities should make more use of day treatmen for maladjusted children, particularly special schools and part-tim special classes.

(2) in the organisation of part-time special classes

(*a*) children should be admitted or discharged on the recommenda tion of the child guidance service, and in consultation with th teacher of the special class and the head of the child's ordinar school.

(*b*) teachers should be allowed sufficient time for keeping in touc with the parents, the child guidance service and the ordinar schools from which the children come.

(3) in the organisation of special schools

(*a*) children should be admitted or discharged on the recommenda tion of the child guidance service and in consultation with th head of the school.

(*b*) adequate arrangements should be made for keeping in clos touch with the parents.

(*c*) a school should contain not less than about 20 children, an ordinarily not more than about 50.

(*d*) staffing should be based on the principle that ordinarily teacher cannot satisfactorily meet the needs of more than maladjusted children, and that for some purposes a grou may need to be considerably smaller.

CHAPTER VIII

RESIDENTIAL TREATMENT: (1) PRELIMINARY CONSIDERATIONS

239. We said earlier* that failure in personal relationships was the most important factor in maladjustment. If the relationships within the family become seriously disturbed, it may not be possible to repair them unless the child leaves home for a time. That in essence is the reason why facilities for residential treatment need to be available, but such treatment should be given only if it is clear that there is no hope of treating the child successfully while he remains at home.

240. There can be no simple prescription for determining the circumstances in which a child should go away from home for treatment; for, as Tolstoy said, "all happy families are alike, but an unhappy family is unhappy after its own fashion". Apart from cases of rejection, which may itself take many forms, there may be a variety of reasons which make it impossible for the parents to cope with a child or for a child to cope with his home surroundings. The parents may not be able to control him or tolerate his behaviour; he may be a persistent truant from home or school or he may be a delinquent. They may themselves be bad managers or of low mentality. There may be continual friction in the home or intense jealousy between the children. If a child is separated for a time from his parents, each gets a respite from the other, and both child and parents can be helped to look at the situation more objectively and so overcome their difficulties.

241. When it is decided that a child needs treatment away from home, the aim should be to prepare the way for his return home at the earliest possible date, however long and difficult the process may prove to be. It should never be assumed from the start that the child's parting from his parents must be final, even when they deliberately reject him and neither parent appears to have any love for him. Almost always one of them, at any rate, will have some remnant of affection, however overlaid it may be by feelings of anger, despair or guilt. The child, too, may blossom in a kindlier environment, and become in his parents' eyes more acceptable.

242. The different types of residential treatment will be discussed in detail in the two following chapters. There are many possibilities: a hostel for maladjusted children or a foster-home, from which a child will go out to attend an ordinary day school; a boarding special school for maladjusted children or, possibly, one for delicate children; an independent (or other) boarding school catering mainly for maladjusted children or one catering mainly for ordinary children; or a children's unit attached to a hospital. The statutory authority for treating maladjusted children in hostels, foster-homes and boarding schools was set out in Chapter V.

243. These establishments may have any or all of the following aims:—

(*a*) to provide the child with a temporary substitute for his own home, in which he can feel emotional security and establish satisfactory relationships both with adults and other children, and so to help him to take his place again in his family;

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* See Chapter IV, para. 119.

(*b*) to provide him with special teaching if his emotional disturban has made it impossible for him, at any rate for the time being, make satisfactory progress in an ordinary school;

(*c*) to provide, in co-operation with a child guidance clinic, therapeut treatment both for child and parents, in order to make the chi fit to return home and the home fit to receive him.

244. It is obvious that there will be variations in aim not only amor different types of residential establishment but also among establishmen of the same type. No general rules can be laid down for choice of establis ment or type of treatment. Since each child's problems must be considere as individual problems, it is essential that there should be the closest c operation between the child guidance clinic and the local education authori in the reaching and carrying out of any decision. The authority shou recognise that the clinic staff may have some knowledge of a variety boarding schools and hostels: the clinic staff should tell the authority terms intelligible to laymen what appears to be wrong with a child ar what treatment they recommend. The parents should be fully consulte not merely as a formality but because their co-operation is a condition successful treatment, given that the aim is to restore the child to his home.

245. Before a recommendation about residential treatment is made, a chil guidance clinic needs to have fairly full information about the chil and his background. The best way to obtain this is to observe him in th setting of his home, in order to see how the various members of his famil get on with each other, and how capable and co-operative the parents ar Sometimes, however, the home is so unsatisfactory and the parents so clearl unco-operative that the child has to be removed without delay, and a perio of observation away from home may well be essential before the rigl recommendation about placement can be made.

246. At present there is no provision under the Education Act for estab lishments where children can be observed, but under Section 15 of th Children Act, 1948, local authorities have to make arrangements for th temporary reception of children with "the necessary facilities for observa tion of their physical and mental condition". Since the number of ma adjusted children needing a period under observation away from home not likely to be large, duplication of staff and premises would be wastefu except possibly in the largest areas, and might lead to staffing difficultie Accordingly, we suggest that consideration should be given to the practi ability of arranging for some of the children we have in mind to be sen for a few weeks only, to selected reception centres provided under th Children Act. For observing maladjusted children and for reporting o them, use should only be made of reception centres which are suitabl staffed and where the interests of the other children in them would in n way suffer.

247. In the remainder of this chapter we discuss some of the difficu questions which affect any decision to resort to residential treatment and th choice of the school or hostel to which a child is to be sent. First, howeve assuming that the decision has been taken and the place chosen, it is desirab to emphasise certain fundamental points, elementary though they are. Fiv parties, at least, are involved—the child, the school, the clinic, the paren and the office of the local education authority. If the special education treatment is to be successful, there are many contacts to be maintained an developed. It is not enough that the child should be sent to the school, h fees paid, reports on him received, his journeys arranged and so on. Wh

will maintain real contact with the school or hostel and keep it informed of events and of any improvement in the home? How will decisions be reached on whether the child should go home in the holidays and when he can be discharged? If the child is given psychiatric treatment at school, by a child guidance clinic or otherwise, how will this be co-ordinated with the efforts of the recommending clinic to treat the parents? On such points as these it seems to us inevitable that the best and most convenient arrangements will often differ from area to area, from boarding establishment to boarding establishment and from child to child. The essential point is that in every case there should be a plan of campaign to fit the circumstances, that the responsibility should be settled for the different parts of it, and that the local education authority should watch over it as a whole and take any initiative and make any adjustments needed.

248. Another set of questions needs to be asked before any recommendation is made or decision taken about placing a child in a boarding school or hostel. The recommending clinic and the local education authority responsible for providing the residential treatment should have a clear idea of what they hope to achieve and how they hope to achieve it. Is the process of adjustment likely to be rapid or will the child have to remain away for a long time? In either case, how can arrangements best be made for him so as to avoid unnecessary breaks in his education or changes of school? What can be done to help his parents while he is away? Is it likely that he will achieve stability before his home is fit to receive him? If so, where is he to live and be educated during this interim period? Is there a possibility that he may never be able to live at home again and that other arrangements may have to be made for him when the time comes for him to leave school?

249. These are difficult questions, and no one can hope to predict a child's development with sufficient accuracy to be sure of answering them correctly. But they should be present in the mind of anyone recommending that a child should go away from home for treatment or choosing a place in which such treatment is to be given; and they should be considered jointly by the recommending clinic and officers of the local education authority responsible for reaching decisions. In this way there is reasonable hope that the arrangements made will be flexible enough to meet a possible variety of developments. The child should be told simply what has been decided, where he will be going and what it will be like. If he can understand it, he should also be told the reason for the decision; indeed with older children their co-operation can often be secured in this way.

250. The practical implications of all this can best be illustrated if we consider the kind of problem which is likely to arise. Let us consider, for instance, the case of a child who has been sent to a boarding school or hostel for junior children and who reaches the normal upper age limit for that school or hostel while still unfit to return home. An arbitrary transfer from one school or hostel to another is to be avoided, since one of the most usual reasons for sending a maladjusted child to a boarding school or hostel is to provide him with a stable environment and a sense of security; and if a child is not able to form another set of emotional relationships, a move may be disastrous. Every effort should be made in such a case to keep him where he is until he is ready to return home. It follows that the age of transfer should have a wide margin of variation. A boarding school or hostel for juniors which takes in a child of 9 should normally be prepared to keep him till the age of 13 if necessary; similarly, one for seniors should be prepared to admit junior children of 10 (or even exceptionally 9) if they are likely to need to stay on beyond the age of

12 or 13. Those responsible for placing maladjusted children should also choose a school or hostel at which the child is likely to be able to remain as long as he needs to be away from home.

251. Other problems may arise over the return of children to ordinary schools near their home. For example, a child of primary school age sent to a boarding special school may be sufficiently recovered to return home when he is 10, but if he then goes to the local primary school he will be faced with a further move to a secondary school in perhaps only a term or two*. Such a double change, coupled with the return to home life, may well be more than he is yet able to face. If so, it would be better for him to stay on at boarding school for a while till he could go straight to a secondary school. In the case of another child, the age for transfer to secondary school may arrive before he is fit to return home. The risk of an early return must then be weighed against difficulties which may arise from late entry to a secondary school. Additional complications will be introduced if, instead of attending a boarding special school and being taught on the premises, a child has been going out from a hostel to a primary school in the locality.

252. When a child returns home, careful thought is needed about the day school which he should attend. He should not automatically be placed in the school which he was attending before he was sent away from home or in the secondary school to which his old schoolfellows have been transferred from the primary school. It may be important to give him a fresh start away from children who exerted a bad influence on him in the past even if this entails for him a longer daily journey and for the local education authority the payment of fares.

253. It may be found that a child over the age of 11 is ready to return home at a time when a change of school would be educationally undesirable. Where, for instance, a boy or girl has been living in a hostel and attending a grammar school, the need for avoiding a break in the grammar school course has to be weighed against the advantage of returning home. If it is decided to avoid a change of school, it may still be open to question whether it is desirable for a child who has overcome his disability to continue to live in a hostel for maladjusted pupils; in some cases it may be best for him to be boarded with foster-parents during the term and to live at home in the holidays.

254. A further problem will arise if a child has overcome his difficulties before his home is ready to receive him back. If there is hope that he will soon be able to return home, it may be best to keep him where he is for a further limited period. Where this is for any reason impracticable, it will normally be best to provide him with a suitable home—with foster-parents or in a children's home. It is particularly necessary to do this if there is any likelihood that his home may never be able to receive him back; in such a case it will be better, after preparing him for the change, to take action under the Children Act rather than continue to handle the problem as an educational one. Ordinary boarding schools are no solution in such cases, unless the child is also provided with a stable home background to which he will return in the holidays. There is a real risk that a maladjusted child who has been kept in a boarding school or hostel till the end of his schooldays, without any natural or substitute home background, may drift out into the adult world without any secure anchorage.

255. We have said enough to show the problems and difficulties which beset the path of those who have to recommend, choose or provide boarding education for maladjusted children. The closest co-operation is necessary

* The normal practice is for transfers from primary to secondary schools to take place once a year only, in September.

throughout between clinic and school staffs, administrators and parents, in order that decisions may be taken with the fullest possible knowledge of the child as an individual, of the many facets of his personality, of his home and school background and of his varying problems and difficulties. Those responsible for his welfare have a bewildering task, which demands the skill of Socrates in asking the right questions and the wisdom of Solomon in answering them.

Recommendations

We recommend that

(1) a child should be given residential treatment only if there appears to be no hope of treating him successfully while he remains at home; and, where it is given, the aim should be to prepare the way for his return home as soon as possible.

(2) where children are deemed to need a period under observation away from home before a recommendation can be made about their treatment, consideration should be given to the practicability of sending some of them for a few weeks to selected reception centres provided under the Children Act.

(3) in reaching and carrying out a decision to provide residential treatment for a child, a local education authority should act in close consultation with the child guidance clinic; and they should together make a plan to suit the individual child, which covers his home and his education as well as his treatment for maladjustment, and is flexible enough to allow for possible developments.

(4) in order to avoid unnecessary moves before treatment is completed, the age-range of boarding special schools and hostels should be sufficiently elastic to enable children to be retained at establishments for juniors until the age of 13 and to be admitted to establishments for seniors at the age of 10 (or exceptionally 9).

(5) the local education authority should make every effort to ensure that a child has a satisfactory home base before he leaves school, if necessary through the local authority taking him into care under the Children Act.

CHAPTER IX

RESIDENTIAL TREATMENT: (2) HOSTELS AND FOSTER-HOMES

(i) Hostels

256. The distinctive feature of a hostel is that children go out to ordinary day schools in the locality. They thus divide their time between two communities, and in this way the conditions of normal life are in some measure reproduced. The hostel is, essentially, a substitute for a child's own home. Although at most existing hostels regular visits are paid by psychiatrists or other child guidance workers, the main object generally is to provide a happy and ordered home life. Hostels are unlikely to be suitable for children who are very disturbed or withdrawn ; for those whose conduct would upset an ordinary day school and the neighbourhood, e.g., persistent truants or pilferers ; or for children who have educational difficulties which would prevent their fitting into an ordinary school. In other words, they do not cater for children who require a consistent and protective environment throughout the 24 hours.

257. There are at present 45 hostels (37 of which are maintained by local education authorities and 8 by voluntary bodies) providing altogether places for some 830 children. A few boarding special schools, as we shall see later* send out some of their children to local schools after an initial period of teaching within the boarding establishment†.

258. *Location.* The first hostels developed from war-time hostels in reception areas for " difficult children " who could not be billeted out. Some children will derive great benefit from the healthy surroundings and the wide scope for outdoor activities which a hostel in the country provides. Most, however, of the children in hostels come from urban areas, and for some of them life in the country is too strange to be a good preparation for their return home ; further, there may be only one or two small schools which the children can attend. On the other hand, to place a hostel near the centre of a large town would have obvious drawbacks. There is much to be said for establishing most hostels either in small towns or on the edge of large towns, where the environment is likely to be more natural for most of the children and a variety of schools will be available. Integration into the local community may be easier to achieve in small towns, whereas contact with parents and supervision by a child guidance team may be easier to arrange where a hostel is on the edge of a large town.

259. *Staff.* The 41 hostels in existence at the beginning of 1954 had 118 resident staff other than domestics. The average ratio of staff of all kinds to children was 1 : 3, and in most hostels the number of resident staff was between two and four. In 24 hostels the matron was the warden's wife. The qualifications and experience of wardens, matrons and assistant

* See Chapter X, paragraph 309.

† In addition, the Caldecott Community near Ashford in Kent, which caters for some ordinary and some deprived children as well as some who are maladjusted, sends out all the seniors to local schools.

house-staff* varied greatly. Two of our members who in the winter of 1953–54 visited between them all 41 hostels met men and women who had no special training but who were doing excellent work. Without question, most people will benefit from training, however good their personal qualities are, and we shall discuss in Chapter XV the training as well as the qualities needed: but no training can make up for the lack of love of children, warmth of heart and common sense.

260. *Size, and organisation by age and sex.* Of the forty-five existing hostels, only eight have accommodation for more than 24 children; thirty of them accommodate between 12 and 20 children. Eighteen take boys only, nine take girls only and six take girls of all ages and junior boys. Since the aim is to provide a substitute home, the natural pattern would be to have boys and girls together at the senior stage as well as the junior, but the practical difficulties are obvious and it is noteworthy that only eight hostels follow this pattern. We shall discuss the problems more fully in the next chapter when we deal with boarding special schools†.

261. *Selection and admission of children.* Most authorities only send children to hostels on the recommendation of a child guidance clinic, and we think that this should be the invariable practice. Further, no child should be sent to a hostel unless it is certain that there is within reach a day school to suit him. The warden should always be consulted about admissions and have the right to refuse to accept any child. A maladjusted child cannot be expected to fit into every hostel for maladjusted children, and the warden should not have to take children whom he thinks will not fit into his existing family group.

262. *Supervision by child guidance staff and school medical officers.* The two members of the Committee who saw all the hostels in 1953–54 found that every hostel run by a local education authority was visited periodically by at least one member of a child guidance team, but owing to shortages of staff visits could in many cases only be made once a month or even less frequently. Five of the seven hostels run by voluntary bodies were not visited by any member of a child guidance team, though at least two occasionally referred children to clinics. All children who are maladjusted and require to leave home for a time need emotional support in going through a difficult phase; and it seems to us essential that all hostels should be visited regularly by a psychiatrist, who will both see the children as necessary and give guidance to the warden in handling them. In general, there should be the closest touch between hostel staff and the staff of a child guidance clinic. It is best to discuss cases on the spot, so that members of the hostel staff can take part. Where hostels are maintained by local education authorities, the Principal School Medical Officer should be responsible for the health and general well-being of the children.

263. *Premises and equipment.* The building should not be too large to be homely and the standard of comfort should be similar to that of an ordinary home. It is an advantage if the older children, especially girls, can have a small sitting room away from the younger children. The accommodation for the staff should afford all of them reasonable comfort and privacy: it is, for example, a serious drawback in trying to recruit a married couple if they cannot have a sitting room to themselves. The hostel should have plenty of ground where the children can play. Equipment and materials

* By house-staff we mean those who have actual care of the children and whose main role is that of substitute parents, as distinct from domestic staff. The two categories are not, however, mutually exclusive and in most hostels, especially the smaller ones, many domestic duties are carried out by house-staff.

† See Chapter X, paragraphs 296–298.

are needed to enable a variety of crafts and of hobbies to be practised in the children's spare time. No attempt should be made to fill up every minute of their day ; children like to be free to follow their own inclinations for part of the time, and the exercise of this freedom is of value in developing character.

264. *Relations with schools.* It is the warden's duty to give to the schools which the children attend any information which he thinks is likely to be of help in handling them. He should also work in close co-operation with the schools, so that there may be consistency in the treatment which each child receives. Hostel children should be allowed—and encouraged—to take as full a part as possible in school journeys and other activities. The two members who visited all the hostels spoke to teachers at nearly all the schools attended by hostel children, and it is of interest that they were almost invariably told that these children gave no more trouble than the others and that there were worse-behaved children in the school. At the same time, the teachers said that many of the children were backward, and ability to give special attention to backwardness is one of the features to be looked for in choosing schools for hostel children to attend.

265. *Relations with the community.* The more that hostel children are brought into the life of the community, the better it is for them. Children should be encouraged to join local youth organisations and to invite their school friends to tea and play. We gather that, even in some areas where school friends are invited in, hostel children are seldom invited out. This underlines the need for the warden and other staff to take part in the social life of the neighbourhood, so that they, and the children through them, become accepted members of the community.

266. All children should have a reasonable amount of pocket money to enable them to make small purchases of their own. It is best for both parents and children if this can be provided by the parents, as it is by many at present. If, however, the parents are unable or unwilling to send pocket money, the local education authority responsible for the child should provide it. Further, it should be open to a hostel child, in the same way as for a child living at home, to supplement his pocket money by doing any suitable small jobs in the neighbourhood which are allowed by the local bye-laws.

267. *Relations with parents.* Since the aim ordinarily is that children should go back home when they no longer need to live at the hostel, their homes should be prepared for their return. At present, largely because of the shortage of staff, very little work with the parents is done by child guidance clinics ; indeed in some areas any work begun is stopped if the child is admitted to a boarding establishment. We only know of two areas where regular visits are paid to the parents of hostel children by psychiatric social workers*.

268. It is important that there should be adequate arrangements for maintaining contact between parents and their children, and between parents and hostel staff. Regular contact between parents and children through visits, letters and telephone calls is usually to be encouraged. In addition to visits by the parents, where they do not live far from the hostel a child may be allowed to go home for some week-ends in term-time. The warden should keep in touch with the parents by correspondence and by seeing them on visiting days ; some wardens also manage to visit the parents.

269. *Holidays and length of stay.* At the time they were visited, out of 41 hostels only 19 remained open throughout the year. There will be times when it is best that a child should stay in the hostel through the holidays, as for

* Visits from a psychiatric social worker may not be enough for some parents, who will need treatment by a psychiatrist. More will be said in Chapter X about ways of helping parents (see paragraphs 305–307).

instance when he is still too disturbed to tolerate a change of environment. No hostel should ever be closed if it is in the best interests of any child that he should stay there, and this should be borne in mind in staffing hostels. Staff, however, cannot be sure whether a child is becoming readjusted to home conditions except by sending him home for a visit, and usually children should go home for part of the holidays. The period spent at home can be lengthened as it is found that parents and children can tolerate longer periods in each other's company. After a few terms, a child may be able to go home for the whole holiday, and when he can spend six weeks on end at home in the summer he may soon be able to return home for good. In practice it is usually found that children in hostels are ready to go home within two years. Before any child is discharged, there should be consultation between all the parties concerned, including the parents and the recommending clinic.

270. Children who cannot as yet go home for any part of the holidays should, if possible, spend part of the school vacation, even if only a few days, away from the hostel with relatives or at a children's home or foster-home. Responsibility for making suitable arrangements rests with the local education authority, who have power under Section 50 of the Education Act, 1944 (as amended by the Education (Miscellaneous Provisions) Act, 1948) to provide board and lodging where these are necessary to enable children to receive the required special educational treatment.

271. If the circumstances which prevent a child returning home for the school holidays seem likely to persist, the local education authority should consult with the children's authority* at an early stage, so that steps can be taken, if and when necessary, for the child's reception into care (cf. Chapter VIII, paragraph 254). Much difficulty can be avoided if the local education authority consult the children's authority for the area of the child's home rather than the authority for the area of the hostel; the children's officer for the home area can then make any necessary arrangements with the children's officer for the hostel area. This applies even where it is preferable for the child to be taken into care in the hostel area.

272. *Planning of future provision.* The two members who visited all the hostels in 1953–54 were surprised to find that a considerable number of hostels had vacancies; and eight of them had more than 4. In a few cases hostels were deliberately not kept full to capacity because of inability to recruit suitable staff or were in process of building up their numbers, but the total number of vacancies (102) suggests that there was not at that time a general shortage of places; the number of hostels has since increased by four. Certain regions, however, e.g. the North of England, have very few hostels, and in areas where hostels are more plentiful there may be a disproportion in the number of places for boys and girls or for seniors and juniors, or a lack of provision for maladjusted children with certain characteristics.

273. The general position will need to be reviewed from time to time in the light of developments, but, as an immediate step, a larger measure of regional co-operation is desirable in the use of existing hostels in order to ensure that provision is balanced. The only planning on a regional basis which we have heard of is carried out in Berkshire, where three hostels run by the county authority and two run by Reading specialise in maladjusted children with certain characteristics. Some degree of specialisation is also likely to lead to greater success in helping maladjusted children, since the staff of a particular hostel are naturally better at handling some maladjusted

* The local authority acting under the Children and Young Persons Act, 1933, or the Children Act, 1948, is often referred to as "the children's authority"; and this shorter designation will generally be used in this report.

children than others. We hope that, where a region is sufficiently populous to supply enough children to fill several hostels and sufficiently compact to avoid the need for any children to be sent a long way from home, more co-operation of this kind will develop*.

(ii) **Foster-homes**

274. The advantage of placing a child with foster-parents is that he will be in an ordinary home with a normal adult background, instead of having perhaps to compete with other children for the affection of several adults. It is, however, the most difficult form of treatment to arrange under conditions conducive to success. It is never easy for a child to accept strangers as substitutes for his parents when his own father and mother, however badly or incompetently they have treated him, are still alive. Further, the parents' feelings of jealousy may endanger the whole enterprise. In comparison with the other forms of residential treatment, the child also suffers most if it fails ; he may feel that there is no place where he is wanted and thus become very difficult to treat by other means.

275. A child should not be placed with foster-parents unless it is clear that he is able to tolerate the tensions of intimate relationships inside a family. Foster-parents should only be chosen for a maladjusted child if they can deal with his particular difficulties, and are prepared to go on dealing with them so long as he needs a foster-home ; and if they can satisfy his emotional demands without becoming possessive or seeking to supplant his own parents, to whom he will, it is hoped, one day return. Before a decision is reached about placing a child in a foster-home, it is generally wise to send him there for part of one of his holidays, where this can be arranged, to test whether the child and the foster-parents are suited to each other.

276. Some of the bodies who referred in their evidence to placing with foster-parents were inclined to the view that the risks were too great to justify using this as a way of treating maladjusted children, except where the maladjustment is slight or no longer severe. We are satisfied, however, that there are cases where it can be successful, especially with anxious, unhappy children. Advice and help should be available when required ; regular visits to the foster-home should be paid, on behalf of the local education authority, by a psychiatric social worker or some other officer working in close co-operation with her.

277. Foster-parents deserve adequate remuneration, since maladjusted children make heavy demands on clothing and on the fabric of the home as well as on the emotions. We understand that some local authorities already pay a little above normal rates to foster-parents who take in difficult children. The general experience however is that it is very hard to find suitable foster-parents for maladjusted children, and we think it essential that those who are suitable should not be deterred from taking children by a fear that they would be out of pocket.

278. If it appears likely that a maladjusted child placed in a foster-home by the local education authority will never be able to return home, it is best, as we saw in Chapter VIII (paragraph 254), that he should be taken into care by the local authority under the Children Act. Close liaison between the Education and Children's Committees will then be required to ensure that the child, who already has a substitute home with his foster-parents, is not moved unnecessarily.

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* See also Chapter X, paragraph 314, where regional planning of boarding special schools is discussed.

Recommendations

We recommend that, in relation to hostels,

(1) children should be admitted only on the recommendation of a child guidance clinic and with the agreement of the warden.

(2) a child should not be admitted to a particular hostel unless there is a day school suitable for him within reach.

(3) arrangements should be made for hostels to be visited regularly by a psychiatrist and to keep in close touch with a child guidance clinic.

(4) where a local education authority maintain a hostel, the Principal School Medical Officer should be responsible for the health and general well-being of the children.

(5) the premises should provide a standard of comfort similar to that of an ordinary home ; and equipment and materials should be supplied for a variety of crafts and hobbies.

(6) adequate accommodation should be provided for staff, married and single.

(7) the warden should work in co-operation with the school which a child attends, and should give the school any information which may be of help to it in handling the child.

(8) children should be allowed—and encouraged—to take as full a part as possible in the activities of their school and in the life of the community.

(9) adequate arrangements should be made for maintaining contact between parents and their children and between parents and hostel staff.

(10) a hostel should remain open in the school holidays if it is in the best interests of any child that he should stay there ; but, normally, local education authorities should arrange for children to go away for at least part of the holidays.

(11) before any child is discharged, there should be consultation between the local education authority, the parents, the child guidance clinic which recommended treatment, the hostel, the head of the local day school and any other clinic providing supervision or treatment while the child has been at the hostel.

(12) a larger measure of regional co-operation should be developed in the use of hostels.

in relation to foster-homes,

(13) a child should not be placed with foster-parents unless he can tolerate the tensions of intimate relationships inside a family.

(14) foster-parents should be chosen for a child only if it appears that they can deal with his difficulties and, without becoming possessive, satisfy his emotional demands.

(15) The local education authority should arrange for regular visits to be paid to the foster-home, and advice and help should be available to the foster-parents when required.

(16) foster-parents taking maladjusted children should receive adequate remuneration.

CHAPTER X

RESIDENTIAL TREATMENT: (3) BOARDING SCHOOLS AND CONCLUSIONS

Boarding Schools

279. A boarding school, unlike a hostel, provides throughout the twenty-four hours a consistent and protective environment. Boarding special schools will be considered in paragraphs 280–315, and the use of independent and other boarding schools in paragraphs 316–321.

(i) *Boarding special schools*

280. The aim of a boarding special school for maladjusted pupils is to provide an environment in which their emotional, educational and physical needs can be cared for and every aspect of their life can be made to contribute to their treatment. There are at present 32 such schools, of which 20 are maintained by 13 local education authorities and 12 by voluntary bodies ("non-maintained special schools"). Five out of the seven schools maintained by the London County Council, and one or two others, act as hostels as well as schools, sending boys and girls out to local day schools as soon as they are fit to go.

281. *Educational treatment.* While a pupil is at a boarding special school and is not receiving any education off the premises, the school cannot think solely of treating his maladjustment or backwardness, but must provide all the ingredients of a full education suited to his needs. Most schools give prominence to some kinds of imaginative activities, such as painting and drama, which allow children to work through some of their problems; to practical activities such as woodwork, gardening and hobbies; to the keeping of pets or the care of animals. In almost all schools emphasis is also laid upon remedial teaching. The simple fact of receiving individual attention in a small class in an informal non-competitive atmosphere often enables a boy or girl to make progress and this can be of help in solving a child's emotional problems*.

282. Good opportunities for varied, undirected play are also needed. Even for the normal child, play has an educative function and gives a sense of release. For the maladjusted child it has a particular value, in that the world of play is more under his control than the ordinary world with which he is out of step, and he can more easily find himself within it. Some children require a period of treatment before they can join a class for work requiring sustained attention; and for these practical activities and play are of special help.

283. The wider therapeutic purpose of a special school for maladjusted children, and the initial scope needed in the classroom (as well as outside it) for them to express their maladjustment, were described in Chapter VII, paragraphs 209 and 210. What was said there in the context of day special

* See Chapter VII, paragraph 207.

schools applies with even greater force to boarding special schools, as these are likely to contain a higher proportion of seriously maladjusted children.

284. *Staff*. The headmaster or headmistress ought to take a share in the teaching of the children, and the staffing and organisation of a school should allow for this. It is however very difficult for the head to carry out a regular programme of teaching, because of the variety of other duties falling to him, some of which may make unexpected calls upon his time at any hour of the day. These duties include seeing individual children (including, in some cases, former pupils) and their parents, and holding staff conferences and co-ordinating reports on children received from various sources. One of the teaching staff should be appointed as deputy head, and normally either the head or the deputy head should be on the school premises. If this is ever impracticable, a responsible member of the staff should be left in charge. If the school is open for any part of the holidays (see paragraph 308), either the head or the deputy head should normally be in residence.

285. The duties of a matron, apart from caring for children who are sick, will include organising all domestic work, supervision of the general cleanliness of children, ordering and seeing to clothing, ordering food and drawing up menus, and making replacements as necessary to household stock. Sometimes the wife of the headmaster acts as matron, and this arrangement can work very well. In addition to the matron, an assistant matron is required.

286. The amount of additional staff needed, both teaching and other, will depend on a number of variable factors. What was said in Chapter VII, paragraph 229, about the size of groups in a day special school applies to boarding special schools : and, for teaching purposes only, the ratio of teachers suggested there for a day special school of the same size will be adequate.

287. A true picture of boarding school life cannot, however, be obtained by dividing the day into two parts, school hours and the children's free time, and by regarding as entirely separate the activities which belong to each. Activities in and out of school hours often overlap or are linked together: for example, some piece of carpentry begun in school hours may be continued in the evening, or a week-end excursion may provide a subject for written work in an English period.

288. It follows from this that the special advantages of a boarding school would be lost if children were looked after by two completely different sets of staff in and out of school hours ; and for maladjusted children, consistency in treatment and the formation of sound personal relationships are of particular importance. We therefore consider it essential that the teachers in a boarding special school for the maladjusted should take some responsibility for the children in the evening and at week-ends ; and the staff on duty out of school hours should normally include a teacher.

289. On this basis there are still two possible ways of staffing a school :

(*a*) The teachers and the matron take full charge of the children out of school hours as well as in. The argument for this is that sound relationships with sympathetic adults can best be achieved if children come in contact with one set of staff only throughout the day.

(*b*) Only a proportion of the teachers have any dealings with the children out of school hours, and part of the responsibility is taken by another type of staff, house-staff, who were referred to in connection with hostels in the last chapter (paragraph 259). The arguments for this are that children at home are used to being in contact with two sets of adults, and that the two kinds of staff provide children with a wider choice of an adult to whom to attach themselves.

290. We have heard of more than one school which is staffed on the first pattern, but the second is more usually adopted. In practice, family ties or the difficulty of obtaining accommodation in or near the school are likely to prevent some of the teaching staff from taking a share in out-of-school duties. In our view, it is desirable and should be practicable for a minimum of half the teaching staff to take a share, whether they live on the premises or not.

291. In a school where half the teaching staff take a share in extraneous duties one more teacher will be required than in a day special school of the same size. The ratio of teaching staff, therefore, might appropriately be :

20 to 25 children—a head and 3 other teachers,

26 to 35 children—a head and 4 other teachers,

36 to 45 children—a head and 5 other teachers,

46 to 50 children—a head and 6 other teachers.

Variations in the number of teachers will be necessary where either more or less of the out-of-school duties are carried out by house-staff, where a number of children go out to local day schools (see paragraphs 309–310) or where, as in one or two schools at present, the head of a school is not a teacher.

292. It is impossible to make definite and detailed recommendations about the number of house-staff required. There will need to be sufficient to supervise and take part in out-of-school activities, in so far as this is not done by the teaching staff. But the nature and type of these activities will vary greatly from one school to another, as will the amount of supervision needed. Some of the more important variable factors are :—

(*a*) the age-range and sex of the children in the school (see paragraphs 296–298 below) ;

(*b*) the characteristics of the children, e.g., how many are aggressive or otherwise difficult in their behaviour ;

(*c*) the dining arrangements, i.e., whether all the children eat together or in several separate houses ;

(*d*) the nature of the premises ;

(*e*) the number of staff whom it is thought necessary to have on duty out of school hours in order to provide adequate (but not excessive) supervision*.

293. The number of house-staff needed will also be affected by the number and quality of domestic staff. It is usual for house-staff to have certain domestic responsibilities, e.g., for the cleanliness and tidiness of the children's sleeping quarters ; minor repairs to clothing, shoes and bedding ; and the collection and distribution of laundry. How far they will themselves take a hand in this work depends on the domestic staff available.

294. It is also essential that, whatever the proportion of teaching and house-staff employed, all staff should have sufficient free time. In addition to annual holidays, staff need enough time off through the week to enable them to preserve their freshness and sense of proportion. Staffing must be adequate to cover all the work of the school, not just on a particular day but throughout term-time†.

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* Supervision does not imply that children require to be closely watched all the time; nor would this be conducive to their development.

† If a school is open for part at least of the holidays, the staffing must be adjusted to allow the staff on duty then to take part of their own holidays during term. This is exacting work, and all staff should be able to take the holidays to which they are entitled.

295. *Size.* A boarding school community of less than 20 would be even less satisfactory and even less economical to run than a day school community of the same size*. We regard about 20 as the lowest suitable number† and, for the same reasons as for day special schools‡, we consider about 50 to be ordinarily the highest suitable number for a boarding special school.

296. *Organisation by age and sex.* It is generally agreed to be both desirable and practicable to have boys and girls in the same school until they reach the age of 11. Most of our witnesses considered that it was better for boys and girls to remain together after that age, but opinion was divided about the practicability of this. It is hard to see how maladjusted children can be prepared for life in the world and a healthy attitude to sex be developed, if in adolescence they have no chance to mix with the other sex under good conditions ; and many maladjusted children will not have this chance during any holidays they spend at home. We recognise that certain children, for example sexually precocious girls whose maladjustment only comes to light at the age of 13 or 14, may need to go to schools where there are no senior boys. We see however no a priori reason why, under favourable conditions, other schools should not have boys and girls over the age of 11. The success of such schools will almost entirely depend on the attitude of the staff, and on their confidence in their ability to handle the situation. The risks can also be reduced in various ways, the most obvious being not to admit any child over the age of 11 so as to ensure that the seniors have grown up together. Another possibility is for the boys and girls to meet for lessons, games and social activities but to live in separate houses.

297. There has been too little experience of co-educational schools for maladjusted children for us to be able to make any recommendation about the balance of the number of boys and girls to be observed in such schools. There is a higher demand for places for boys than for girls ; a co-educational school planned to serve a given area would thus tend to have a preponderance of boys. It is interesting to note that the experience at one school has been that girls make much greater affective demands on the staff, female as well as male, so that if numbers are equal the boys are unlikely to obtain a fair share of the staff's attention. But there are obviously disadvantages in having only a few girls in a school in which boys predominate.

298. The most usually advocated alternative to co-education at the senior stage is to combine juniors of both sexes and senior girls in one school and to put senior boys, who form the biggest group, in another. We were much struck by the view of one headmaster, who, supporter of co-education though he was, attached so much importance to continuity of treatment that he thought an all-age single-sex school preferable to a mixed school where boys have to leave at 11. It should however be possible to avoid the need for moves in the course of treatment, if, as was suggested in Chapter VIII (paragraph 250), a wide margin of variation is allowed in the age of transfer.

299. *Selection and admission of children.* Children should not be admitted except on the recommendation of a child guidance clinic§ ; and the head of a school should always be consulted about admissions and should have

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* See Chapter VII, paragraph 227.

† If, as is desirable, a school's numbers are built up slowly, some schools will contain less than 20 children in their first year or two.

‡ See Chapter VII, paragraph 228.

§ Or a child guidance team working in a remand home or reception centre.

the right to refuse to accept any child. The abilities and temperaments of the staff are the most important factor in deciding which children can safely be admitted; nobody can be equally successful with every maladjusted child, and all staff must learn to know their own limitations. A promising school can easily be ruined if the staff are tempted by success to take on a greater number or a wider variety of children than they can manage. The art of selection is to find compatible children and the right proportions in which to combine children with different characteristics; as one witness said, running a special school is like mixing a pudding.

300. *Régime.* Although most of the existing boarding special schools adopt the general approach to the treatment of maladjusted children described in Chapter VII, paragraphs 209 and 210, and referred to earlier in this chapter (paragraph 283), wide differences will be found in the régime of individual schools. The way in which a school is run largely depends on the opinions held about the place of discipline and freedom in the school. Broadly speaking, there are four main points of view:

(i) Anti-social behaviour must be tolerated, because maladjusted children need to work through their emotional problems for themselves. The staff's function is to help a child through the phases of love and hate, damage and restitution, until he attains some stability and feels safe in forming relationships with adults.

(ii) Maladjusted children should be given a large share in the running of the school, since they can only appreciate the effects of anti-social behaviour in the light of experience. Through this they will learn that rules are needed in any community and that, once made, rules must be kept.

(iii) Maladjusted children like a regular pattern for their lives with an adult to tell them what to do, i.e., they are suited by a school run as a benevolent dictatorship. Since they are emotionally young for their age, they may be frightened by too much freedom.

(iv) After an initial period of tolerance, maladjusted children are expected to learn that there is a difference between right and wrong, and that wrong-doing may earn punishment. They can, and should, be treated in many respects just like normal children.

301. Schools do not, of course, give expression to these points of view in the absolute form in which we have stated them; a number of variations is possible. In all schools, too, personal relationships with the staff and the astringent attitude of the group play a big part in treatment. It is desirable that there should continue to be variety in the ways in which schools are run, since different children will respond to different types of régime. It may not be possible to generalise about the type of régime which will best suit children with particular characteristics, but a child guidance clinic should often be able, from its knowledge and experience, to recommend a particular school for a particular child*.

302. *Supervision by child guidance staff and school medical officers.* The arrangements suggested for hostels in Chapter IX, paragraph 262, are desirable for boarding special schools. Indeed, in view of the fact that boarding special schools usually have their pupils in their care throughout the twenty-four hours, regular visits by a psychiatrist and close touch with a child guidance clinic are even more important. It is of great help in maintaining the confidence of the school staff if they are able to have regular consultations with a member of a child guidance team.

* See also Chapter VIII, paragraph 244.

303. *Psychiatric treatment.* There is at present a considerable difference of opinion about the need to have facilities for psychotherapy in boarding special schools, whether it is provided by a psychiatrist or by a non-medical child psychotherapist. Some people doubt whether a boarding school is the right place for children needing intensive treatment ; and one local education authority maintaining a boarding special school stated that in their experience " the stable environment and special education provided by the residential school are much more important than continual specialist psychiatric treatment . . . ". On the other hand, other evidence suggested that without psychotherapy a child's basic attitudes cannot be altered ; and the headmaster of one school for 45 boys and girls told us that he would like to have the services of a psychotherapist for four sessions a week.

304. In our view, there is a place both for schools which provide psychotherapy and for those which do not. Much can be done for most maladjusted children through personal relationships in a good environment where they feel that they are accepted. At the same time, where psychotherapy has been available, it has been found that some children respond more quickly while others make progress who would have been intractable if nothing but a good environment had been provided. Much more experience is required with group therapy as well as individual therapy before the value of psychotherapy in boarding schools can be accurately gauged. It is, of course, essential that it should only be undertaken by a psychiatrist or somebody with adequate training working under his direction.

305. *Relations with parents and their treatment.* As was indicated in Chapter VIII, unless in a particular case hope of re-uniting parents and child has to be abandoned, the time of separation should be used for helping the parents just as much as the child. The maintenance of contact with parents by the child's school and their treatment should be planned together, even if treatment is undertaken by some other agency, e.g. the recommending clinic. The plan must be flexible, so that it can easily be altered, but it must at the same time be definite and realistic. The staff of the school and the child guidance clinic must be guided by circumstances, but by circumstances which they have sought to create.

306. Great efforts are at present made by special schools to keep in touch with parents, and particular resourcefulness is displayed by non-maintained schools which may draw children from all over the country. The following are some of the methods used : regular reports and letters are sent, couched in language that is simple and not likely to be misinterpreted ; open days are held, and parents are encouraged to visit at other times ; the staff escort children home at the end of term or visit homes in the holidays ; meetings with parents are held at some convenient centre. The few schools which have a psychiatric or other social worker attached to them employ her to visit the homes, and at one school she runs discussion groups for parents. Not all parents respond, but some co-operate with the school and take a great interest in what it is doing. We heard of one who was so delighted with the improvement in her child after a period at a boarding special school that she asked if she could put his brother's name down for admission!

307. In spite of this, not enough is at present done to help parents. Sometimes a psychiatric social worker from the recommending clinic continues to see parents after their child has begun to attend a boarding school, but it is generally acknowledged that the number of psychiatric social workers must be substantially increased before much effective work can be done. Where a social worker is attached to the school, she can visit the parents, working in co-operation with the recommending clinic. A few parents may need treatment by a psychiatrist ; if it is given, as it may well be, by a different

psychiatrist from the one treating the child, the two psychiatrists should keep in close touch. When parents visit schools, the head and other staff often manage to help them by having a talk with them and encouraging them to discuss their own problems, if they wish, as well as those of their children. In this way a deep and lasting relationship can be built up with some parents, which may help as much as any other factor to make a resumption of family life possible.

308. *Holidays and length of stay.* The same considerations about keeping open in the holidays and arranging for children to go away for part at least of the time apply to boarding special schools as to hostels (Chapter IX, paragraphs 269-271). In some cases it may be necessary for a child to stay as long as four or five years in a boarding special school, in others only one or two. Before any child is discharged, there should be consultation between all the parties concerned.

309. *Use of school as hostel.* In most of the boarding special schools maintained by London, when children are fit to attend an ordinary school plans are made for them to go out to a suitable day school in the locality. Some children need a much longer time than others, perhaps a year or more, before they are ready for the change, and the nature of the difficulties which first have to be overcome varies : for example, a child may be violent, hysterical or given to pilfering, or he may have lost all self-confidence through failure to learn to read.

310. The use of a boarding special school as a hostel has much to commend it, and we should like to see this system generally adopted. Just as when children are sent home for holidays, it provides a safe means of trying them out in a normal environment ; if the experiment is a failure, the child can return without any upheaval to the sheltered environment of the boarding school for a further period of stabilisation and remedial teaching. It is also natural for children, especially older children, as they recover, to wish to be more independent. To go out to an ordinary day school is one way in which this urge can be satisfied ; another way is to encourage them to make friends locally and to allow them to go out on their own at week-ends. Where it is intended that a boarding school should serve as a hostel, the need for a variety of day schools in the neighbourhood must be borne in mind in siting it. Consultation will also be needed between the staffs of the boarding school and of the local day schools to ensure that the teaching methods used in the boarding school do not conflict with those employed in the other schools.

311. *Location, Premises and equipment, and Relations with the community.* What was said in Chapter IX in paragraphs 258, 263 and 265-266 applies to boarding special schools as much as to hostels. References to the need for a variety of day schools in the neighbourhood and to the inviting in of school friends are relevant in view of the suggestion in paragraph 310 above that in all boarding schools children should go out to local day schools when they are ready for this.

312. *Planning of future provision.* Hitherto, with few exceptions, new schools have not been planned in relation to existing schools, with the result that provision for boys and girls or for seniors and juniors may be out of proportion, and provision for maladjusted children with certain characteristics may be gravely deficient or even entirely lacking. In the evidence presented to us, attention was called to the general shortage of places for children over the age of 11, and to two categories in particular :

(a) *Boys with I.Qs. below* 85-90. From several sources we were informed that the greatest difficulty was found in placing the duller senior boys ; schools taking senior boys tend to give preference to the more intelligent.

(b) *Children of grammar school calibre.* It was suggested that more places were needed for maladjusted children suited to a grammar school course. One non-maintained special school in Kent has for a number of years catered solely for boys in this category, and its numbers are being increased from 45 to 55. We carried out an investigation into the subsequent history of the children of grammar school calibre whom this school had had to refuse between 1943 and 1952. Of 103 who could be traced, the placing of only 5 was regarded by their local education authority as unsatisfactory; some had been sent to other special schools. On the other hand, it was known that this school had a considerable waiting-list, so that applications would not have been made to it on behalf of all boys of grammar school calibre who required to go to a special school. For girls, no special school provides a grammar school course, but we have heard of no demand for such a course expressly for girls; it appears to be easier to find a suitable independent school for them than it is for boys*. The need for more special school places for these children, some of whom may be best suited to a technical school course, is thus at present not clear†; but we consider that this question, in addition to the need for more places for seniors generally and for the duller senior boys in particular, should be kept under review. Maladjusted children of high intelligence are often very sensitive, and it is most important that they should be placed in an environment where their varied needs are understood and can be met.

313. It is impossible to forecast the total number of places in boarding special schools which will ultimately be needed. It is however clear from the list of children awaiting places in special schools (681 in December, 1954), apart from other considerations, that, even if a great expansion of day special schools and classes takes place, an increase in the number of boarding special schools will be required. We hope that local education authorities and voluntary bodies, in formulating proposals for special schools, and the Minister of Education, in consulting with them and in deciding which proposals to approve, will take carefully into account the balance of existing provision and the needs that are most pressing at the time.

314. In particular, it seems to us desirable that authorities within a region should consult each other and any voluntary bodies concerned, to see whether a scheme could be worked out whereby each school in the region meets a particular need and accepts children from anywhere in the region. It is of interest that the London County Council, the only authority maintaining more than two schools, have arranged for a certain amount of specialisation in their seven schools. We hope, too, that regional planning will eventually enable authorities to place nearly all their boys and girls inside the region. thus facilitating contact between a school, its pupils' homes and the recommending clinics.

315. *Boarding special schools for delicate children.* We said in Chapter VII, in paragraph 233, that day open-air schools are likely to contain some children who are maladjusted as well as delicate, and some accept a few children who are maladjusted but not delicate. The same applies to boarding open-air schools. It has been suggested to us that these schools can be useful as a means of building up the physical health and nervous strength

* The use of independent and other boarding schools for maladjusted children of grammar school calibre is referred to in paragraph 319 below.

† A number of boys and girls attend local grammar schools from hostels for maladjusted pupils.

of anxious or highly-strung children, whose maladjustment can then be treated at home through a child guidance clinic or a day special school or class. The ordered life in pleasant surroundings, with rest periods and an abundance of fresh air and good food, can in a few months make a considerable difference to children of this type.

(ii) *Independent and other boarding schools*

316. The extent to which local education authorities are making use of independent schools is shown by the fact that in December, 1954, 1,077 maladjusted children were being maintained in independent schools, compared with 1,157 in boarding special schools. Some of the schools only took one or two maladjusted children, but 16 schools took 20 or more and some of these catered solely for maladjusted children sent by authorities. Another significant fact is that, of the 1,077 children, no less than 868 were in schools not recognised by the Ministry of Education as efficient*. Although some of these schools would undoubtedly receive recognition if they applied for it, the fact remains that a large number of maladjusted children were being maintained out of public funds at schools which had received no form of official recognition.

317. There are, of course, some safeguards. It was made clear to authorities in a Manual of Guidance issued in 1950† that, unless there are special circumstances, a place should only be taken up at an independent school when no suitable place can be found in a special school. Authorities were also made responsible for satisfying themselves that the school chosen is suitable for the child concerned. They have to arrange for his medical examination at least once a year, and for periodical visits to the school in order to see that he is benefiting from the special educational treatment provided. Further, Her Majesty's Inspectors and other persons authorised by the Minister have the right to visit without notice or to inspect any independent school; and the Minister has power‡ to notify authorities that an independent school is in his opinion unsuitable for the purpose of providing special educational treatment for handicapped children generally, for a particular category of handicapped children or for a particular child, whereupon authorities have to withdraw the children concerned.

318. Nevertheless, it was not intended that the use of independent schools for maladjusted children should develop in the way it has. The original idea was that some maladjusted children might benefit from a period in a good, small independent school for ordinary children. Two new factors however encouraged a much wider use of independent schools: a number of schools began to specialise to some extent in treating maladjustment and at the same time authorities found that far more maladjusted children were being recommended for boarding special schools than there were places available.

319. Independent schools catering mainly for maladjusted children and those catering mainly for ordinary children each have their own characteristics. Those which cater mainly for maladjusted children have in their attitude to their task much in common with non-maintained special schools, but their ideas about treatment may be more unorthodox, their standards of accommodation may not be so good and they are more likely to be disorganised by domestic or other crises. Independent schools catering mainly for ordinary children provide a grammar school course generally at the secondary stage, and they tend to give preference to maladjusted children who

* See Chapter V, paragraph 148, and Appendix E.

† Manual of Guidance, Special Services, No. 1, paragraph 5.

‡ See Section 33 (2) of the Education Act, 1944, as amended by the Education (Miscellaneous Provisions) Act, 1953, which is reproduced in Chapter V, para. 143.

are reasonably intelligent and well-behaved. These schools are different in one respect from all other boarding establishments taking maladjusted children : they usually expect to keep a child until the end of his school life, even though he may become completely readjusted much earlier and his home be fit to receive him. Some of these schools (and a few grant-aided schools with boarding accommodation) have considerable insight into the problems of maladjusted children, though very few have any arrangements for providing psychiatric supervision or treatment. It is of interest that two of the authorities making most use of independent schools prefer independent schools which only take one or two maladjusted children, and ideally would only use independent schools for a few maladjusted children of very high intelligence.

320. Should independent schools for maladjusted children continue to be used by local education authorities? In view of the shortage of special school places, the use of independent schools for a number of years is inevitable. We do not consider that it is ever satisfactory to place the entire responsibility for deciding whether a school is a good school upon individual authorities, nor is it fair to expect them to do this. Accordingly, we recommend that local education authorities should be allowed to maintain maladjusted children at an independent school only if it is recognised by the Ministry of Education as efficient. This requirement obviously cannot be imposed overnight, but we hope that the Ministry will find it possible to introduce it in the fairly near future. When it is in force, authorities should continue to be responsible for satisfying themselves that the school chosen is suitable for the child concerned.

321. We hope that the number of maladjusted children in independent boarding schools can gradually be reduced within the next few years. We are sensible however of the valuable experimental work which, both in the past and at the present time, has been done by independent schools, and we do not suggest that they should eventually not be used for maladjusted children at all. There will always be the exceptional child who is best suited to an independent school. We also have in mind a not uncommon situation in which a period at an independent or other boarding school for ordinary children can be of great value at the stage when maladjustment is only incipient. Parents may be ill-fitted by temperament or circumstances to cope with a difficult child. If the child is left at home, maladjustment may develop and family relationships become strained to breaking-point, with the result that he ends up before a juvenile court, either charged with an offence or brought by his parents as beyond control. If however the child can go away for a short period, the tension in the home is relaxed and the difficulties on both sides can be seen in their true perspective. After the breathing space a fresh start can be made with much greater chances of success.

(iii) *Hospital and other units for seriously disturbed children*

322. A small proportion of maladjusted children are so acutely disturbed that they are unfitted for any formal education and may need special medical investigation and treatment. This group includes, but is not confined to, children who are psychotic. Boarding special schools or hostels cannot cope with them. Such children are a serious problem to local education authorities, who realise that they cannot be treated within the educational system, but find difficulty in arranging for them to be otherwise dealt with. At present, so far as we know, there are only six children's departments

of hospitals or other children's units providing facilities for these children*, and the main emphasis in these establishments appears to be on investigation and diagnosis rather than on long-term treatment. The Royal Commission on Mental Illness and Mental Deficiency, which is now sitting, is considering the legal and administrative arrangements by which mentally ill persons are admitted to hospital; and we hope that, as a result of the Commission's deliberations, the task of securing treatment for seriously disturbed children will be made easier.

Conclusions

323. In our view hostels and boarding special schools should continue to be the main forms of residential provision for maladjusted children. Although we have recommended that boarding special schools should serve as hostels for their children as soon as these are fit to attend a local day school, there will still be a place for separate hostels, and it is not intended that boarding special schools and hostels should carry out the same functions. At any given time, either a hostel or a special school is likely to be more suitable for any individual child; decisions by authorities about placement should be based on the needs of the children concerned and should not be influenced by the fact that the authority maintain one type of establishment but not the other. The broad lines on which existing hostels and special schools are run seem to us sound; we have however made a number of minor recommendations about their organisation and functioning.

324. We do not suggest that, as a form of treatment for maladjusted children, the use of either foster-homes or boarding special schools for delicate children should be widely extended, but, within limits, we consider that both are beneficial for certain maladjusted children. The use of independent boarding schools should, in our opinion, be more strictly controlled and also reduced.

325. Although it is not practicable to make an accurate estimate of the number of places needed in the various types of boarding establishment, it is clear that there is a general shortage and the demand for places will grow as the use of independent schools, which over 1,000 children were attending in December, 1954, is reduced. The position will need to be reviewed periodically by the Minister and by local education authorities, in order to assess in the light of developments the extent and nature of current requirements.

326. Wherever residential treatment is given, it is not likely to be successful unless it is based on a plan which covers the parents as well as the child; and unless consultation is kept up throughout the period that the child is away from home between the authority, the recommending clinic, the establishments providing treatment and the parents.

Recommendations

We recommend that, in relation to boarding special schools for maladjusted pupils,

(1) staffing should be based on the principle that ordinarily a teacher cannot satisfactorily meet the needs of more than 10 maladjusted children, and that for some purposes a group may need to be considerably smaller.

* At the Bethlem and Maudsley Hospitals, London; St. Ebba's Hospital, Epsom; St. James' Hospital, Portsmouth; Tone Vale Hospital, Taunton; Mapperley Hospital, Nottingham; and High Wick, Tyttenhanger, near St. Albans. The local education authority for the area provides education for the children who are patients in these hospitals, in so far as they are capable of benefiting from it.

(2) even where house-staff are employed, the teachers should take some responsibility for the children in the evening and at week-ends.

(3) a school should contain not less than about 20 children, and ordinarily not more than about 50.

(4) children should be admitted only on the recommendation of a child guidance clinic and with the agreement of the head of the school.

(5) arrangements should be made for schools to be visited regularly by a psychiatrist and to keep in close touch with a child guidance clinic.

(6) where a local education authority maintain a special school, the Principal School Medical Officer should be responsible for the health and general well-being of the children.

(7) adequate arrangements should be made for maintaining contact between parents and their children and between parents and the school staff; and for securing treatment, where necessary, for the parents.

(8) a school should remain open in the holidays if it is in the best interests of any child that he should stay there; but normally local education authorities should arrange for children to go away for at least part of the holidays.

(9) before any child is discharged, there should be consultation between the local education authority, the parents, the child guidance clinic which recommended treatment, the special school and any other clinic providing supervision or treatment while the child has been there.

(10) the system should be generally adopted whereby children, when they are fit to attend an ordinary school and it can be arranged, go out for their education to a suitable day school in the locality.

(11) the premises should provide a standard of comfort similar to that of an ordinary home; and equipment and materials should be supplied for a variety of crafts and hobbies.

(12) adequate accommodation should be provided for staff, married and single.

(13) children should be allowed—and encouraged—to take as full a part as possible in the life of the community and, where they go out to a local day school, in its activities.

(14) the Minister of Education and the local education authorities should keep under review the need for more places for maladjusted pupils over the age of 11, in particular boys with I.Q.s below 85–90 and children suited to a grammar or a technical school course.

(15) local education authorities within a region should consult each other and any voluntary bodies concerned, to see whether a scheme can be worked out whereby each special school for maladjusted pupils in the region meets a particular need, with the ultimate object of enabling authorities to place nearly all their maladjusted boys and girls inside the region.

in relation to independent schools,

(16) as from an appropriate date as soon as possible, local education authorities should be permitted to maintain maladjusted pupils only in those independent schools which are recognised by the Minister of Education as efficient.

in relation to residential treatment generally,

(17) hostels and boarding special schools should continue to be the main forms of residential provision for maladjusted children.

CHAPTER XI

AFTER-CARE

327. Even when treatment for maladjustment has ceased, it is necessary to guard against possible recurrence, perhaps in a different guise. The provision of further help, when needed, seems to us an essential part of treatment, without which the effect of the treatment already given may be wiped out. Help will also be needed for those boys and girls who leave school while still having treatment or whose troubles do not come to light until they have entered employment. In this chapter, under the general title of " After-care ", we consider the kinds of help which are available or needed for these different groups of children or young people.

(i) Children still at school

328. It is relatively easy to keep in touch with boys and girls who are still attending school after their treatment for maladjustment has finished, and this is done in various ways. In some areas arrangements are made by the local education authority. Sometimes the psychiatric social worker from the child guidance clinic which has either treated a child or has recommended him for residential treatment will endeavour to keep in touch with him afterwards. At least two local education authorities employ welfare officers for handicapped children who, in addition to seeing to the welfare of children attending boarding special schools, continue to follow them up after they have returned to an ordinary school.

329. Some special schools or hostels maintain contact with former pupils—by regular letters, by visits to their homes or by invitations to spend holidays at the school or hostel. A few schools have the services of a psychiatric social worker, whose function it is to know what is happening to their former pupils after their return home and to offer help if it is needed. The interest taken by boarding establishments in boys and girls after they leave is greatly to be welcomed, but many are at some distance from the homes of their pupils and, as a result, the attention they can give to former pupils is bound to be less regular and thorough than could be given by someone living closer at hand.

330. In our view, the local education authority of a child's home area is in the best position to see that the arrangements made for him are satisfactory, and responsibility should be placed on that authority. What is mainly needed is a wise and sympathetic adult to keep an eye on the child, and to give him the support he needs in so far as his home is incapable of giving him the necessary affection and encouragement. The child guidance clinic which has treated a child, or recommended him for treatment in a special school or hostel, should be responsible for assessing whether he needs supervision or help after treatment has ceased, and a psychiatric social worker on the staff of the clinic is often in the best position to keep in touch with him. Psychiatric social workers, however, will not always have the necessary time ; nor will school nurses, who are also well placed for this work. Sometimes other social workers or teachers will be more suitable. There is also no reason why a local education authority should not use the services of a voluntary body where there is one in the area able and willing to tackle the job.

331. Work of this kind has not as yet been sufficiently widely developed to make it desirable or practicable for us to make specific recommendations as to the ways in which local education authorities should do it; and in any case experiment and diversity will always be desirable. The essential need, in our opinion, is that all local education authorities should tackle the problem systematically and make plans for providing a comprehensive service.

(ii) **Boys and girls who have left school**

(a) *Service of personal help*

332. The provision of help for boys and girls who have ceased to have or to need treatment and are no longer at school is more difficult. The adolescent feels that in leaving school he has left behind him the supervision of adults. As we mentioned in Chapter III, paragraph 81, he is struggling to free himself finally from dependence on the family and on adults in general, and to accept the responsibility of ordering his own life. Yet at this stage also there is need of a wise and sympathetic adult to give advice and help over personal problems. The adolescent, especially if he is emotionally disturbed, may be highly suspicious of any interference with his affairs, and will not turn to such an adult or accept advice unless his confidence has been completely won.

333. Of the agencies in the field, the youth employment service is at present the one most likely to be in touch with boys and girls up to the age of 18 after they have left school. The service is administered by roughly two-thirds of local education authorities and in the remaining areas by the local offices of the Ministry of Labour and National Service. Its main functions are to provide young people with individual guidance on the choice of a suitable occupation and with help in finding and keeping satisfactory employment. It is also the responsibility of the youth employment officer to bear in mind the various facilities for vocational training and to advise on suitable training courses. Where a boy or girl presents a specially difficult problem of assessment, use can be made of the facilities at the industrial rehabilitation units of the Ministry of Labour, and expert advice obtained from psychologists and others as to the most suitable type of employment. Maladjusted young people who have reached the age of 16* can be admitted to the full course at industrial rehabilitation units, which lasts on the average from six to eight weeks.

334. The general arrangements under which the youth employment service works apply alike to the non-handicapped and to the handicapped, and special attention has lately been given to the problems of the latter. In August, 1953, the Central Youth Employment Executive issued a memorandum on "The Youth Employment Service and Handicapped Young People", which discussed their special problems and needs, and suggested ways of dealing with these. It is recognised that "each case demands, in general, much more time and care in both the assessment and placing action to be undertaken, than for those who have no such handicap". The need for the youth employment officer to work closely with the staff of the school is stated to be especially important in dealing with children who are maladjusted. It is also held desirable that he should develop close relationships with child guidance services, children's officers, probation officers, etc., so that he is kept fully informed about factors relevant to the employment of maladjusted boys and girls.

* We understand that this age-limit is being reviewed by the Committee of Inquiry on the Rehabilitation of Disabled Persons (usually known as the Piercy Committee).

335. The responsibility of the service extends to the period after boys and girls have been found work, since it has to ensure, as far as possible, that the placing has been satisfactory and to give the young worker, until he reaches the age of 18, an opportunity to discuss his progress, if he so wishes, and any problems arising from his work. The youth employment officer can thus play a valuable part in securing help for maladjusted boys and girls who have started work, as he is in close contact with employers and they can consult him when any of their young workers appear to be in need of assistance; in this way he can assist young workers to use the educational, medical, social and recreational services provided for them. His usefulness is limited by statutory restrictions placed on the information which may be passed by the school to him or by him to the employer. The confidential school report sent to the youth employment officer is restricted to purely factual information under four headings: health, general ability, educational attainments and aptitudes. Thus it does not contain information about those problems or difficulties which may be most relevant and important if a child who has been maladjusted is to be helped to make a smooth transition to the adult world.

336. This may well be in general a wise and necessary limitation. Boys and girls and their parents have a right to exercise their own judgment and to have their confidences respected; and it may sometimes be salutary for no information about personal difficulties to be passed on and for the young worker to know this, in order to encourage in him the growth of independence and a sense of responsibility. We are, however, confident that it is in the interest of some maladjusted children that the youth employment officer should be fully informed about them and allowed to use his discretion about giving this information to prospective employers. Accordingly, if it appears to be in the best interests of individual boys or girls that the youth employment officer should know about their difficulties and if the parents agree, it should in our view be possible for the school or the parents to pass on the information to the youth employment officer and for him to pass it on to employers if he considers they will use it wisely. A policy of frankness may make it harder to place some children in employment; but an employer who knowingly takes on a boy or girl who has been or is maladjusted is more likely to show tolerance and sympathy when difficulties arise, with a resulting reduction in the risk of breakdown or early dismissal.

337. The suggestion has been made to us that the youth employment service is fitted to provide personal help for maladjusted boys and girls who have left school; and there are indeed obvious advantages in having one service to handle all the personal problems and difficulties of a boy or girl. In our opinion, however, it would be a mistake to ask the youth employment service to take on this work which is so much wider than its present function and for which it is not equipped. The type of service needed is much more akin to the one which we have already recommended, in paragraph 330 above, for boys and girls still at school. It is even more important when they have left school that personal help should be provided by somebody living close at hand and with the necessary time, though the continuing interest in an adolescent of a boarding establishment which he has attended earlier should be welcomed. Here again we do not wish to make specific suggestions as to the way in which such a service should be developed; we do urge, however, that local education authorities should be encouraged and enabled to provide help for maladjusted boys and girls who have left school, either themselves or by arrangement with bodies working in their areas.

338. By being responsible for helping maladjusted children both after treatment and after they have left school, the local education authority would better be able to ensure continuity, a most important element in a service provided for young people who have recently made the abrupt transition from school to work; indeed one witness went so far as to say that continuity is the whole secret of treating maladjusted children. Stability in relationships and the avoidance of changes in the people dealing with a child are essential if he is to learn to trust adults and attain a sense of security. It will be of advantage if the person who keeps in touch with a boy or girl after the transition from school to employment is somebody whom he or she has known before. At the same time, it will be important for the service to treat the adolescent, not as a ward to be supervised and restrained, but as a responsible individual who needs help to stand on his own feet and make the best use of his increasing freedom. There is always a danger that establishments or people who have had a child under their care before adolescence may, from the best motives, wish as he grows up to exercise the same control over him as before. They must learn when to slacken their hold and when to let go completely.

(b) *Accommodation*

339. A service of personal help such as we have been considering is not enough for those maladjusted boys and girls who have to live away from home when they take up employment. If they are to cope successfully with all the problems arising from adolescence, their new-found freedom and their employment, good accommodation is essential with a landlady or hostel warden who will provide some unobtrusive support. It is, however, difficult enough for young people to secure good lodgings at a price they can afford, even when there are no complications of maladjustment and emotional disturbance. Nor do hostels such as those run in some large towns, by bodies like the Y.M.C.A. or the Salvation Army, meet the particular needs of the maladjusted, since the supervision is not adequate for these young people with their special difficulties. The same objection applies to most hostels run by industrial or commercial firms for their young workers. There are also few opportunities for maladjusted boys and girls to obtain residential employment.

340. In our opinion the gap can only be filled if local authorities provide accommodation which is suitable for young workers who are or have been maladjusted. Local authorities already have certain powers under which they can provide residential accommodation. Under Section 28 of the National Health Service Act, 1946, a local health authority may make arrangements for the after-care of "persons suffering from illness or mental defectiveness", and under Section 29 of the National Assistance Act, 1948, a local authority may make arrangements for promoting the welfare of "persons who are substantially and permanently handicapped by illness . . . or such other disability as may be prescribed by the Minister". Hostels can also be provided under Section 19 of the Children Act, 1948, for boys and girls over compulsory school age and under 21 who are, or have been since ceasing to be of compulsory school age, in care*. Some children who have never been in care can be accommodated in these hostels; indeed the intention, we understand, is that in them children who are or have been in care should have the chance of associating with some who have not.

341. These powers exist and it is obviously undesirable to duplicate powers unnecessarily. We understand, however, that the provision of accommodation for boys and girls after their treatment for maladjustment has

* If necessary, a child can be received into care after leaving school, though it is preferable that the decision should be taken earlier (see Chapter VIII, paragraph 254).

ended could not easily be covered by the sections quoted of the National Health Service and National Assistance Acts; and the number of these children whom hostels provided under the Children Act could absorb may be limited. Close co-ordination will be needed between the various departments of a local authority to ensure that any facilities available are used to the best advantage, but it appears unlikely that these facilities will be adequate for the purpose which we have in mind.

342. It is, therefore, for consideration whether power should not be given to local authorities in their capacity as local education authority to provide accommodation where it is needed for boys and girls up to the age of about 18, at least for those who have finished their school-days at a special school or hostel for maladjusted children. In this way continuity could be ensured. Suggestions have, for example, been made that a hostel might usefully be provided for school-leavers adjacent to a special school; school-leavers who could not live at home would then be able to transfer to the hostel on taking up employment. Such an arrangement would, of course, only be practicable where local conditions of employment were favourable and the character and age-range of the school were suitable. It is also for consideration whether local education authorities should have powers to provide lodgings; some maladjusted boys and girls will get on better living with adults in lodgings than mixing with adolescents of their own age in a hostel. In suitable circumstances lodgings might be in the vicinity of the special school the boy or girl has been attending, thus helping to secure continuity of treatment.

343. If local education authorities were given power to provide hostel or lodging accommodation, it should include a power to relate the charge made to the earnings of the boy or girl so as to leave them with adequate spending money.

(c) *Child guidance facilities*

344. Maladjusted boys and girls may also still need psychiatric treatment at the time they leave school or may come to need it later on. If they have already had child guidance treatment as school children, it is best that the clinic which treated them in their school-days should try to give any help they require afterwards, whether it is provided by a hospital board or by a local education authority*. Not only is continuity, as we have seen, most important for the child but it will be much easier for a hard-pressed clinic to find time for boys and girls between the ages of 15 and 18 if it knows something about them already; further, this will be a means of maintaining any link with the family made by the clinic. It may sometimes be practicable for young workers to attend a child guidance clinic during working hours if they are prepared to ask for time off for this purpose and their firm is sympathetic, or if the management arrange it themselves; but often young workers may wish to keep to themselves the fact that they are going to a clinic, and for these it will be a great advantage if evening sessions can be held.

(d) *Co-operation between agencies*

345. The needs of the maladjusted boy or girl who has just left school and entered the adult world are so complex that no one service can hope to meet them all. Co-operation between all the agencies is essential. Local authorities, youth employment services, hostels, child guidance clinics and others giving advice and help over personal problems should be aware of

* Local health authorities have power, as we saw in Chapter V, paragraph 158, to provide child guidance for boys and girls not at school.

each other's existence and aims. It is important that those who first know of personal difficulties affecting a boy or girl should be ready and able to consult or call in others who can help.

(iii) **Extension of powers of local education authorities necessary**

346. There is considerable doubt whether local education authorities have the necessary powers to provide, even for children still at school, a service of the type we have suggested. Certainly they have no power to incur expenditure on a service of personal help and the provision of accommodation for boys and girls who have left school. Legislation would therefore be necessary to enable our recommendations about these matters to be implemented. It should be in sufficiently wide terms to permit experiment and variety of development, and should be permissive rather than mandatory; our wish is to see local education authorities given the power to develop their own services and to modify them as necessary in the light of further experience. Any proposal to extend powers in this way should be further considered in relation to any recommendations on this subject that may be made by the Piercy Committee.

Recommendations

We recommend that

(*a*) for children attending school after their treatment as maladjusted pupils has ceased, local education authorities should provide, where appropriate by arrangement with voluntary bodies, a comprehensive service of personal help; and, if necessary, the law should be amended to enable authorities to do this.

(*b*) for boys and girls up to the age of about 18 who are no longer at school and who were during their school-days treated as maladjusted pupils,

(i) local education authorities should provide, where appropriate by arrangement with voluntary bodies, a comprehensive service of personal help; and the law should be amended to enable authorities to do this.

(ii) consideration should be given to the question whether local education authorities should be given power to provide accommodation, either in hostels or lodgings or both, at least for those who finished their school-days at a special school or hostel for maladjusted children.

(iii) any power given to local education authorities to provide accommodation should include a power to make a charge for it which is in relation to earnings and so calculated as to leave boys and girls with adequate spending money.

CHAPTER XII

THE MALADJUSTED CHILD IN RELATION TO THE JUVENILE COURTS

347. Although the jurisdiction and procedure of juvenile courts are outside our terms of reference*, we are concerned with the arrangements to be made for those maladjusted children who appear before a court and are found to need special educational treatment. We also need to consider the circumstances in which the child guidance services are likely to be used on behalf of children who are before juvenile courts, or in remand homes, reception centres taking remand cases ("special reception centres") or approved schools.

Maladjustment in children before juvenile courts

348. If maladjustment were always detected and any necessary treatment provided at an early stage, many maladjusted children who are brought before a juvenile court would never have needed to appear there, and nearly all of those who did appear would already be known as maladjusted to the local education authority. The medical and educational reports ordinarily submitted to the court would make it clear that these children were maladjusted and in need of special educational treatment.

349. In fact, at the present time discovery is far from complete, and there appear before the courts a considerable number of children whose maladjustment is not known to the local education authority. How do magistrates find out that such children are maladjusted and what help can or should be provided by local education authorities?

350. The mere fact that a child has committed an offence against the law is no indication that he is maladjusted. It was pointed out earlier that delinquency cannot be equated with maladjustment. Some maladjusted children are timid and well-behaved: on the other hand, the offences of some delinquent children may be attributed to the fact that they had never been taught to conform to ordinary standards of behaviour. Alternatively, their misdeeds may be natural reactions to a bad or frustrating environment. A child, for example, who breaks into a shop may do it because he has failed to meet with the stimulus and outlet needed for the development of his physical, intellectual or imaginative faculties, or it may be the recognised pastime of the gang to which he belongs. (Not that no members of gangs are ever maladjusted; it sometimes happens that a maladjusted child gathers a gang around him, and if he can be picked out and treated, undesirable activities of the gang may well come to an end.)

351. It might, nevertheless, be thought that children who have committed offences against the law are more likely to be maladjusted than those who are in need of care or protection, are beyond control, or have played truant from school. In fact, children may be brought before the court for an isolated minor offence, e.g. breaking into bomb-damaged premises in the course of a

* Some knowledge of the functions and procedure of a juvenile court will, however, be a help in reading this chapter; for the benefit of readers who are not familiar with the subject, the relevant information is set out in Appendix G.

mischievous game, whereas there is usually a long history of trouble before the competent authority brings a child to court for any of the other reasons. It is also often a matter of chance which of the various avenues leads a child to the court.

352. A child's conduct, his past history or the educational and medical reports about him are more likely to suggest that the possibility of maladjustment should be investigated. In their evidence the London Society of Juvenile Court Probation Officers stated that the following are among the reasons why magistrates in the London juvenile courts ask for special psychiatric reports:

"(1) The irrationality of a child's conduct.

(2) In recidivism, a desire to establish whether or not the child is capable of being influenced by ordinary methods or whether the cause of his repeated delinquencies lies deeper.

(3) The known existence of traits in addition to the delinquency itself, such as bed-wetting, that may indicate maladjustment.

(4) The sexual nature of an offence, when it is felt important to gain knowledge of the child's state of mind.

(5) When removal from home is under consideration."

353. Before passing on, we should like to call attention to certain circumstances in which it should not be necessary for children to be brought before a court as beyond control, as they sometimes are at present. If parents in need of help with their children's behaviour difficulties do not seek it early enough, or if it is not immediately available, they may reach a stage where they cannot tolerate a child's behaviour at home any longer. It is, we understand, very doubtful whether local authorities have any duty under the Children Act, 1948*, to receive children into care in such circumstances; and as a result it sometimes happens that parents bring a child before a court as beyond control, for the sole purpose of securing his admission to a reception centre or children's home until a decision can be made about his future. The child's feeling that his parents have criticised and humiliated him before strangers may be hard to eradicate and can permanently impair his relations with his parents. The immediate solution of this problem lies outside the educational system†, but we are concerned about the serious effects which the present inability to provide temporary accommodation in these circumstances may have for children who are either maladjusted or predisposed to maladjustment.

354. The responsibility for procuring for the court information about a child's general conduct, home surroundings, school record and medical history rests with the local authority under the Children and Young Persons Act, 1933*, except that in most areas arrangements have been made for reports on the home surroundings to be provided by the probation service. This service is particularly concerned with the relationship between parent and child in the home. If the child or a brother or sister has previously been placed on probation or under supervision, it should be possible to obtain further information about the family background as well as about the child himself. We have had evidence to show that probation officers

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* As explained in the footnote to paragraph 271 (Chapter IX), the local authority acting under the Children and Young Persons Act, 1933, or the Children Act, 1948, is often referred to as " the children's authority ".

† The long-term solution is to see that all parents can readily obtain advice and help over their children's behaviour difficulties. We said something about this in Chapter VI on Child Guidance, and we shall say more in Chapter XVI on Prevention.

are on the look-out for maladjustment and that their training enables them to recognise it in, at any rate, some of its manifestations.

355. Information regarding the child's school career, health and other matters within the knowledge of the education service will normally be obtained from the local education authority. It is most important that, when asked for reports, the local education authority should mention anything known about a child's earliest years, since, as we said in Chapter IV (paragraphs 119–121), the loss of his mother and the lack of a permanent mother-substitute, or a long separation from his mother in infancy, may predispose a child towards maladjustment. It is very helpful if the school report and medical history are frank and comprehensive; educational difficulties, physical disabilities or a long illness may all be relevant. Reports should be based as far as possible on facts and not on opinions, so that they can be substantiated by oral evidence if any point in them is contested by the parents.

356. When the court ask for a special report on a child, the children's authority may arrange with the education authority for one of their child guidance clinics to examine him. It should not, however, be taken for granted that clinics will give priority to these special reports. Urgent cases come to clinics from other sources, and consultation is needed with the local education authority to see whether any special arrangements can be made.

357. In their reports on court cases it would be helpful if child guidance clinics could give reasons for their recommendations, so that if the course of action suggested cannot be carried out the court will be in a position to know the best alternative. It would also be helpful if clinics could indicate whether any particular methods of treatment are to be avoided: some maladjusted children, for example, unconsciously seek punishment, and discipline appropriate for ordinary children may only feed their maladjustment, even though on the surface they seem to respond well to a strict régime.

358. There is one way in particular in which child guidance clinics can assist juvenile courts. In their evidence the Magistrates' Association stated: "... the usefulness of the reports from the clinics depends on the ability of the staff to put their findings into language intelligible to laymen. The undue use of obscure terms is a real difficulty to magistrates and is apt, more than anything else, to deter courts from seeking help".

359. We also endorse the suggestion of the Magistrates' Association that "to increase mutual understanding, to break down prejudices and to heighten awareness of each other's problems ... meetings should be encouraged between magistrates, staffs of child guidance clinics and others connected with psychiatric work to discuss questions of common interest". Visits of magistrates to clinics, and of members of child guidance teams to juvenile courts, have also been suggested and would be of value.

Special educational treatment for maladjusted children appearing before juvenile courts

360. We have set out in paragraph 7 of Appendix G a number of ways in which supervision while a child remains at home, or boarding away from home, can be combined with special educational treatment or child guidance. The most difficult problem is presented by the maladjusted child who requires to go to a boarding school: should he be sent to an approved school or to a special school? The general view of the Home Office and the Ministry of Education is that "delinquent children who are also so handicapped as to need education in a special school should be sent to special schools

rather than to approved schools "*. The records, however, of some children appearing before a juvenile court may be such that the magistrates, and the local education authority, feel that committal to an approved school is the only practical course.

361. It is recognised that, owing to the shortage of places in special schools, especially for educationally sub-normal children, and the reluctance of special schools to take children aged 14 or over, many children who ought to be in special schools have had to be sent to approved schools; and approved schools in general are accustomed to coping with a minority of children exhibiting a considerable degree of backwardness and behaviour difficulties. Approved schools are, however, primarily designed for children whose handicaps are not severe; and the period in an approved school depends not on the nature of a child's handicap and the speed with which it will yield to treatment, but on his behaviour while there and the prospects of good behaviour after release. Where bad behaviour is due to maladjustment, inability to return home without risk of relapse may lead to a child being retained longer in the school than would otherwise be necessary, unless the school can arrange to place him in a different environment. Further, a maximum period (usually three years) is fixed in advance beyond which a child cannot stay in an approved school even if the nature of his handicap or the progress of his treatment makes this desirable.

362. We regard the general principle set out in paragraph 360 as the right approach to the problem, provided that certain points are fully understood and accepted. In order to safeguard the interests of the other maladjusted children in special schools, it must be recognised that a special school has a right to refuse admission to a child whom the staff doubt their ability to handle, or to exclude at any time a child who is found unmanageable. Most special schools should be able to absorb one or two very difficult children, but there are a few children who exercise such a strong influence over their fellows that they can disrupt a whole school. Some of these children will never appear before a juvenile court. A proportion, of course, may need in-patient treatment in a hospital; experiment is needed to discover the best methods of dealing with the other children of this type.

363. Once a court has decided that a maladjusted child should be dealt with inside the educational system, it is for the local education authority to determine, in consultation with the parents, the form of special educational or medical treatment he should receive and the establishment or service which should provide it. Where, however, parents refuse their consent to a child going to a boarding special school, the only certain means of securing his attendance at the school is (as we saw in Chapter V, paragraph 145) for the court to make a Fit Person Order.

364. The views expressed in the preceding paragraphs are general in character and necessarily based upon the existing framework. We recognise, however, that the distinction between the maladjusted child and the delinquent must often be administrative rather than real, and is likely to be affected by the suitability of available vacancies. Apart from the legal limitations outlined in paragraph 361, there may be little difference in régime between some special schools and certain approved schools where there is a psychiatric approach. Growing children can never be fitted into categories or labelled once and for all. What is needed is a system sufficiently flexible to ensure that, where residential treatment is necessary, it will be provided to suit the needs of the individual child.

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* See paragraph 16 in Appendix I of the joint Circular from the Home Office and the Ministry of Education on Juvenile Delinquency issued in July, 1953 (Home Office Circular 99—Ministry of Education Circular 265).

Use of child guidance facilities by juvenile courts, remand homes, special reception centres and approved schools

365. The children's authorities are responsible for providing remand homes, reception centres and a number of approved schools. Arrangements, therefore, for making use of child guidance services for children in these establishments are in the hands of the children's authority, just as are the arrangements for children before juvenile courts on whom magistrates require special reports. It is impossible at the present time to estimate the number of children for whom the children's authority will require child guidance facilities. The number obtaining child guidance treatment will largely depend on the nature of the facilities available in the area. If it ever becomes possible to send to special schools all maladjusted children who need special educational treatment in a boarding school, and if maladjusted children are more frequently discovered and treated before any question arises of bringing them before a juvenile court, the calls made by the children's authority on the child guidance services will be greatly diminished. For the present, however, it appears to be the general tendency, from the evidence received about juvenile courts, remand homes and approved schools, to make more use of the child guidance facilities than was done even a few years ago.

Recommendations

We recommend that

(1) as a means of increasing mutual understanding, meetings should be arranged between magistrates of juvenile courts and the staff of child guidance clinics.

(2) in general, every child appearing before a juvenile court who is so handicapped as to need special educational treatment in a boarding school should be provided with residential treatment by the local education authority rather than be sent by the court to an approved school.

CHAPTER XIII

THE SIZE OF THE PROBLEM

366. It would have been more in accordance with the usual practice of Committees charged with an investigation such as ours, if we had devoted one of the opening chapters of this report to an estimate of the size of the problem before us. This was our original intention. We realised from the outset that we must make an estimate of its size, both to enable its dimensions as a human problem to be appreciated and to give an idea of the staff and facilities needed for tackling it.

367. We first attempted to make an estimate of the incidence of maladjustment, expressed as a percentage of the child population ; from that we hoped to be able to deduce approximately the staff and facilities likely to be required. We had to abandon this attempt, however, for reasons which will be explained below. We decided that, in the present state of knowledge, we should be performing a more useful service if we made a purely practical estimate of what should be attempted in the next decade as a guide for those responsible for planning future developments.

368. In the early part of this chapter (paragraphs 370-378) we give some account of our attempts to arrive at an estimate of incidence and the difficulties involved. This will, we hope, serve to give a general idea, however approximate, of the size of the problem in relation to the school population as a whole, and may at the same time be of some use to those who wish to conduct further research into the incidence of maladjustment. In the remainder of the chapter (paragraphs 379-386), we give our assessment of what might be attempted in the next decade, expressing this in terms of the number of trained staff in child guidance services, special schools and hostels —psychiatrists, educational psychologists, psychiatric social workers, teachers and house-staff.

369. Since we have decided to express our views on the size of the problem in terms of staff required, it has seemed better to us to make this one of the later chapters in our report, following those in which we have discussed methods of treatment and preceding those in which we deal with recruitment and training of staff.

Difficulties in estimating incidence of maladjustment

370. A percentage of incidence can be expressed in a number of different ways, even if only those children are being considered who are at school and need to attend a child guidance clinic, e.g.,

(*a*) the percentage (of the school population) at any given moment needing to attend a child guidance clinic ;

(*b*) the percentage in any twelve months needing to attend a clinic ;

(*c*) the percentage needing to attend a clinic at some point in their school career.

371. Even if the basis is clear on which a percentage is calculated (and this is not clear for some of the estimates made in the past), the size of percentages based on (*a*) or (*b*) will be affected by the adequacy of the child guidance facilities already available. The less adequate the facilities the

higher will be the percentage, because it will include an accumulation of children over a period of years who continue to be in need of treatment but have never received it.

372. Even if there were an area with a sufficiently adequate child guidance service to ensure that there was no accumulation of cases awaiting attention—and there is certainly no such area in the country at the present time—there are other variable factors which would need to be taken into account. One element of uncertainty is the average length of time which a course of treatment is likely to take. The severity of maladjustment varies and the troubles of some children will clear up much more quickly than those of others ; treatment also is itself an elastic process, depending on the approach and methods of the staff responsible for giving the treatment. Another element of uncertainty is the number of children who may need to attend a clinic at more than one point in their school career.

373. In order to obtain a reasonably accurate picture of incidence which could be used for planning, it would be necessary to select several areas with a sufficiently adequate child guidance service to ensure that all children requiring treatment were discovered and treated, and to secure from each of these areas the following estimates:—

(i) the number of maladjusted children who began to be treated at a child guidance clinic in the course of one year ;

(ii) the number of these who had previously had courses of treatment and been discharged as cured ;

(iii) the duration of the treatment of each child discharged as cured during the year, and the amount of time which each of the different members of the team devoted to him during the course of treatment.

It will be many years before there is any area in the country with a well enough developed service of sufficient experience to answer these questions with any hope of accuracy.

Estimates of incidence attempted by the Committee

374. The full extent of the difficulties in estimating the incidence of maladjustment which we have just mentioned only became apparent to us in the course of our deliberations. At an early stage we set up a sub-committee to investigate incidence. This sub-committee in the autumn of 1951 held a conference with officers of six local education authorities* having well-established child guidance services, with a view to forming a preliminary idea of the size of the problem. After this meeting one of the authorities, Somerset, suggested that an ad hoc investigation was required and offered to carry out a pilot survey. This offer was most gratefully accepted by the Committee, and the survey was carried out in the first part of 1952. Following on this, two other authorities, Berkshire and Birmingham, kindly agreed to carry out similar surveys in 1953.

375. Summaries of the reports on these three surveys will be found in Section (*a*) of Appendix H, from which it will be seen that for the purpose of the surveys the definition of maladjustment was related closely to a child's need to attend a child guidance clinic, at least for a diagnostic interview. The proportion of children requiring to attend a child guidance clinic in the sample of the child population taken by each of these authorities was variously estimated as 5·4 per cent. in Berkshire, 7·7 per cent. in Birmingham and 11·8 per cent. in Somerset. Though each of these authorities had a relatively well developed child guidance service, these percentage figures,

* Bristol, Essex, Leicester, Nottingham, Sheffield and Somerset.

which represent a snapshot of the situation in each area as it was at a given date, undoubtedly include also an accumulation of undiscovered and untreated cases which could have been previously discovered and treated if the services had been more nearly adequate. The wide divergence between these percentages also conceals some difference of approach between the investigations in the different areas, though we had endeavoured to ensure that the broad line of approach was similar in each.

376. Although one result of these pilot surveys has been to warn us of the danger of attempting, at the present stage of knowledge and development, to make an *a priori* estimate of requirements based on a percentage of incidence, there is much material in Appendix H which may be of use for further research. We hope that the three authorities may be able to follow up in a few years the children investigated in their samples, since a comparison between their conditions then and at the time of the survey should reveal much about the effects of treatment and about the extent to which maladjustment rights itself in the normal process of development. The material already collected throws light on such matters as the discrepancies between parents' and teachers' assessments of children, and the age-groups and the types of area in which maladjustment is most prevalent.

Other published estimates

377. We think that it may be of interest to mention some other published estimates of incidence. In 1946 the Ministry of Education published a pamphlet on " Special Educational Treatment " in which it was suggested that maladjusted children constituted about 1 per cent. of the registered pupils in maintained schools. We understand that this estimate was intended to mean that about 1 per cent. would need treatment in any one year, although this was not made clear in the pamphlet. Similarly, Dr. C. P. Blacker, in his book " Neurosis and the Mental Health Services ", also published in 1946, wrote : " It has been estimated that, in an average school population, between 1 and 2 per cent. of all children need guidance each year ".*

378. Another estimate was given by the Advisory Council on Education in Scotland in their report " Pupils who are Maladjusted because of Social Handicaps ", published in 1952. In this report, the Advisory Council recommended " that in planning the education and treatment of maladjusted pupils an incidence of 5 per cent. of pupils of school age be assumed ", and " acceptance of the estimate that between 3 per cent. and 4 per cent. of pupils of school age require clinical child guidance services ". This figure unfortunately cannot be compared with any of the others, because the Council did not make it clear whether the percentage related to the number of pupils requiring treatment at any one time or at any point in their school career.†

Number of child guidance staff required

379. As we said at the beginning of this chapter, we decided to make a purely practical estimate of what should be attempted during the next decade. As a preliminary to this, we addressed an enquiry to the chief education officers of a 1 in 3 sample of the 96 local education authorities which had a child guidance service in 1952. Each chief education officer was asked, after any local consultation deemed appropriate, to give his opinion, based on recent experience, of the number of child guidance staff

* An attempt is made in Section (*b*) of Appendix H to compare the results of the three pilot surveys with the two estimates quoted in this paragraph.

† Three further estimates of incidence among children and adults are given in Section (*c*) of Appendix H.

required to deal adequately with all the children in his authority's area who need to attend a child guidance clinic. The range of estimates was wide, but the majority were bunched fairly closely together. The staff estimated to be needed for the 32 areas was (expressed as full-time equivalents) 31 psychiatrists, 61 educational psychologists and 74 psychiatric social workers, giving a ratio of 1:2:2½.

380. In Chapter VI we came to the conclusion that the most suitable ratio between psychiatrists, educational psychologists and psychiatric social workers was 1:2:3, as compared with the ratio of 1:2:2½ shown in this estimate from the 32 local education authorities. If the estimate received from the 32 areas is applied to England and Wales as a whole, but an increase in the number of psychiatric social workers is allowed for so as to give a 1:2:3 ratio, the total number of child guidance staff in these three categories required in England and Wales would be the equivalent of 140 full-time psychiatrists, 280 educational psychologists and 420 psychiatric social workers. The number of staff employed by local education authorities in England and Wales in December, 1954, including psychiatrists whose services were made available to them by regional hospital boards, was, in terms of full-time equivalents, 56 psychiatrists, 141 educational psychologists and 109 psychiatric social workers.

381. This estimate is thus far in excess of the number of clinic staff at present available. Expansion to this level would, on the average, entail a doubling of the service in the areas of the 32 local education authorities consulted and a roughly similar expansion in the areas of the remainder of the 64 authorities which had a child guidance service in December, 1952; the remaining 50 authorities had no child guidance service at all. Nevertheless, we are satisfied that this estimate, based as it is on the experience of a number of authorities in running a child guidance service, is the most realistic objective which we can suggest at the present time. It would certainly be impracticable to suggest aiming any higher in view of the wide disparity between even this figure and the clinic staff at present available. We suggest in our next chapter ways in which the supply of clinic staff might be increased; it would indeed be gratifying if the comparatively modest* objective we have set were attained during the next decade.

382. We desire to emphasise most strongly that this ten-year objective is in no sense an attempt to forecast ultimate requirements. The way in which the figure was arrived at clearly rules this out. We have, for instance, made no allowance for any marked increase in the number of pre-school children seen and treated. If there were a substantial increase in the number of these seen (as we hope there will be), fewer school children could be seen unless staff were increased. On the other hand, the treatment of an increasing number of children of pre-school age may reduce the number of children of school age who need treatment. As the number of areas increases in which a reasonably adequate service is available, it will be possible to make further estimates of the true extent of the problem and to vary the expansion of child guidance services accordingly.

383. Authorities responsible for making plans will need to know how large a school population can be adequately served by a child guidance

* The largest increase proposed is in the number of psychiatric social workers. The Committee on Social Workers in the Mental Health Services, however, which reported in 1951, described as conservative a figure of 500 psychiatric social workers merely for child guidance centres provided by local education authorities. Some of the recommendations of the Committee (which is usually known as the Mackintosh Committee) will be discussed in the next chapter.

team consisting of the equivalent of one full-time psychiatrist, two educational psychologists and three psychiatric social workers. Our ten-year objective would allow for one such team to approximately 45,000 school children*. As against this, it should be mentioned that some child guidance teams already serve areas containing smaller numbers of children, and that Essex, one of the largest authorities in the sample of 32, estimate from the experience of the well developed service they already have that one team of this size can only adequately cover a school population of about 35,000.

384. An estimate of incidence can also be worked out from the information available about the child guidance staff of the 32 authorities. In these areas it is known that about 0·5 per cent. of the school population attended a child guidance clinic in 1952. Since those authorities estimated that, to meet the needs of their areas, they require approximately double the staff which they then had, it would seem that in their view roughly 1 per cent. of the school population would need to attend a child guidance clinic in any one year. This figure can be compared with those in paragraph 377.

Number of teachers required

385. There are at present about 120 teachers in special schools for maladjusted pupils. It is impossible to forecast the number of additional day or boarding special schools likely to be needed for maladjusted pupils during the next decade, but, as we saw in Chapter X, there is a general shortage of special school places. An accurate estimate at the present time is impossible, but the number of teachers needed in special schools for the maladjusted is likely, on the most conservative forecast, to double from 120 to 240 over the next ten years.

Number of house-staff required

386. There are at present about 250 house-staff in boarding special schools and hostels for maladjusted pupils—about half in each. The number of house-staff is likely to increase less rapidly than the number of teachers, since we hope that some of the additional provision made will be in the form of day special schools. The number of house-staff needed ten years hence is, however, likely to be at least 400.

Recommendations

We recommend that, over the next decade,

(1) the objective should be to increase the number of child guidance staff to the equivalent of approximately 140 full-time psychiatrists, 280 educational psychologists and 420 psychiatric social workers.

(2) local education authorities should plan on the assumption that a child guidance team, consisting of the equivalent of one full-time psychiatrist, two educational psychologists and three psychiatric social workers, can adequately serve 45,000 school children.

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* This figure is obtained by dividing the school population of England and Wales (say 6,500,000) by the number of psychiatrists in our estimate expressed as a full-time equivalent (140).

CHAPTER XIV

THE TRAINING AND SUPPLY OF CHILD GUIDANCE STAFF

387. In Chapter XIII an attempt was made to give some idea of the size of the problem of maladjustment in terms of the number of trained staff needed in child guidance services, special schools and hostels—psychiatrists, educational psychologists, psychiatric social workers, teachers and house-staff. In this and the following chapter we shall discuss the training which the various kinds of staff require for carrying out their functions, the training facilities needed and the supply of candidates. Where appropriate, we shall say something about selection and about ways of reducing the gap between supply and demand.

388. In Chapter VI, paragraph 182, we mentioned some other workers who may usefully be associated with a child guidance team; they will all require professional training but, apart from the non-medical child psychotherapists whose numbers are very small, the others' main field of interest is not child guidance. We therefore propose to deal only with the three basic members of a child guidance team. Although psychiatrists, educational psychologists and psychiatric social workers all receive professional training which prepares them for other work besides child guidance, our concern is to see how far their training is an adequate preparation for child guidance, including the work of a school psychological service.

389. Not only must the training received by each profession fit its members to carry out their own special functions, but it must prepare them for work in a team. The training and supply of psychiatrists, educational psychologists and psychiatric social workers will be considered separately, but it is important not to lose sight of their interdependence in child guidance work; and it will be seen that some of the factors affecting supply and training apply to each of the three groups.

390. The contribution made by psycho-analysis to the preparation for child guidance work should be mentioned here. Many psychiatrists, psychologists and psychiatric social workers decide to undergo a personal analysis as part of their training, though this is in no way obligatory. Analysis is of necessity a lengthy procedure, lasting years rather than months, but it can be—and normally is—combined with the holding of a salaried post; there are, however, few centres outside London where an analysis can be obtained. It is of interest that the three training courses for non-medical child psychotherapists which are recognised by their professional association regard a personal analysis as an essential part of the preparation for this work.

Psychiatrists

Functions

391. The work of a psychiatrist in a child guidance service has been described in Chapter VI and Appendix F; and the need for a psychiatrist to pay regular visits to hostels and boarding special schools has been mentioned in Chapter IX (paragraph 262) and Chapter X (paragraph 302).

Training

392. The special qualification normally held by psychiatrists is the Diploma in Psychological Medicine, the examination for which covers nervous diseases, mental illness in children and adults, and mental deficiency. Most candidates take the conjoint D.P.M. of the Royal College of Physicians and the Royal College of Surgeons. This is now the only external examination; five universities in England and Wales and one in Scotland hold internal examinations for the D.P.M.

393. The general training of a doctor usually takes six years, with a requirement to spend a further year in obtaining hospital experience in approved posts before final registration as a medical practitioner. After this, a doctor who proposes to specialise in psychiatry often seeks over a period to increase his experience and qualifications in general medicine, e.g. by taking a M.D. or M.R.C.P., before starting his training in psychiatry. Under the regulations for the conjoint D.P.M. of the Royal College of Physicians and the Royal College of Surgeons, a candidate cannot take the final part of the examination unless he has had at least "two-years' whole-time experience in a recognised psychiatric hospital, centre or department, of which not more than twelve months may be spent in a hospital or department without psychiatric beds". No child guidance clinic has so far been recognised for this purpose and, although a candidate knowing nothing about child psychiatry would be at a serious disadvantage, it is theoretically possible for somebody without any experience or knowledge of it to obtain a D.P.M. Possession of a D.P.M. can in any event only be looked on as a qualification in general psychiatry; training and experience in child psychiatry have to be obtained afterwards.

394. Post-graduate training for a doctor is bound to be arduous, since during most of it he has to earn a living and obtain practical experience by holding salaried posts at the same time as he is acquiring theoretical knowledge for passing his higher examinations. After the intending psychiatrist has completed his general medical training and obtained a D.P.M., he may still have to hold relatively junior posts while he is acquiring the necessary training and experience in child psychiatry.

395. A well-qualified doctor who expects to attain consultant rank in child psychiatry will thus have undergone ten to eleven years training before finally concentrating on the study of maladjusted children. This length of training in general medicine and general psychiatry may be a necessary basis for the study of children, but it is to be regretted that, until a doctor begins to concentrate on psychiatry some eight or nine years after acceptance as a medical student, he may in class or clinic spend a very small proportion of his time on the study of psychiatry and even less on general and child psychology.

396. For post-diploma training, it will be necessary to provide sufficient paid training posts. A number of child guidance clinics with facilities for training will be required. The essentials for a clinic undertaking training are: above all, a consultant psychiatrist who has had enough experience to enable him to teach child psychiatry; a full team, so that the child psychiatrist in training can learn to work with other members; space to work in; and time for full discussion of cases, seminars, etc. We hope that all of the child psychiatrist's training can be provided in association with a university; and it is important that clinics used for training should be within reach of one, so that psychiatrists in training can obtain clinical teaching there without difficulty. Facilities for obtaining a personal analysis will also be an advantage.

Selection

397. In evidence from one training centre we were told that many applicants for training were unsuitable. The personality of a psychiatrist is one of the chief factors governing his success in his work, and it is essential that all candidates should be interviewed, as personal qualities cannot be assessed from written reports. No candidate should be considered suitable unless he has a genuine interest in and understanding of children. The selection board should include at least one child psychiatrist.

Supply

398. In Chapter XIII we recommended that the immediate aim, during the next decade, should be to secure the equivalent of 140 full-time psychiatrists in the child guidance service. There were in December, 1954, the equivalent of only 56 employed in clinics provided by local education authorities, including those whose services were made available by hospital boards. There are also some psychiatrists employed in child guidance clinics provided by hospital boards: in 1951 the full-time equivalent of these was 39*, though there may have been some overlap with the number returned for local education authorities' clinics. The present shortage is felt most keenly in the Midlands, the North of England and Wales because of the reluctance of many psychiatrists to settle down a long distance from London.

399. In addition to the quantitative deficiency, there is also the problem of quality. Witnesses have told us that not all the psychiatrists working in child guidance services have had suitable training for work with children. This may have arisen during a period of shortage of fully-trained child psychiatrists, but we are seriously concerned at the double inadequacy of the present supply. Some ways of improving the position are:

(i) All medical students should be given lectures on general and child psychology.

(ii) Many medical students are told very little about child psychiatry. It is during a doctor's general training that interest in a speciality is aroused, and we think that all medical students should attend a child psychiatric department.

(iii) All medical schools should have links with a child guidance clinic, either one already established close at hand or one specially provided for training purposes in attachment to the medical school. These training clinics would not only be available for the post-diploma studies of intending child psychiatrists, but would also assist in preparing doctors for the D.P.M. and afford an opportunity for medical students to learn the elements of child guidance. The establishment in areas a long way from London of training units of high professional standing should help to attract child psychiatrists to apply for posts in those areas.

(iv) A fully trained paediatrician may wish to train as a child psychiatrist, but at present the training ladders of the two specialities are quite separate. We agree with the views expressed to us that paediatricians could make a valuable contribution to child psychiatry, and that arrangements should be made to enable some of those who wish to take up child psychiatry to obtain the necessary training without loss of status.

400. We have confined our recommendations to the field of child psychiatry and to the training and preparation of the doctor for this work, because the general subject of psychiatry is outside our terms of reference. We recognise, however, that, since child psychiatrists need to have a basic training in general psychiatry, the problems of the training and supply of child psychiatrists cannot effectively be tackled apart from the training and supply of psychiatrists generally.

* No more up-to-date figures are available.

Educational Psychologists

Meaning of terms "Educational psychologist" and "Clinical psychologist"

401. It was pointed out to us in evidence that there are several current meanings of "educational psychologist". We are concerned with psychologists who work in child guidance clinics or school psychological services or both and are mainly dealing with individual children. Sometimes, however, the term "educational psychologist" is used to describe psychologists working in the educational field who are mainly concerned with group testing (e.g. at the age of 11), statistical techniques and research; or lecturers in universities and training colleges who in their studies have gained a systematic theoretical knowledge of educational psychology.

402. A source of confusion is the term "clinical psychologist", which is used in several senses and may overlap "educational psychologist". The present trend is to regard a clinical psychologist not as somebody with a particular kind of training but as somebody doing a particular kind of work, e.g. in clinics, especially hospital clinics, or mental hospitals. Similarly, a psychologist who works in schools as well as clinics is generally described as an educational psychologist.

Functions

403. The functions of an educational psychologist in a school psychological service and a child guidance clinic have been described in Chapter VI and Appendix F.

Training

404. The training of an educational psychologist for child guidance work normally consists at present of a full-time post-graduate course lasting an academic year (October to July). Such courses are held in London at the Child Guidance Training Centre (4 places a year); the Tavistock Clinic (4 places); the Department of Psychology, University College (4 places); and the Department of Psychological Medicine, Guy's Hospital (1 place): and in Birmingham at the University's Department of Education (4 places). The Maudsley Hospital in London offers a 13-months' course in clinical psychology, which is recognised as suitable for educational psychologists provided that students have had at least three years' teaching experience; of the 12 places available annually in this course only one or two have usually been filled by students with this teaching experience. These are all the training facilities in England and Wales recognised by the British Psychological Society through its Committee of Professional Psychologists (Mental Health). In addition, a number of educational psychologists employed in England and Wales were trained in Scotland; the facilities for training in Scotland will be mentioned in paragraph 426 (iv).

405. In any future expansion or development of the training facilities, we recommend that two general considerations should be borne in mind:

(*a*) There are advantages in training educational psychologists of the kind we have in mind in the same establishment as psychiatrists and psychiatric social workers, since joint sessions and discussions of cases during training are a good preparation for work as a team later on. These conditions are fulfilled at the London Child Guidance Training Centre and the Department of Psychological Medicine at Guy's Hospital.

(*b*) There are also advantages in courses being run by university departments of psychology or education. Teachers of a university standard are available; the link which a university usually has with a teaching hospital is valuable; and students are brought into contact with other problems, and with research which might help them in their own work. Moreover, a university department is likely to keep educational values to the forefront.

406. Periods of practical work in child guidance clinics during the year's training are, of course, essential; and for this more clinics are needed with the facilities for training which have already been mentioned in this chapter in the section dealing with psychiatrists (paragraph 396). It has been suggested to us that it would be desirable for a newly-trained educational psychologist to gain further clinical experience by spending the first year of employment in a clinic where he would be under the supervision of a more experienced psychologist. This system would have the advantage of ensuring that a newly-qualified psychologist did not have to gain his experience (as he often has to at present) while working as the only psychologist in a child guidance clinic. Probably the psychologist would wish to stay on for a period after his first year had finished; and this would be advantageous to the working of the clinic and the school psychological service, even though it would mean that a clinic could only take a newly-trained psychologist at irregular intervals. Very few clinics at the present time employ more than one educational psychologist, so that it would be impracticable to insist on the first year always being under supervision. Where, however, conditions allow this to be done, it would be most valuable. When there are more child guidance clinics able to undertake training and more training centres, the practicability of a general scheme for an initial period of clinic work under supervision should be further considered in the light of the experience which has been gained.

407. The training of a psychologist should help him to acquire the art of approaching children as individuals, whatever their age and the type and extent of their handicap. As the British Psychological Society said in their evidence: "Unless he can make a satisfactory contact with a child and an appropriate adaptation to him during the testing interview, there is no assurance that the resulting assessment of the child's abilities, or the use he is making of these abilities, is sufficiently reliable to be used as a basis for recommendations". The psychologist must also learn the art of winning the confidence of parents and teachers, and must be conversant with the powers and responsibilities of the various social workers and agencies with which a child may come in contact, including of course the education service itself.

408. It would not be appropriate for us to examine in detail the content of the present training courses. There is need for a permanent body to bring together all the psychological, educational and medical interests involved in the training of educational psychologists, and we welcome a suggestion by the British Psychological Society that a Training Council should be set up to be the recognising body for training courses and to advise on their content and standards. It should seek to secure a higher status for training courses and for the whole profession of educational psychology, through setting up recognised standards and giving advice when required to those running courses. We also consider that it would be in the general interests of child guidance if meetings could be arranged between a Training Council set up by the educational psychologists and any organisations representing other professions concerned (e.g. the Association of Psychiatric Social Workers—see paragraph 430).

Qualifications and length of training

409. At present candidates for the one-year training courses in child guidance work are required to possess a suitable university degree and normally to have had at least three years' teaching experience; before teaching, many graduates take a one-year teacher training course. This means that training occupies five years (three years' degree course, one year's training as a teacher and one year's course in child guidance work), with a break of three years while the candidate is serving as a teacher—i.e. eight years in all.

410. Only certain degrees are accepted as a suitable preliminary to a one-year course in child guidance work—an honours degree in psychology, a Master of Education or Bachelor of Education of a British University, or a degree in some other subject provided that it includes sufficient study of psychology. Graduates holding other degrees can qualify as educational psychologists by taking a two years' course for the post-graduate diploma in psychology at University College, London, open to graduates who have had experience in work with children—usually teaching experience. The first year's syllabus of this course covers the relevant parts of an honours degree in psychology, while in the second year the student takes the ordinary post-graduate course in psychology to which holders of honours degrees in psychology (or of equivalent degrees) proceed direct. It may thus take graduates in subjects other than psychology nine years after leaving school to become educational psychologists—three years' degree course, one year's training as a teacher, three years' teaching and two years' course in psychology.

411. We have considered carefully whether it would be practicable to shorten and simplify the stages which lead to qualification. Teaching experience is clearly an essential part of an educational psychologist's background. He has to advise teachers on the handling of the educational problems of individual children; and his advice will not readily be accepted unless teachers know that it is based on experience of facing in the classroom the same sort of difficulties as they do. Experience in a primary school has the greatest value, but most graduates entering the teaching profession take posts in secondary grammar schools; many intending educational psychologists are thus unlikely to gain experience with young children. Moreover, very few boys or girls think of educational psychology as a career at the time they leave school or even at the university. Educational psychologists are recruited largely from the ranks of serving teachers; and in many cases it is as a result of their experience as teachers that their interest is aroused in the possibility of specialising in psychology. So far from suggesting, therefore, that the minimum period of teaching experience should be reduced below three years, we hope that many educational psychologists will have had longer experience than this before finally deciding to specialise. In this way not only will their decision be more soundly based, but they will be more mature when they qualify as psychologists.

412. If educational psychologists are to be recruited mainly from the ranks of serving teachers, it follows that they must first be qualified teachers. At present graduates are not obliged to take a one-year training course in order to qualify as teachers, though the great majority in fact do so. If at some future date graduates intending to qualify as teachers are required to take a one-year training course, educational psychologists will inevitably have had to take such a course as well as have adequate teaching experience.

413. We have considered the possibility of reducing below two years the course in psychology which has to be taken by candidates who have graduated in other subjects; and in particular whether in their year's training as a

teacher graduates might have acquired sufficient practical knowledge of psychology to enable them to train as educational psychologists in one year. But no reduction in the length of the two years' course seems to be practicable. A full year is needed to acquire the necessary theoretical knowledge of psychology, and a further year for clinical training.

414. Since it is accepted that graduates in subjects other than psychology can learn enough about psychology in a two years' course (see paragraph 410), we have considered whether experienced non-graduate teachers could not also be enabled to train as educational psychologists through such a course. Not only would a new field of candidates be opened up but the total length of training would be reduced (two years' training as a teacher, three years' teaching and two years' course in psychology—seven years in all). The psychologists to whom we have put this question have agreed that there may well be certain non-graduate teachers who could be trained to become satisfactory educational psychologists, but in the evidence submitted to us no suggestion has been made that this should be done. It is clear that psychologists would much prefer to remain a graduate profession ; indeed it is not in doubt that a university training should be valuable to an educational psychologist, giving him a high standard of intellectual integrity, helping him to think clearly and developing his critical powers. Whether it is worth exploring further the possibility of admitting non-graduate teachers to courses in psychology leading to qualification as an educational psychologist will depend on the extent to which the supply of graduates, after adoption of the measures we suggest, proves to be sufficient.

415. A way of reducing by one year the length of time before a psychologist holds a salaried post would be to substitute in-service training for the one-year course in child guidance work ; and an experiment on these lines is being conducted in Leicester. A psychologist trainee has been appointed to the child guidance service outside the establishment of educational psychologists, and she is being given training, theoretical as well as practical, which will last two years. The qualifications asked for were a degree in psychology and " appropriate previous experience (e.g. teaching) ". An obvious difficulty with this form of training is the arrangement of the lectures and seminars which are needed on the theoretical side ; and we understand that the Committee of Professional Psychologists have not yet determined their attitude to the Leicester scheme. It is, however, of value that such an experiment should be carried out in an area where there is a comprehensive child guidance service, including a well-established school psychological service, and the results will be awaited with interest.

Selection

416. We spoke in paragraph 407 about the need that an educational psychologist should be able to put children at their ease so as to obtain a good response from them when they are being tested. His work will of course bring him into contact with children in a wide variety of other ways. Training can help him to acquire the art of approaching children, but he will not succeed in this unless he has the personal qualities for this work. Selection of educational psychologists, therefore, as of psychiatrists and psychiatric social workers, should take into account personal qualities as well as qualifications and previous experience.

Training in the National Health Service

417. Another method of training psychologists was established in February, 1954, when the Whitley Council for the Health Services instituted a new grade of Psychologist. People are eligible for appointment who hold an

honours degree in psychology or other approved qualification. The intention is that Psychologists should only be appointed to departments where there is a Senior or Top grade Psychologist. The Psychologist serves a probationary period of three years, after which he has to obtain a certificate of proficiency from his employing authority. For the probationary period the salary scale ranges from £415 to £500, and, after a certificate of proficiency has been obtained, from £575 to £850.

418. These Psychologists might be employed in child guidance clinics and so gain practical experience of the clinical side of work with maladjusted children. They might however be employed in mental hospitals or in other types of establishment ; and, even if they worked in child guidance clinics, it is unlikely that they would have had either training or experience as a teacher or would work part-time in a school psychological service. We cannot therefore regard somebody who has had employment as a Psychologist in the health service as necessarily possessing suitable qualifications or having had adequate training for work as an educational psychologist.

419. The financial conditions for Psychologists in the health service are much more attractive than the present grant arrangements for training as an educational psychologist (see paragraph 425 (i)) ; and apprehension has been expressed that most of the best graduates in psychology might apply for posts as Psychologists in the health service even if they hoped to work as educational psychologists later on. It is too early to measure the effect of the introduction of this new grade on the number and quality of applicants for training as educational psychologists, but the position will clearly need to be kept under careful review.

420. Fears expressed on two other counts have not been realised. Nine out of the 17 places available annually for training educational psychologists (see paragraph 404 above) are in establishments which come under the national health service, but none of these has been reserved for the new grade of Psychologist. The annual Exchequer grant to the National Association for Mental Health, part of which is used to provide fellowships for some of the educational psychologists in training in London (see paragraph 425 (i)), has not been reduced ; indeed for the year 1954–55 it was increased, and for 1955–56 it has been maintained at the same figure.

421. Although experience as a Psychologist in the health service cannot be regarded as sufficient qualification for a post as an educational psychologist, there are advantages in avoiding a complete division in training. A training course giving adequate training for work in either the educational or the health services would widen the field of opportunity and so make the career of a psychologist more attractive ; and the fact that some psychologists in the two services have had a common basic training should promote understanding and co-operation between them. The difference in the work of the two services need be no obstacle to the provision of a common basic training. Although psychologists in the health service deal mainly with adults and psychologists in the educational service mainly with children, it is important that psychologists in either service should know about both adults and children. In fact, some of the educational psychologists trained at nearly all the courses except the Birmingham course have taken posts in the health service. There thus seems to be no reason why the basic training of psychologists intending to work in either service should not be the same ; and we hope that, when changes in the training of either educational or clinical psychologists are under consideration, this point will be borne in mind. Towards the end of courses a certain amount of specialisation, mainly in the practical work undertaken, could be introduced.

Supply

422. In the last chapter we recommended that the immediate aim, during the next decade, should be to secure the equivalent of 280 full-time educational psychologists in the child guidance service. In December, 1954, there were only the equivalent of 141 full-time educational psychologists employed by local education authorities. A further number are employed in clinics provided by hospital boards, but probably the majority of psychologists employed by hospital boards (in 1951 the full-time equivalent was 25*) are not trained as educational psychologists.

423. As with psychiatrists, in addition to the quantitative deficiency there is also the problem of quality. From an enquiry made by the Association of Education Committees in August, 1953, it appeared that, not only had the great majority of authorities experienced considerable difficulty in filling vacancies within their existing establishments, but, even when vacancies had been filled, the field of candidates was usually small and it was a common observation that applicants were newly qualified and had had insufficient teaching experience. It is known from other sources that, in the absence of educational psychologists with the proper experience and training for work with individual children, some applicants without these have in the past been accepted for work in child guidance clinics and school psychological services. As in the case of psychiatrists, the shortage is aggravated by uneven distribution ; many educational psychologists are reluctant to leave the South of England.

Reasons for the shortage

424. We do not believe that salaries play a large part in causing the shortage. The great majority of educational psychologists are paid on the scales laid down by the Soulbury Committee, though these are not mandatory. In its third report issued in 1954 the Committee recommended as the salaries " appropriate as a minimum provision " for educational psychologists three scales, which are related to the type of work performed and the degree of responsibility carried†.

425. In our view the reasons for the shortage must be looked for elsewhere:

(i) *Uncertainty about obtaining adequate financial assistance while training*

There are four ways in which assistance can be obtained with the cost of training:

(*a*) for training at the Department of Education, University of Birmingham, up to 1955‡, through a grant to cover the tuition fee and assist with maintenance, which is paid to the Department by the Ministry of Education under the Training of Teachers Grant Regulations, 1950 ;

(*b*) for training elsewhere, through secondment by a local education authority under the terms of the Ministry of Education's Circular 160§, whereby authorities can second teachers for a year's training and pay their salaries ;

(*c*) for training elsewhere, through a further education grant from their authority ;

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* No more up-to-date figures are available.

† The lowest scale is £775×£25—£915 for a man, £705×£20—£815 for a woman; the middle one is £915×£25—£1,115 for a man, £815×£20—£965 for a woman; and the highest is £1,115×£25—£1,300 for a man, £965×£20—£1,100 for a woman.

‡ [*Note by the Ministry of Education. From 1955–56 teachers employed by local education authorities may be seconded on full salary to attend this course, the authorities' expenditure on salaries being "pooled". Grant will continue to be payable in respect of teachers ineligible for secondment.*]

§ " Training of Staff for Child Guidance ", issued on 29th January, 1948.

(*d*) as well as through (*b*) or (*c*), assistance for training at the London Child Guidance Training Centre, the Tavistock Clinic or the Department of Psychological Medicine at Guy's Hospital may be obtained through a fellowship awarded by the National Association for Mental Health.

Of the four methods, (*b*) and (*c*) and, up to 1954, (*d*) have proved unsatisfactory in practice. Secondment is usually more advantageous financially than a further education grant, but local education authorities have seconded very few teachers under the terms of Circular 160. Many authorities have been reluctant to help teachers to train if their own posts for educational psychologists are filled; and, where they have seconded somebody, it has on occasion been made a condition that he should return to the service of the authority for a period of, perhaps, two years, even though there is no post for an educational psychologist available. Few further education grants have been made, partly because some authorities regard assistance to students taking post-graduate courses as outside their province. The National Association for Mental Health had up to 1954-55 been able to devote only about £1,000 of the grant they receive from the Exchequer to providing fellowships for as many of the nine holders of places under the scheme administered by the Association as need help; in 1952-53, for example, £945 had to be divided between seven people. The Association were the first to recognise the inadequacy of many of their grants, especially for Fellows who are married. A number of excellent candidates have not pursued their enquiries when the financial prospects were explained. For 1954-55 and 1955-56 the Association's grant from the Ministry of Health has, as mentioned already, been increased and they have been able to devote about £3,000 to providing fellowships.

The variety of ways in which assistance can be obtained for training, the doubts about the division of responsibility between government departments and local authorities, and the difficulty in many cases of obtaining sufficient help from any source, have all led to a general uncertainty which is bound to have an adverse effect on recruitment. Confusion is also caused by the fact that the Exchequer grant to the National Association for Mental Health, which is in respect of other activities besides the training of educational psychologists, is paid as a matter of administrative convenience by the Ministry of Health; it is often not realised that the Exchequer is acting on the joint advice of the Ministries of Education and Health.

(ii) *Concentration of training facilities in two areas*

Training facilities are at present only available in London and Birmingham. People living in places beyond daily travelling distance of these cities may be put off applying by the prospect either of moving their families twice in a year or of having to keep a home going while they are in lodgings elsewhere, which would be difficult enough on their pay as a teacher but is far harder if they are not seconded with pay and are receiving only a small grant.

(iii) *Ignorance and misunderstanding of the nature of the work*

Many serving teachers have never thought of educational psychology as a career. Even among psychologists in training misunderstandings arise. The tutor at one of the training centres has said that frequently students have an entirely false impression of the work done by an educational psychologist in the schools; they believe it will involve "a lot of routine I.Q.ing". It is often not understood that the psychologist in a school psychological service has the very responsible task of helping children with disabilities of

any kind to make the best use of their faculties, and that as a result a wide variety of work comes his way. It is also not realised that an educational psychologist may maintain contact with individual children over a long period. Similar misunderstandings arise about the nature of work in a child guidance clinic.

(iv) *Narrowness of the field from which educational psychologists are drawn*

As we said in paragraph 411, of those who at some stage think of educational psychology as a career, most only do so after they have had some experience of teaching. They are then debarred from training to become educational psychologists unless :

(*a*) they are graduates in psychology or its equivalent ;

(*b*) they are graduates in some other subject and can obtain one of the places (probably not more than two*) available annually to such candidates in the two-year course at University College, London ;

or

(*c*) they are prepared to devote much of their spare time for four years to taking a degree course in psychology at London University (which only at Birkbeck College can be taken as an internal degree).

Out of some 40,000 graduate teachers in grant-aided primary and secondary schools, very few can be graduates in psychology, since only about 100 students a year in the United Kingdom take honours degrees in which psychology is the main subject. As a result, the great majority of graduate teachers can become educational psychologists only if they obtain one of two places available annually in a two-year course or are prepared to train for five years (four part-time and one full-time). The latter is the only way open to any non-graduate teacher who thinks of entering this field of work.

426. *Suggestions for overcoming the shortage*

(i) *Make it possible for all accepted for training as educational psychologists to attend courses without financial anxiety*

The present unsatisfactory and haphazard arrangements for providing financial assistance to men and women training as educational psychologists need to be completely revised, so as to ensure that it will be possible for any suitable candidate accepted for a course to undertake training without financial anxiety. Since intending educational psychologists are or should be drawn from the ranks of teachers with some years' experience, financial assistance will need to take due account of the additional responsibilities of married candidates with families.

We recommend that the Minister of Education should have powers to arrange for the training of educational psychologists analogous to his powers to arrange for the training of teachers ; and that these should be sufficient to enable him, so far as possible, to relate the supply to the probable demand and to secure that adequate facilities and financial assistance are available for candidates in training. These powers should be exercised in close co-operation with the Minister of Health, in order that there may be a common approach to the training of clinical and educational psychologists, as suggested in paragraph 421.

* Only four places are available in all for students taking either the one-year or the two-year course, and hitherto only about one third have taken the two-year course.

We also recommend that there should be a clearly formulated policy about the source and extent of the training grants that may be forthcoming, and that every effort should be made to ensure that the facts about these are likely to be known to anyone who may be interested in training as an educational psychologist.

(ii) *Increase the number of training courses outside London*

For the reason given in paragraph 425 (ii), we think that a number of people who do not now apply for training might come forward if courses were established in other centres of population nearer their homes. In any event, any additional places required will have to be provided at new training centres, as the existing courses, mainly because of the limited clinic facilities, could not easily accommodate more students than they do now. We have already pointed out the desirability of educational psychologists being trained in university departments where psychiatrists and psychiatric social workers are also being trained. Outside London there is at present no place in England or Wales where psychiatrists and psychiatric social workers are both trained, so that, until there is, we can only suggest that training courses should be established in departments of universities in the North of England, the Midlands and Wales where training is provided either for psychiatrists or for psychiatric social workers.

(iii) *Spread knowledge of what the work of an educational psychologist is*

It is very important that serving teachers should have the idea of becoming an educational psychologist put before them. Training colleges and university departments of education can play a part in this, and a Training Council set up on the lines suggested in paragraph 408 might produce a pamphlet for teachers about educational psychology as a career. Hospitals and centres where training is given to both educational and clinical psychologists should know about the richness and variety of the work of an educational psychologist in a child guidance service, as the misunderstanding of this may easily prevent people giving any consideration to this sort of psychological work as a career. Further, if more graduates in other subjects (see (iv)) are to think of educational psychology as a career, it is important that university staff and appointments boards should be well informed about it.

(iv) *Extend the field from which educational psychologists are drawn*

In our opinion the door should be opened wider to people who have not already taken an honours course in psychology at the university. Some boys and girls will decide at the age of 17 or 18 that they wish to study psychology when they leave school: many others will continue at the university subjects studied at school. If some of this second group turn to psychology at a later age they may know their minds more clearly and bring more to the subject, even if they have much more to learn about psychology than the first group. Accordingly, in increasing the number of training centres some priority should be given to the establishment of more two years' courses for those who have graduated in other subjects. The example of University College, London, shows how the second year of such courses can, if required, be treated as a separate one-year course for graduates in psychology.

A form of training on the lines of the Scottish system should also be considered. At Edinburgh, Glasgow, St. Andrews and Aberdeen universities graduates in other subjects can in one year train as teachers and at the same time take the first or diploma part of the Ed.B. or B.Ed. At Edinburgh a further year's full-time training is needed to complete the B.Ed., but

students from the other three universities can after their one year's training earn a salary, and no further full-time training is required. They can complete the Ed.B. by spare-time study in two years while teaching, and then gain clinical experience by taking a paid post as a psychologist in a child guidance clinic which has more than one psychologist on the staff. After one year's clinical experience they are recognised as fully qualified educational psychologists by the Scottish section of the Committee of Professional Psychologists referred to in paragraph 404.

It does not seem reasonable to expect that a large number of non-graduate teachers should qualify for the final year's training as an educational psychologist through working in their spare time for a degree in psychology. Nevertheless, we think that more non-graduate teachers might be attracted by educational psychology as a career if such a degree could be taken at other universities besides London and if, at least for those who have attended a two-year teacher training course, the degree could be taken after three instead of four years' part-time study. We hope that careful thought will be given to the possibility of making such arrangements.

Psychiatric Social Workers

Functions

427. The functions of a psychiatric social worker in a child guidance service have been described in Chapter VI and Appendix F; and the need for a psychiatric social worker to keep in touch with the parents of any child sent to a boarding establishment, and to prepare the home for the child's return, has been mentioned in Chapters IX and X. In a few large boarding special schools which draw their children from close at hand, it may be possible to appoint a psychiatric social worker to the staff of the school. Otherwise, it will be necessary to use the services of psychiatric social workers on the staff of clinics in the children's home areas, who if there is a clinic near the boarding establishment may work in co-operation with a psychiatric social worker from that clinic. Psychiatric social workers may also, as was mentioned in Chapter XI, be asked to keep in touch with children in their area on their discharge from boarding special schools or hostels.

Training

428. The three main courses of training are the mental health courses lasting twelve months which are provided by the London School of Economics and Political Science (35–40 places) and by the Universities of Manchester (12 places) and Edinburgh (12 places). A further course was started in 1954 at the University of Liverpool. These courses prepare students for psychiatric social work with adult psychiatric patients as well as with children.

429. Full consideration was given to training by the Committee on Social Workers in the Mental Health Services (commonly known from its Chairman, Professor J. M. Mackintosh, as the Mackintosh Committee). The Committee was appointed by the Minister of Health in July, 1948, "to consider and make recommendations upon questions arising in regard to the supply and demand, training and qualifications of social workers in the mental health service. The Committee to present an interim report on these questions in relation to psychiatric social workers". In April, 1949, the interim report, which was not published, was presented to the Minister of Health, and in January, 1951, the final report. The Committee recommended that the standards of training set by the London, Manchester and Edinburgh Courses should be maintained, and we entirely agree. The work carried out by

psychiatric social workers is so exacting and responsible that it would be a cardinal error to recommend any lowering of standards of training or, as we shall see later, of entry. Indeed, if standards were lowered, not only would the work suffer but it might well result in further demands on another type of specialist in short supply, since psychiatrists might be less confident in sharing so much responsibility with psychiatric social workers.

430. We have been impressed with the value of a vigorous professional body, which concerns itself not only with conditions of employment, but also with standards of training and selection and with the continued education of its members. The Association of Psychiatric Social Workers has, we understand, from the outset expressed views about the standard of training provided and has restricted membership to those who have successfully completed an approved mental health course. In this way, the cumulative experience of members can be used to set standards for the whole profession, without seeking to make all courses completely uniform or infringing the independence of the universities responsible for running them.

431. The Mackintosh Committee also recommended that students should be given a greater theoretical knowledge and practical experience of mental deficiency, especially community care, and that more attention should be given to abnormal mental states. Whatever the merits of these subjects, we think that there is a risk of overcrowding the mental health course. It appears to be generally agreed that students are over-pressed already, and it therefore seems unwise to suggest the inclusion of something extra in the course unless something else of at least equal weight were left out or the length of the course were extended. The Mackintosh Committee did not contemplate any extension of the course, but suggested that physiology and normal psychology should be covered in the basic social science course instead of in the mental health course.

432. While we appreciate the fact that psychiatric social workers need a good knowledge of a wide range of pathological conditions, it is most important that this should be based on a sound understanding of normal development, which should include direct experience of ordinary children. In paragraph 434 certain changes in the basic training for social work will be mentioned which should to some extent remedy the danger of concentrating at too early a stage upon abnormal conditions of children ; they may also result in relieving some of the pressure upon students during a one-year mental health course.

Qualifications for training

433. A degree, certificate or diploma in the social sciences and some experience of social work are normally required for admission to a mental health course. We regard these conditions as generally important ; indeed experience in London has shown that candidates accepted without at least a certificate or diploma in social science have tended to fail on the academic side. Nevertheless a few trained workers without these qualifications have been accepted for extended training covering two years, e.g. health visitors with some general experience of social work and teachers who have studied social science subjects in evening classes ; and we should not wish to close the door to experiments of this kind. It is also to the good that candidates who lack adequate experience of social work, but are otherwise suitable, are encouraged to apply again when they have obtained it. It is valuable for students who have had no residential experience before starting the course to spend even a short period in some residential establishment, e.g. a children's home or a boarding school or hostel ; it is only possible to get to know children throughly by living with them.

434. The contents of social science courses affect the contents not only of mental health courses but of other vocational courses for social workers for which general training is required as a condition of entry. It is argued in the report of the Mackintosh Committee that, if these preliminary courses were designed to provide a more thorough understanding of human behaviour, the training in case work now falling largely upon the mental health courses would be shared by all qualified social workers. This would facilitate mobility in employment and co-operation between the various branches of social work, and would also provide a better foundation for the study of pathological conditions. We understand that there is a considerable body of opinion supporting a common professional training in social case-work which might serve to off-set the present tendency towards over-specialisation. We think there is force in these arguments, and would like to see experiments made in improving the general standard of theoretical and practical training for skilled social service to families.

435. Two interesting departures have taken place in the autumn of 1954. At Liverpool University, the students taking a mental health course are to combine with child care students for the early part of their training; and at the London School of Economics a course in applied social study has been started for entrants to a variety of branches of social work (but not psychiatric social work), after they have secured a certificate in social science. Careful consideration should be given to the effect of courses like the London one upon the conditions of entry to a mental health course and upon its content and length, especially if courses in applied social study could lead to a shorter period of specialisation.

Selection

436. Earlier in this chapter we expressed the opinion that the personality of a psychiatrist or an educational psychologist was one of the chief factors governing his success in his work; this also applies to psychiatric social workers. We are satisfied that due attention is paid to personal qualities when candidates for mental health courses are interviewed. It is important however to guard against a natural tendency to form too stereotyped a picture of the kind of person who is ideal for this work. We understand that, from an assessment of psychiatric social workers' performance after qualification, there is some evidence of a tendency to under-estimate the abilities of some candidates at the time of their selection and training. If this is true, it suggests the importance of recognising that a wide variety of individuals can after training develop the abilities needed and that some of these will not be easy to assess at a given point of time. In order to avoid rejecting candidates who would prove successful at psychiatric social work, it is necessary—since no selection procedure can be perfect—to take risks and to accept some who will fall below expectations. Candidates have to be at least 22 years old and the experience is that 23-35 are the best ages for training, but it is all to the good that discretion is allowed in accepting people over the age of 35.

Supply

437. In Chapter XIII we recommended that the immediate aim, during the next decade, should be to secure the equivalent of 420 full-time psychiatric social workers in the child guidance service*. In December, 1954, there were

* The Mackintosh Committee, on the other hand, described as conservative the figure of 500 psychiatric social workers for child guidance centres provided by local education authorities which was put forward by Dr. C. P. Blacker in 1946; and estimated that more than 1,500 would be needed for all types of psychiatric social work.

only the equivalent of 109 full-time psychiatric social workers employed in child guidance clinics provided by local education authorities. There are also some psychiatric social workers in clinics provided by hospital boards; in June, 1955, less than 40 members of the Association of Psychiatric Social Workers were working in these clinics—and not necessarily full-time. It is clear that the shortage of psychiatric social workers is even more serious than the shortage of psychiatrists and educational psychologists.

438. The general shortage is aggravated by the uneven distribution of psychiatric social workers throughout the country. According to the Mackintosh Committee, out of 318 psychiatric social workers at work in England and Wales in 1949, no less than 231 (73 per cent.) were in the South of England, leaving only 39 in the Midlands and East Anglia, 43 in the North of England and 5 in Wales; there is no reason to think that the distribution has substantially improved since 1949. It is true that the majority of child guidance clinics are in the South of England, but the proportion is not large enough to account for the pattern of the distribution of psychiatric social workers.

Reasons for shortage

439. We believe that the following factors contribute to the shortage of suitable candidates for mental health courses or, in the case of (*f*), to the depletion in the ranks of trained psychiatric social workers. Where the Mackintosh Committee reached a similar conclusion, this will be mentioned:

(a) *Unattractiveness of salaries*

The Mackintosh Committee recommended that psychiatric social workers should be regarded as specialists and better paid. Two years after the final report of the Committee salaries were considerably improved, and at the time of writing of this present report we understand that the responsible Whitley Council for the Health Services has under consideration a further improvement in the salary scales. We hope that the new scales* will prove more attractive than the previous ones†, which in our view were not likely to attract young women (and still less young men‡) comparing prospects as a psychiatric social worker with prospects outside the field of social work. If a greatly increased flow of recruits is to be secured, many young women (and men) must be attracted who at present do not take up social work of any kind. It is not suggested that the rate of pay is more important to the majority of young men and women of the right calibre than the nature of the work; but increasingly few can afford to ignore it. The lack of agreed rates of pay for part-time workers has also been unfortunate; we understand that rates are shortly to be announced by the Whitley Council*.

(b) *Uncertainty about obtaining adequate financial assistance while training*

There has been a variety of arrangements for giving assistance to students in training at the different centres. Although we are not directly concerned with the Edinburgh course, we understand that some English

* [*Note by the Ministry of Education. Since this report was written, new salary scales have been announced in P.T.A. Circular No.* 33, *dated* 19*th July*, 1955. *The main scale is now to be* £495—£750, *and* £925, *which includes a research allowance of* £75, *is to be the ceiling for the profession. Part-time rates are also set out in the circular.*]

† A basic salary scale of £470—£560 with a ceiling for the profession of £725. This ceiling is less than the starting salary for a man educational psychologist and only £20 more than the starting salary for a woman educational psychologist paid on the lowest of the three scales (see footnote to paragraph 424).

‡ In June, 1955, only 39 out of the 590 members of the Association of Psychiatric Social Workers were men, i.e. only 1 in 15. The Mackintosh Committee recommended that the recruitment of men should be encouraged, and we endorse this.

students attending it have received grants from their local authorities; and a few students have had grants from the Department of Health for Scotland, on the condition that they will work in Scotland for at least two years after training. In England the Ministry of Health has annually since 1949 made available a sum of £8,000 to assist students to attend mental health courses. In the first three years only the students attending the annual course at the London School of Economics were able to get help from this source, as Manchester University refused an offer of part of the £8,000 for the assistance of their students. In 1952 they accepted £1,000 for this purpose; and in 1954 £1,000 was allocated to Liverpool, but it was not fully used there and the balance was made available to Manchester. Some students have received grants from their local authorities or, in earlier years, from the Ministry of Education under the Further Education and Training Scheme for ex-service men and women.

We see no reason why students should not be expected to contribute to the cost of their training and maintenance when their means allow this, but many students cannot manage this and considerable difficulty is still experienced by some in obtaining sufficient help. We have been told of instances where local education authorities have refused to help students on the grounds that grant-aid was obtainable from the Ministry of Health. Local authorities do not at present know the extent of the grants made by the Ministry of Health, and may assume that, in proportion to its size, each mental health course receives an equivalent sum. In fact, it has been much harder for a student attending the Manchester course to obtain a grant from Ministry of Health funds than it has been for a London student: in 1952, for example, grants to three students at Manchester took up the whole of the £1,000 available*.

(c) *Concentration of training facilities in four areas*

A very much smaller proportion of psychiatric social workers than educational psychologists have married by the time they take the last part of their training, but many of them—and many potential recruits—have home ties which prevent them from training unless they can do it locally. The Manchester course, for example, began with six students of whom four could not have gone to a course outside the area. There must be a number of potential recruits who do not live within reach of London, Manchester, Liverpool or Edinburgh.

(d) *Ignorance and prejudice about psychiatric social work*

A boy or girl leaving school should not be expected to choose psychiatric social work as a career. The difficulty is that those who go into business, industry, the Civil Service or other work and fail to find those jobs fully satisfying are unlikely, even at that stage, to have heard of the possibilities of psychiatric (and other forms of) social work. Even when young people have embarked on a social science course, psychiatric social work may be regarded by those around them as less suitable than other forms of social work. It has been reported to us that social science departments of universities are sometimes reluctant to advise students to take up this particular branch of social work; and some parents discourage their children from going in for a profession which will bring them into contact with people who are mentally handicapped.

* Students' needs are assessed under the scale used by the Ministry of Education for mature state scholarships.

(e) *Lack of mobility between branches of social work*

At present, in addition to a basic social science course, many branches of social work, e.g., almoning and probation work, require a further period of training as a qualification for their particular field, and this makes transfers between the various branches much more difficult to arrange. It also acts as a deterrent to potential recruits. The wider the field of employment open to those who have taken a particular form of training, the more appeal the training seems likely to have, especially for young people.

(f) *Depletion in number of trained psychiatric social workers through marriage*

The proportion of the membership of the Association of Psychiatric Social Workers not working in June, 1955, was 13 per cent. The majority of the 80 listed as not working had given up on or soon after marriage, though some of these had given a number of years of service before marriage and some with children would return to the work when their children were older.

Suggestions for overcoming the shortage

440. First of all, we take in order the five factors contributing to the shortage of psychiatric social workers which were discussed in the last paragraph:

(a) *Make salaries more attractive*

Enough has been said already about the need for salaries to be made more attractive.

(b) *Make it possible for all students to attend mental health courses without financial anxiety*

We first considered whether existing hardships could not best be removed by instituting a system of part-time training, in order to allow students to support themselves during the course by taking part-time jobs. Instead of one year full-time a mental health course might then take two years part-time. There are obvious difficulties. Paid part-time jobs, not only in social work but of all kinds, are not easy to find, especially when the employee would not be able to continue after his training was completed. Further, it would be hard to arrange consecutive time off for the period of full-time practical training in child guidance which would still be necessary. Nevertheless, the possibility of part-time training, which is the practice in certain other professions, is worth exploring further, though it could not be a short-term solution to our problem.

As a more immediate step, we recommend that grants should be available from public funds, to enable all students attending mental health courses, even if they have family responsibilities, to take part in the course without financial anxiety; and, further, that the grants should be sufficiently generous not to deter people who have been in paid employment for a year or two from the prospect of a break in their earning. A clear policy is required about the extent and sources of the grants which may be forthcoming.

We recommend that the Minister of Education should have powers to arrange for the training of psychiatric social workers similar to those which we have recommended that he should have for the training of educational psychologists, and that these powers should similarly be exercised in close co-operation with the Minister of Health (cf. paragraph 426 (i) above).

(c) *Establish more training centres in different areas*

This will be necessary if the output of psychiatric social workers is to be expanded, since the number of students which the established courses can take is limited by the number of clinics within reach whose staff have the time and whose premises have the space to fit in students for supervised practical work. Training should ideally be carried out in university departments where both psychiatrists and educational psychologists are also being trained ; until that is possible, courses should be established in universities where training is provided for either psychiatrists or educational psychologists. It is, of course, essential that there should be in the area child guidance clinics which can undertake practical training. We believe that the spreading of training among more universities in different parts of the country would not only attract people who though already interested cannot get to any of the present courses, but would also bring to notice the possibilities of psychiatric social work as a career in areas where hardly anything is known about it. In addition, the opening of training centres in new areas would help to relieve the present maldistribution of psychiatric social workers. One reason for the great pull exercised by the South of England is the wish of psychiatric social workers to be within reach of a centre providing stimulus to the workers in the field through meetings, refresher courses and other opportunities for exchanging ideas.

(d) *Spread knowledge of the work of a psychiatric social worker*

Full information about psychiatric social work as a career should be in the hands of all appointments boards and other employment agencies which might be approached by graduates and by people in their early twenties in business, industry and the Civil Service who wish to change jobs. Universities and their social science departments need to know more about the richness and variety of the work. Through these channels a clearer picture of the profession should also reach parents.

(e) *Make it easier to move between branches of social work*

The development of a common professional training in social casework, which was discussed in paragraph 434, would make it much easier to transfer from one branch of social work to another with little additional training, at least on the academic side.

(f) *Make it easier for married psychiatric social workers to come back as part-time workers*

This is another of the recommendations of the Mackintosh Committee which we fully endorse. Some local education authorities dislike having a call on only part of the time of anybody who works for them, but many authorities are already taking on psychiatric social workers part-time as well as other child guidance workers, and it is essential that authorities generally should be willing to do this. It is also of the greatest value that some working psychiatric social workers should be married women ; their experience of home-making and family responsibilities will be added qualifications. Agreement on rates of remuneration for part-time work will be of particular benefit in this connection.

441. The adoption of the suggestions we have put forward should result in some increase in the number of psychiatric social workers, but we realise that the increase is unlikely to be sufficient to bring the total working in the child guidance service up to the figure we took as the immediate aim. There is however another approach to the problem of supply which may be more effective and which can be combined with the first : to economise in the use

of psychiatric social workers. This can be done chiefly through the employment of other less highly trained workers to perform some of their present duties, and through preventive work which will relieve them and child guidance clinics of part of their present case-load. The following are some of the measures which might be taken:

(g) *Use psychiatric social workers only for psychiatric social work*

In the first years of the profession many psychiatric social workers were drawn into work which other social workers should be able to do if they had better training in the understanding of individual behaviour and human relationships and in the skill needed for good case-work. Even in June 1955, of the 446 members of the Association of Psychiatric Social Workers who were known to be working in the British Isles, 23 were engaged in other forms of social work, 14 in teaching students at universities who did not intend to become psychiatric social workers, and 20 were doing other kinds of work (which was not psychiatric social work). These figures account for 12 per cent. of the total. In addition, a high proportion of the 160 psychiatric social workers who were not members of the Association were believed to be doing other kinds of social work.

(h) *Appoint a secretary to every child guidance clinic to see to its routine running*

We have already referred in Chapter VI, paragraph 183, to the need for a secretary who is efficient enough to relieve the psychiatric social worker of the clerical work of the clinic and who has the right personal qualities to receive parents and other visitors on arrival.

(i) *Use trainees in child guidance clinics*

The Mackintosh Committee recommended the organisation of a scheme for a preliminary apprenticeship lasting two years under the supervision of psychiatric social workers. They hoped that most of the trainees would then go on to take a mental health course. So far all that has been done to implement this recommendation is the placing, under arrangements made by the Association of Psychiatric Social Workers, in mental hospitals or in community care work under local authorities of a few social workers with a general qualification.

It was the Mackintosh Committee's hope that a trainee scheme of this kind would not only increase recruitment into the profession, but would also bring about an immediate alleviation of the shortage of psychiatric social workers, inasmuch as the trainees would under supervision be able to undertake some of their work. The view has been expressed to us that there is little scope for a long-term policy of using semi-trained social workers in child guidance clinics, since the work there taxes fully-trained psychiatric social workers to the full. Nevertheless the fact of the present shortage of psychiatric social workers must be faced; and an apprenticeship scheme on the lines recommended by the Mackintosh Committee might prove a useful way of interesting potential candidates in this kind of work who would otherwise overlook its possibilities. It also would be a means of providing experience in social work for people who have already applied to take a mental health course but do not possess the experience usually expected.

In our view, however, the selection of trainees for clinics should be cautious; we would not, for example, envisage accepting, as the Mackintosh Committee did, people who are not fitted for academic training or who for other reasons will never be able to take a mental

health course. We suggest that applications should be scrutinised by a central body as well as by clinics, and that nobody should be accepted who is not thought to have a reasonable chance of qualifying later as a psychiatric social worker. Trainees should only be appointed to clinics where there is one psychiatric social worker in post of at least two years' standing, and where the staff are well suited and willing to undertake training responsibility. Watch should be kept by a central body to see when each trainee's period of apprenticeship came to an end ; and any trainee not then accepted for a mental health course should be advised to look for other work.

(j) *Reduce by preventive work the number of children and families needing the attention of a psychiatric social worker*

In our opinion teachers, health visitors and other workers under local education and health authorities could be helped to handle many minor troubles which at present either are referred to clinics, if detected at that stage, or, if they remain undetected and untreated, develop into maladjustment later on and take up much more of a clinic's time. It should, of course, be made possible for these workers to obtain the advice or help of a psychiatric social worker or other child guidance staff when required. We shall deal with this subject in Chapter XVI on Prevention.

Recommendations

We recommend that, in relation to child psychiatrists, educational psychologists and psychiatric social workers,

(1) candidates should not be accepted for child guidance training unless they are judged to have the right personal qualities for work with children.

(2) as a means of attracting more recruits and improving the distribution of trained staff, the number of centres outside London where training can be obtained should be increased.

(3) training should be arranged in association with a university ; and, in order to allow some of the training to be shared, facilities for training all three professions should be provided by some universities.

(4) more child guidance clinics should be provided with the staff and the space to enable them to undertake practical training.

in relation to child psychiatrists,

(5) all medical students should be given lectures on general and child psychology and should attend a child psychiatric department.

(6) all medical schools should have links with a child guidance clinic, which could be used for the training of medical students and of doctors preparing for the Diploma in Psychological Medicine, as well as for the post-diploma studies of intending child psychiatrists.

in relation to educational psychologists and psychiatric social workers,

(7) the Minister of Education should have power to make arrangements to ensure that there are sufficient facilities available for training and for the provision of financial assistance during training.

(8) a clear policy should be drawn up and made known about the sources and extent of grants which are available for staff in training.

(9) knowledge about educational psychology and psychiatric social work as careers, and about work in a child guidance service, should be spread both in the field from which recruits are at present drawn, including the centres where basic qualifications are obtained, and further afield.

in relation to educational psychologists,

(10) where possible, a newly-trained psychologist should work in a child guidance clinic where he would for the first year be under the supervision of a more experienced psychologist.

(11) a Training Council should be set up to be the recognising body for training courses and to advise on their content and standards.

(12) the Minister of Education should keep under review the effect which the introduction in the national health service of the grade of Psychologist has on the number and quality of applicants for training as educational psychologists.

(13) in increasing the number of training courses, some priority should be given to the establishment of additional two-year courses for those who have graduated in subjects other than psychology.

(14) consideration should be given to the establishment of a form of training on the lines of the Scottish system, whereby graduates who intend to become educational psychologists, after one year's full-time training (which includes their training as a teacher), can complete the rest of their training while they are holding salaried posts.

(15) consideration should be given to the possibility of arranging for a degree in psychology to be taken through part-time study in some universities outside London and for the course of study to be completed in a minimum of three years.

in relation to psychiatric social workers,

(16) if a greatly increased flow of recruits is to be secured, the salary scales need to be attractive to young men and women who do not at present take up any form of social work.

(17) more opportunities should be provided for married psychiatric social workers to return as part-time workers.

(18) in order to effect economies in the use of psychiatric social workers, other less highly trained workers in the education and health services should be trained to detect and handle minor troubles of children which either are referred at present to child guidance clinics or, if they remain undetected and untreated, may develop into maladjustment.

CHAPTER XV

THE TRAINING AND SUPPLY OF TEACHERS AND HOUSE STAFF

442. In this chapter we consider the training required by teachers and house-staff in special schools and hostels for maladjusted children, and the qualities to be looked for in selecting them. By house-staff we mean those who have actual care of the children and whose main rôle is that of substitute parents*.

443. We say much less about the supply of teachers and house-staff than we did about the supply of child guidance workers in the last chapter, because the problem hitherto has not been so acute and because the recommendations we make about training should have a substantial effect on recruitment. Nevertheless, apart from training, if a sufficient supply is to be assured of workers of the requisite quality, it is clear that there must be the prospect of an attractive career. For this it is important that the path to attaining the status of a qualified worker should not be made too long; that low rates of pay should not depress existing staff and deter possible recruits; and that opportunities should exist for going on to similar work with other children.

A. The need for training

444. Very few teachers or house-staff at present serving in special schools or classes or hostels for maladjusted children have had any special preparation or training. This is natural in a new service: the few special classes that exist and most of the special schools and hostels have come into existence since 1945. Nor does lack of special training necessarily imply any lack of efficiency on the part of existing staff. Indeed some outstanding work has been done by people without professional qualifications but with a flair for the work. Experience is a good instructor, and the right qualities of character and personality are essential; no training, however thorough, can be a substitute for them.

445. Nevertheless, the difficulties of work with maladjusted children in special schools and hostels need to be emphasised. The unresponsiveness to affection, the variation in moods, the displays of temper and the other characteristics which may be met with in these children make work with them in a day school very exacting. In a boarding school, where the hours in contact with the children may be much longer, the staff are taxed even more severely. In view of this, we are convinced that both teachers and house-staff who are responsible for the education or care of maladjusted children should have the help of special training.

446. In the case of teachers, we are glad to know that we have the support of the Minister of Education's National Advisory Council on the Training and Supply of Teachers, in their report on the supply and training of teachers of handicapped pupils which was published in November, 1954. The following passage from this report seems particularly relevant: "We have become aware of the increasing realisation of the need for a system

* cf. footnote to paragraph 259 in Chapter IX.

of special training for teachers of handicapped children in all categories. This realisation was evident among the teachers themselves. Their representatives clearly expressed the view that devotion and a sense of calling, however essential, are by themselves inadequate to meet the problems presented by the education of the handicapped".

447. The training of house-staff is no less important. They are in constant contact with the children and are bound to influence them greatly; indeed their influence can be the largest single factor in the residential treatment of some maladjusted children. Their responsibility varies according to the size and type of hostel or school: in particular, the warden or matron in charge of a hostel clearly carries a responsibility almost as great as that carried by the headmaster or headmistress of a boarding special school.

448. It has been suggested to us that the domestic and outdoor staff should also be specially trained. In some hostels a friendly cook or gardener is a significant element in the children's lives. It is also healthy for these children to come into contact with men and women whose primary job is not to look after them. But it is in our view neither practicable nor necessary to provide special training for domestic and outdoor staff. Care in their selection, in which the head teacher or warden ought to play a part, and his (or her) influence afterwards should ensure that their attitude to the children is helpful.

B. Qualities needed by teachers and house-staff

449. As we have already said*, training is no substitute for the right qualities of character and personality. We know of no systematic study carried out on the selection of teachers and house-staff for training with a view to work with maladjusted children, but many of the qualities required are the same as those needed for the residential care of ordinary children. Experience shows that some of the qualities to be looked for are the following:—

A stable personality with a sense of vocation, combined with good personal standards of conduct.

Fondness for children and enjoyment of their company, combined with a sufficient degree of satisfaction and ability in making a home.

Tolerance of and a capacity to understand difficult behaviour.

Stamina and good health.

Patience, flexibility and a sense of humour.

Willingness and capacity to learn from experience.

450. It may however be easier than looking for positive qualities to see whether candidates have any characteristics which are likely to stand in the way of successful work. Examples of these are:—

The expectation of finding in the work *all* the emotional satisfaction which the person requires.

An immature attitude towards authority.

A morbid drive towards self-sacrifice and self-punishment.

A rigid or didactic approach.

451. Where, despite careful selection, people are found in the course of training to be obviously unsuited to the work, it is better that they should be asked to withdraw during the course than that they should be failed officially at the end of it.

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* See Chapter IX, para. 259.

C. Training of teachers

452. In this chapter our concern with teachers is only with those working specifically with the maladjusted—in day special schools or classes or in boarding special schools. In the next chapter we speak of teachers in general as important agents in the discovery and prevention of maladjustment, and of the bearing this should have on their general training. In the following paragraphs we are dealing with a more highly specialised aspect of the training of teachers.

453. Teachers of maladjusted children were originally to have been excluded from the report on teachers of the handicapped by the Minister's National Advisory Council (already referred to in paragraph 446). The Council, however, found it impossible "entirely to ignore the question of maladjustment because many children, as a result of other major handicaps, suffer emotional difficulties which may amount to severe maladjustment". The Council made a number of recommendations applicable to teachers of the handicapped generally, including teachers of the maladjusted. During the course of their deliberations, the sub-committee of the Council dealing with the problem of teachers of the handicapped met our own sub-committee dealing with training, and we are in general agreement with the Council's recommendations.

454. The Council recommended that in time all teachers of handicapped children in special schools should be required:

(i) to complete successfully an approved course of training as a teacher,
(ii) to have at least two years' experience in ordinary schools,
(iii) to have sufficient preliminary experience of handicapped children, preferably in a special school, up to a maximum of about one year,
(iv) to undergo special training and to obtain a special qualification as a teacher of handicapped children.

455. For providing special training they suggest that one-year general courses should be established for teachers of the handicapped (except for teachers of the deaf and partially deaf, for whom the teaching techniques required are too highly specialised to make a general course practicable). Since backwardness and emotional disturbance are so often found in all categories of handicapped children, a general course designed primarily to meet the needs of teachers of the educationally sub-normal and the maladjusted, but with opportunities for specialisation in the needs of the other categories of handicapped children, would, in the Council's view, be the best preparation for teaching service in any special school. The Council point out that a general training course would have other advantages: it would encourage recruitment and facilitate the transfer of teachers between different types of special school; it would make teachers better able to handle children with more than one handicap; and finally, it would strengthen the feeling of teachers in the different types of school that they were part of one service for handicapped children. The Council's report also emphasises the desirability of having flexible arrangements for the transfer of teachers between ordinary and special schools.

456. Although the Council lay their main emphasis on the early establishment of one-year special courses of training, they recognise that there would also be a place for shorter courses, possibly of one term's duration. These would mainly deal with particular handicaps and would be intended for teachers already serving in special schools and teachers of the handicapped in ordinary schools, though, until sufficient one-year general courses had been established, these shorter courses would no doubt also be attended by some teachers about to take up special school teaching.

457. The Council appreciate that for the time being it would be impracticable to require attendance at a special course before teachers are allowed to teach in special schools. They recommend that voluntary attendance at these courses should be encouraged until such time as special training and qualification through attendance at a one-year course can be required of all special school teachers. They recognise that, at any rate as an interim measure, it may be desirable to establish one-year courses for teachers of particular categories of handicap, such as the one-year course for teachers of the maladjusted started in the 1953-54 session by the Institute of Education in the University of London.

458. We welcome the idea of general one-year courses for teachers of the handicapped, and are of the opinion that they could be so designed as to be suitable for teachers of maladjusted children. We hope that there will be a steady development of such courses, and that local education authorities and schools will encourage serving and intending teachers of the maladjusted to take them. The detailed recommendations of the Council will need to be flexibly applied and may need modification in the light of experience, as they themselves recognise in their report. For example, since intending teachers of the maladjusted should, if possible, have experience of teaching normal children over a wide age-range, many of them may find it desirable to spend considerably more than two years teaching in an ordinary school; and in their case it might be difficult to insist on a preliminary spell of teaching in a special school as well, even for as little as a term. The path to teaching in special schools must not be allowed to become too long and arduous. Nor should it be made impossible for a young teacher to hold a post for longer than one year in a special school for the maladjusted before taking his special training; there may be occasions when such a school would benefit by having a young teacher on its staff.

459. The Council did not deal in any detail with the content of courses. We would like to put forward the following subjects for inclusion in a general course which teachers of maladjusted children might join:

Further study of the normal development of children in the light of teachers' experience in ordinary schools, with special emphasis on the influence on development of the family and of the experiences of early childhood.

The nature and effects of emotional disturbance, with particular reference to the ways these are shown in social adjustment and in the learning processes of children.

Methods of teaching children with emotional difficulties.

Problems of organisation and discipline as they affect handicapped children.

The medical background of handicapped children.

Children's health, and problems of feeding and diet.

The special school system and the work of child guidance services. Study of the part which psychologists and social workers play in the treatment of handicapped children, with emphasis on the need for teamwork.

We would agree with the Council in suggesting that one part of a year's course might be devoted to general problems of the handicapped; a second might offer opportunity for some specialisation in the needs of particular handicaps; and a third should be largely devoted to supervised teaching in special schools.

460. In Chapter XIII, paragraph 385, we suggested that the objective during the next decade should be to build up a teaching strength of about 240 in special schools and classes for maladjusted children. This would involve an annual demand of 15-30 places in one-year training courses, assuming an annual wastage rate of 7 to 10 per cent. Since the Council's suggested aim is the establishment of general one-year courses for teachers of the handicapped with some 300-350 places annually, the probable training needs of teachers of the maladjusted could easily be met within the framework of the Council's general recommendations on training.

461. We join the Council in hoping that action will be taken by the appropriate authorities to ensure that teachers are not embarrassed financially during their training and that they derive some financial advantage from successfully completing it.

D. Training of house-staff

462. As we saw in Chapter XIII, paragraph 386, the total number of house-staff now working with maladjusted children is probably in the region of 250. They have no common experience or training though, of the 118 house-staff in hostels at the beginning of 1954, more than three quarters (89) had some qualifications or previous experience with children. The commonest kinds of experience had been in children's homes as house-parents (24), in approved schools or remand homes (15), teaching (15) and social work (11). The commonest forms of training were a fourteen-month course leading to the Certificate in the Residential Care of Children (9), training as a nurse (6), a degree or diploma in social science (5) and a degree or diploma in psychology (3).

463. The small numbers involved make the problem of providing special training courses for house-staff one of great difficulty. An attempt was made in 1950 to arrange a refresher course limited to house-staff working with maladjusted children, but it was found that the number able to attend even a short course at any one time would be insufficient to justify a separate course. Arrangements were therefore made early in 1952 between the Home Office and the Ministry of Education to enable house-staff working with maladjusted children to take advantage of the training facilities for the staffs of children's homes offered by the Central Training Council in Child Care*. When local education authorities assist students to attend either a fourteen-month course leading to the Certificate in the Residential Care of Children or a three-week refresher course, their expenditure ranks for the Minister's grant; any similar expenditure incurred by the managers of non-maintained boarding special schools or hostels can be taken into account in assessing the fees charged for children. The Ministry regard the present arrangements with the Central Training Council as subject to revision in the light of this Committee's report and as an interim step designed to meet a need which had been represented as urgent.

464. The work of house-staff in boarding schools and hostels for maladjusted children has much in common with that of house-staff in boarding homes for deprived children. They must understand what is to be expected of children at different ages, and know how to guide their development and make use of the facilities for treatment available. Besides responding to individual needs, they must be able to handle groups, so that the tensions which arise when difficult children live together can be directed to constructive rather than destructive ends. Their task is not only to look after children but

* Ministry of Education Administrative Memorandum No. 412, dated 12th March, 1952

to create a home for them. House-staff must watch over the health of their children without fuss, and impart to them as much as they can of the arts and graces of life. The importance of providing enough opportunities and varied materials for play and recreation should be impressed upon them, and they must be able to help children to make good use of these. Finally, they should give children the guidance in spiritual values which would be provided by good parents.

465. All these needs were recognised by the Curtis Committee*, and the Central Training Council in Child Care has endeavoured to provide for them in their fourteen-month courses for house-mothers and house-fathers in children's homes. We are satisfied that the knowledge, skills and attitudes which these courses try to teach are a very valuable foundation for work with maladjusted children. Clearly it is impracticable to establish separate training courses for house-staff working with maladjusted children. The existing arrangements between the Home Office and the Ministry of Education therefore seem to us right in principle, and it is disappointing that to date only one local education authority (London) has assisted staff to attend fourteen-month courses†. Smaller authorities evidently find it difficult to make use of the arrangements. They cannot spare existing staff on secondment, since (unlike London) they do not maintain a number of special schools or hostels and so their staffing is less flexible. Nor is it easy for them to finance the training of people from their areas if they are unlikely themselves to be able to employ them afterwards and so to get some return for their expenditure.

A wider national qualification in the residential care of children

466. We understand that there is an increasing demand for house-staff in boarding special schools for other categories of handicapped children such as the educationally sub-normal, for whom many more special schools have been provided in recent years; and we suggest that consideration should be given by the two Departments to extending the scope and membership of the Central Training Council to cover the educational field, so that they could organise courses to include all those intending to undertake the residential care of children in schools or boarding homes. It would be necessary for the Ministry of Education to be associated with the Home Office in sponsoring the Central Training Council's widened courses, and to assume an appropriate share of the financial responsibility. In view of the disappointingly small use so far made of the Central Training Council's courses, it is clear that a fresh approach is needed. Only the largest authorities seem likely to offer assistance under the present arrangements; it might therefore be preferable to share expenditure on training among all local education authorities, as is already done in the case of the training of teachers. We recognise that the Minister of Education may require additional powers for these purposes, and see no reason in principle why powers analogous to those already available in respect of the training of teachers should not be granted for the training of ancillary staff, who now play an essential part in the public educational system.

467. We hope that the widened courses will lead to a wider qualification in the residential care of children, and that this will be accepted nationally, just as is the present Certificate in the Residential Care of Children, and have even greater value. If a national qualification is to continue to be obtained from the courses, there must be a general design for them laid

* Report of the Care of Children Committee, August, 1946 (Cmd. 6922).

† London had up to December, 1954, sent 2 house-staff from boarding special schools or hostels for maladjusted children to fourteen-month courses. In addition, up to the same date 14 house-staff, including 5 from London, had attended refresher courses.

down by the Central Training Council. Courses, however, need not be uniform; provided standards are maintained, there is value in a certain amount of variety, such as naturally arises where courses are run in different areas and under different auspices. Further, inside the course the programme of students could, with individual tutorial methods, to some extent be planned to meet their special interests. In particular, a proportion of the practical training could be undertaken in boarding schools and hostels for maladjusted children.

468. For the courses which we have in mind, the age-limits prescribed by the present Central Training Council for their courses seem appropriate. The lower limit for women is 18 and for men 21, and candidates over 45 can be considered only in very special circumstances. Within this age-range people should have the maturity required without the rigidity which makes it difficult for them to accept new ideas or to adjust to student life. At the same time, the content of courses might be modified for some of the older candidates with a certain length of residential experience, e.g., by excusing them part of the practical training; alternatively, if there were a sufficient number, a separate course might be provided for them. We understand that the Central Training Council has, as an experiment, made provision for men and women of 25 years or older with three years' residential experience to qualify for the Council's certificate by means of a course lasting for ten instead of fourteen months.

469. In these ways we hope in the long term that the residential care of children would be built up still further as a profession. In Chapter XIII, paragraph 386, we suggested that about 400 house-staff might be needed over the next decade for hostels and special schools for maladjusted children. To reach this objective, from 20 to 25 places in training courses may be required initially and this number may have to be increased later to 40 or 50. This should not necessitate, at least at the start, any expansion of training facilities, as we understand that the existing facilities are not being used to the full.

470. If our hopes for the profession are to be realised, it is vital that from the outset selection should be rigorous and training of a high standard. The selection procedure might with advantage include an informal interview with one experienced person as well as a final appearance before the selection committee; and, following the practice of the present Central Training Council, at the start of the course there should be a probationary period of practical work. In addition, we suggest that those who have never worked in a boarding special school or hostel for maladjusted children should be advised to spend a short time in one before applying for training, in order to see for themselves what the work is like.

471. In training, learning to deal with the normal should precede study of the abnormal, and the various aspects of the care of children should be properly integrated. Physical and mental health, for example, should always be considered together; and at every stage teaching about the care of the individual child should be closely related to teaching about the running of a household and the handling of a group of children.

472. We also attach great importance to the need for adequate periods of practical work, which should be carefully supervised. Students should take responsibility and have difficult children to deal with. The problems which they have encountered in handling children should then, as far as possible, provide the foundation for child study. Separation of theory from practice can be disastrous: in situations where students would do well to act naturally, they may force themselves to act according to principles which they have not

yet made their own. Students require not only to learn how to deal with difficult children, but also to recognise that they themselves may have strong feelings at the time and to learn how to handle these feelings constructively.

Specialised training for work with maladjusted children

473. In view of the special difficulties involved in work with maladjusted children, we suggest that students who intend to work with them should be encouraged to take a further period of more specialised training after their general training has been completed. We recommend that this training should be organised by the Central Training Council; its length will be for the Council to determine, but we doubt whether a period of less than six months would be adequate. It might be given to the students while they are living and working in a boarding school or hostel for maladjusted children, though it would be necessary to ensure that maladjustment did not make too overwhelming an impact upon students at the start. It is undesirable that this should be a period of paid probationary employment and the need for adequate grants to students would have to be considered, except for those seconded on full salary by their employers. The fact that a student had taken such a course should be endorsed on the certificate he had obtained after successfully completing the initial general course.

474. The number of students each year would not be large and it is probable that, at least for some time, one or two schools or hostels with special facilities would be sufficient. Provision should be made on the staff of the selected school for a person who would have time to act as a supervisor of students rather on the lines of a Sister Tutor in a training school for nurses. The supervisor, besides having charge of the students, should also take a part in the work of the school and be a full member of the school staff; a special allowance might well be paid in respect of this post. Child guidance personnel serving the school and other members of the school staff should also be available to guide and instruct the students in accordance with the general scheme of work laid down by the supervisor. Regular case conferences on the children whom the students were helping to care for would be an essential part of the training, and a series of lectures should be provided to integrate the training given and present the students with a coherent picture of the aims of special educational treatment and residential care of maladjusted children. We suggest that a training fee in respect of each student should be payable to the body maintaining the school or hostel selected as training centre; this body should also be able to claim payment, if desired, for students' board and lodging.

475. There is much to be said for those who have taken the general training serving for a period in schools or boarding homes for normal children before they enter upon the specialised course. On the other hand, there is a danger that persons already in regular employment will find it difficult or unacceptable to return for a further period of training. Moreover, the general course itself will provide for practical experience in the care of children. If, therefore, students intending to work with maladjusted children wish to proceed straight from the general course to the specialised course, we see no serious objection to this.

476. Advanced training should be available to those of good ability who are likely to hold the more responsible posts, such as that of warden in charge of a hostel. Consideration should be given to the possibility of organising a course which could also be taken by teachers in boarding special schools for maladjusted children who are likely to hold senior posts in schools; in this way a common approach to work with maladjusted children could be fostered. Ultimately, advanced courses might be confined to house-staff who had taken the initial training and had served with success

for at least two or three years in hostels or schools for maladjusted children, but in the meantime it would be advantageous if a few carefully selected students of appropriate experience and education could be assisted from public funds to take such training. A course such as the one in child care which was run until recently by the Institute of Education in the University of London would be suitable. Financial assistance would again have to be arranged for staff attending an advanced course.

Refresher courses for existing staff

477. There may well be a few house-parents in post who would wish to take either the general or the specialised initial training, especially if some courses are specially designed for older people with experience of residential work. It will, however, probably be difficult for the more experienced staff to obtain release in order to take either initial course, and their needs will have to be met by short refresher courses. It is of great importance to the whole training scheme that refresher courses should be available for any existing staff who can be interested in attending one. Apart from the benefit to themselves, such a course should enable them to share up-to-date knowledge and ideas, as well as the fruits of their own experience, with students taking the practical part of the initial general training, whom they may be called upon to supervise.

478. Owing to the small number of house-staff at present working with maladjusted children and the difficulty of releasing many even for a few weeks, it is likely to prove impossible to organise separate courses, at least at the start. We hope that it may be possible to arrange refresher courses for house-staff in general, but in the meantime we are satisfied that house-staff in hostels and schools for maladjusted pupils would benefit from the refresher courses already provided for the staff of children's homes. It is desirable that the refresher courses should be sponsored by the same body as that which organises the initial training, in order that the instruction given to new entrants and to older staff can be co-ordinated and mutual understanding be promoted.

E. Supply of house-staff

479. Already local education authorities have had difficulty in securing staff of high calibre, especially for assistant posts ; it has been found particularly hard to recruit married couples. The provision of training leading to a national qualification and the possibility of moving on to work of the same kind with other types of children should do much to stimulate recruitment. As we said in the last chapter, the wider the field of employment open to those who have taken a particular form of training, the greater appeal the training will have. An important step has been the recent establishment for house-parents in children's homes run by local authorities of a salary scale quite different from that for domestic staff. It is likely that this scale will be applied by many employing authorities to house-staff working in hostels and special schools for maladjusted children. This will mean an increase in salary for many house-staff, but the position needs to be carefully watched to ensure that all house-staff working with maladjusted children have salaries commensurate with their qualifications and special responsibilities.

480. Other measures required to make the profession more attractive to potential recruits are: adequate arrangements should be available for obtaining financial assistance during training (we have referred to this in paragraphs 466, 473 and 476 above) ; some financial benefit should accrue from attaining the national qualification ; and better accommodation is needed for married couples (this was touched on in Chapter IX, paragraph 263).

Recommendations

We recommend that, in general,

(1) special training should be provided for teachers and house-staff in special schools and classes and hostels for maladjusted children.

in relation to teachers,

(2) special training should be provided within the framework recommended by the National Advisory Council on the Training and Supply of Teachers in their recent report on the training and supply of teachers of handicapped pupils.

in relation to house-staff,

(3) consideration should be given by the Home Office and the Ministry of Education to extending the scope and membership of the Central Training Council in Child Care to cover the educational field, with the object that the Council should arrange courses which will cater for all those intending to undertake the residential care of children in special schools or boarding homes, and lead to an appropriate national qualification.

(4) the Minister of Education should have power to make arrangements to ensure that there are sufficient facilities available for training and for the provision of financial assistance during training.

(5) shorter courses providing more specialised training should be arranged by the Central Training Council, which students intending to work with maladjusted children should be encouraged to take after their initial general training.

(6) advanced training should be available for staff with suitable experience who show promise of being fit to hold the more responsible posts.

(7) refresher courses should be arranged by the Central Training Council which existing staff should be encouraged to take.

(8) the Minister of Education should keep under review the salaries paid to all staff, with the aim of ensuring, so far as possible, that salaries are commensurate with their qualifications and responsibilities.

(9) staff should derive some financial advantage from obtaining the qualification to which the initial general training leads.

CHAPTER XVI

PREVENTION

Need for a positive approach to mental health

481. In recent years the emphasis in the health services has shifted from the cure of disease to its prevention ; and it is now shifting from prevention of illness to the promotion of health. This change of outlook is taking place in the field of mental, no less than of physical, health, and the importance is being increasingly realised of encouraging the development of an environment and of attitudes of mind which will be conducive to mental health. Bodies such as the National Association for Mental Health in this country and the World Federation for Mental Health in a wider area have done and are doing much to bring about this changed outlook.

482. In dealing in this chapter with the prevention of maladjustment in children, we shall inevitably have to devote most of our attention to the negative aspects of prevention—such as the discovery of incipient deviations from the normal or of minor troubles which, if left untreated, might develop into maladjustment. We wish, however, at the outset to emphasise the importance of the positive approach to mental health ; for the surest way to prevent maladjustment from arising in children is to encourage in every possible way their healthy development, particularly on the emotional side. This is, indeed, what those general practitioners in the art of child guidance—parents and teachers—spend much of their lives in doing. Most of them do it very successfully, since maladjustment, although a formidable problem, does not affect more than a small proportion of children.

Parents and the prevention of maladjustment

483. Apart from their contribution to the promotion of the sound emotional development of their children, parents also have a pre-eminently important part to play in the prevention of maladjustment. They are in the best position to see the first signs of emotional disturbance and can therefore seek advice and help, if they know when and where to look for them, before the disturbance becomes more deep-seated and difficult to eradicate.

484. There has never been an age in which more was known about children, but it is also true that there has never been an age in which parents had less confidence in their own powers to handle their children. In time past, parents relied on instinct and common sense ; but in the complexity of modern civilisation these are overlaid or mistrusted, and popular books on psychology are no substitute. Some of the common beliefs about the behaviour and development of children are very misleading, and many parents become anxious if their children do not develop with the speed and behave in the manner expected. Parents need some understanding of the wide range of normal behaviour in children and of their requirements at different stages of development.

485. Failure to understand these matters may lead some parents to expect too much from their children at too early an age, and may cause others to adopt an over-protective attitude to them. Either course may lead to emotional disturbance in the child, and to feelings of guilt in the parents due to lack of confidence in their ability to bring up their children success-

fully. Lack of adequate knowledge and understanding may sometimes lead parents to regard as abnormal such things as natural high spirits or temporary loss of appetite, and at other times to dismiss grave symptoms of maladjustment with some such phrase as " She'll grow out of it " or " He is just like his father ".

486. The various social services and, in particular, the health and education services, are well placed to give parents advice and help when needed. The aim of these services, including the child guidance service, should be to help parents to understand and handle their own children, not to relieve them of their normal responsibilities. In addition, these services have another contribution to make to the fostering of mental health and the prevention of maladjustment, by their direct impact on children.

The health services

487. Although our terms of reference are limited to treatment of maladjusted children within the education service and although the only branch of the health services coming strictly within our purview is therefore the school health service, we cannot ignore the problem of the young child not yet at school, since the early years are of such paramount importance. It is increasingly held that the most serious emotional damage is often done before a child reaches the age of five or even before the age of two; to a considerable extent, therefore, the problems presented by maladjusted children to the education service are ones which, with more complete co-operation between the available services, might have been dealt with or even prevented from arising before the children became of an age to attend school. For example, the school health and the maternity and child welfare services of the local authority must work closely together to ensure that children under five are, where necessary, referred and admitted to child guidance clinics provided by the local authority.

488. In most areas there is a considerable measure of integration between the school health and the maternity and child welfare services. The authorities responsible for both services are the councils of counties and county boroughs; in all counties and all but three county boroughs the post of Medical Officer of Health and Principal School Medical Officer are held by the same individual. In most cases his staff are jointly appointed to both services, thus making one medical officer responsible for all the health services of the local authority in a particular area or district.

(i) *Ante-natal and child welfare centres*

489. The first opportunity many expectant mothers have for learning parentcraft is when they attend the ante-natal clinic, which may be in a hospital or form part of the local health authority's services. Mothers can continue to learn parentcraft in the child welfare centre. These centres are uniquely placed, since they are not primarily for those who are ill or worried by particular problems, but for mothers seeking advice about the day-to-day task of bringing up their young children. Mothers come, therefore, prepared to receive advice and guidance. The Report of the Ministry of Health for 1953 emphasises the educational and preventive character of this service:

> " From its earliest inception the maternal and child welfare service has been educational and preventive in character; it is not and it has never been an extension of the out-patient department for sick children, for its main concern throughout its long history has been the preservation of the *health* of mother and child. Indeed, the pioneer centres established in England nearly 50 years ago were known as schools for mothers since their primary purpose was training and instruction in

child welfare. . . . Valuable and essential as are the services of the family physician, the hospital medical officer and the consultant, the need for the maternal and child welfare centre with its emphasis on health education remains undiminished"*.

490. Mothers are much more ready to attend child welfare centres during the first year of a child's life than when their children are older; about 75 per cent. of mothers with children under one year attend, whereas only about 27 per cent. of mothers with children between one and five do so. It is therefore important to secure and hold the interest of the mothers at the beginning. One way of doing this is by means of parents' clubs and discussion groups. Witnesses for the Women Public Health Officers' Association told us of mothers' clubs attached to child welfare centres and run by health visitors in a number of areas. The Ministry of Health Report from which we have already quoted has some interesting paragraphs on this subject†:

> "The standard of health teaching in child welfare centres shows considerable variation in quality throughout the country, depending as it does largely on individual effort and enthusiasm. Regular and much too frequent weighing of babies has become a fetish in many centres; the weighing-scales should be used with much more discrimination than they are at present, and the time thus saved used for more creative activity. In many adapted premises the set lecture presents difficulties and may be of small value, but much may be expected from group talks by experienced health visitors in which the mothers are encouraged to participate in the discussion. It is of importance to note that in the field of adult education generally, the usefulness of group discussion is becoming increasingly recognised.
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> . . . . . .
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> Many authorities have established mothers' clubs in connection with their maternal and child welfare schemes, and much success has been reported as a result of this innovation. The sessions, which are held in the evening, are devoted to educational and to social activities, the mothers themselves being largely responsible for their organisation, with the help and advice of medical officers and health visitors. One large authority, in whose area these clubs have been evolved to a high degree, selects each year a special subject for study and discussion, such as home hygiene and mental health, with which are associated competitions in handicrafts relating to child growth and development.
>
> Provision is made in some instances for the co-operation of the fathers either as part of the club, which is then known as a parents' club, or by occasional mixed gatherings to which the fathers are specially invited. It is to be hoped that this invaluable contribution to parental education will extend more widely throughout the country".

491. We should welcome an increase in the number and variety of parents' clubs and discussion groups, since we are sure that they can make a valuable contribution to the prevention of maladjustment and to sound emotional and mental development. Through discussion groups parents can be brought to realise that their particular problems are by no means unique; and they will learn more readily by taking an active part in group discussion than by being merely passive recipients of information. There is the further advantage that group discussions are more economical in the use of skilled manpower than some other methods of disseminating expert knowledge and advice.

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* Report of the Ministry of Health for 1953, Part II, p. 167, published by H.M. Stationery Office, price 7s. 6d. net (Cmd. 9307).

† op. cit., pp. 168–9.

492. We hope that parents' clubs and discussion groups, even though they are formed in conjunction with child welfare centres and so catch parents of young children, will not have rigid upper age-limits, so that parents with children of school age will also be able to attend. We heard of one parents' club which was so popular that mothers had to be asked to give up attending when their children reached the age of 16!

493. In addition to advising parents on the upbringing of children and the problems of child development, the staff of child welfare centres need to be able to recognise at an early stage emotional disturbance in children. If it is incipient, they should be able to deal with it themselves: if it is already serious when they discover it or becomes serious later, they should be able to call on the help of the child guidance clinic staff serving the area, and should be prepared to do so without delay. To make this co-operation fully effective, some modification in the training of health visitors and doctors working in the maternity and child welfare service will be needed; we make further reference to this in paragraphs 500–505 below.

494. In concluding this section on child welfare centres, we think that it may be of interest to mention that in London two child guidance clinics are housed in the same buildings as child welfare centres, and experimental case-conferences have been held between a doctor, a health visitor, a psychiatrist and a psychiatric social worker. A report was published in November, 1954, of a study group set up in 1953 by the Medical Officer of Health for London "to investigate the possibility of increasing preventive mental health work in the maternity and child welfare services"*. The study group, whose valuable report contains many detailed suggestions, were convinced that child welfare centres have many advantages for mental health work. The relationship with the mothers is good and often extends over many years, and the familiar setting of the clinic is reassuring.

(ii) *The school health service*

495. The school health service is another important instrument of prevention. We have dealt in Chapter V with the statutory duties of the local education authority in regard to this service; and in Chapter VI (paragraphs 171–173) with its work in the schools as part of the child guidance service. It remains for us here to describe the system of inspections through which minor troubles or maladjustment can be discovered and to show how the potentialities of the school health service in the field of mental health can be extended and developed. In the main, the service relies on the general medical inspections which local education authorities are required to carry out, at appropriate intervals, at least three times in each child's school career. Parents are given the opportunity of being present at these periodic inspections; and more than 80 per cent. attend the inspection conducted soon after a child goes to school, though fewer attend the subsequent inspections (about one-third in the case of inspections held shortly before a child leaves school). Although the examination is chiefly physical, parents or teachers have an opportunity beforehand or afterwards to mention a child's difficulties to the doctor. In this way problems of emotional and mental development may come to the notice of the inspecting medical officer, but he will not have time to talk at length to many parents; he can only hope to pick out children whose development it will be desirable to discuss with their parents on another occasion, e.g. at a consultation clinic (see next paragraph).

* The report was reproduced in the issue of "The Medical Officer" for 10th December, 1954.

496. A more valuable means of discovering maladjustment is the system of special inspections. Teachers and school nurses have the opportunity of referring for special medical examination to the school medical officer when he visits the school any children thought to be suffering from physical or mental ill-health. In urban areas visits for special inspections can be made regularly and frequently, but in country districts it is only possible to arrange such visits at longer intervals, perhaps not more than once or twice a year. Consultation clinics also are held, usually in the premises of a school clinic. Children can be referred to these not only if they are picked out at periodic or special inspections as needing a further examination, but at any time. At the consultation clinic more time is available for discussion of problems, so that emotional troubles may more easily come to light there.

497. An important innovation was made by the Ministry of Education's 1953 Regulations*. While they retained the requirement that there should be a minimum of three general medical inspections during the period of compulsory school age, they provided that the Minister might approve arrangements providing for fewer than this number. The following paragraph†, from the circular explaining the changes made by these regulations, shows the reason for this particular provision :

> "Authorities will notice that in Regulation 10 (1) (*a*) the Minister may approve arrangements which do not provide for as many as three general medical inspections during the period of compulsory school age. This provision has been included to enable authorities who wish to do so to experiment with other arrangements not based on periodical medical inspections. Where it is possible, for instance, for the school doctor to visit the schools regularly (*e.g.*, at least two or three times a term), it may be found preferable for him to see on each occasion such children as are brought to his attention by parents, teachers, or the school nurse instead of seeing all the children of a particular age group at infrequent intervals. The Minister will be prepared to consider sympathetically any proposals which authorities may wish to put forward. In deciding whether or not to approve them he will be guided by the extent to which they appear likely to make a positive contribution to the efficiency of the preventive work of the School Health Service".

It seems to us that this measure of freedom to experiment should enable local education authorities to develop the preventive work of the school health service and thus enable it to make a more effective contribution to the prevention of maladjustment. We understand that few authorities have so far proposed any changes taking advantage of this concession, which we hope will be more widely used‡.

(iii) *General practitioner services*

498. Where a doctor has watched over the birth and development of a family's younger members, he should be in a good position to detect and advise on any deviation from normal emotional as well as physical development. Although, however, a number of general practitioners are taking an increasing interest in the emotional problems of children, this interest is as yet by no means universal among their ranks. The extent to which family

* Regulation 10 (1) (*a*) of the School Health Service and Handicapped Pupils Regulations, 1953, given in Appendix D.

† Paragraph 10 of Ministry of Education Circular 269, dated 25th August, 1953.

‡ It is of interest that one authority is as an experiment dropping the intermediate inspection, because it has been found that regular visits to schools, when children who are causing concern in any way are discussed with the head teacher and school nurse, enable more such children to be picked out and, where necessary, referred for examination; these include some who are emotionally disturbed.

doctors refer children to the child guidance service varies considerably as between different areas, and clinics thus seem to have had varying degrees of success in winning the confidence of the family doctor. We hope that he will play an increasing part in the work of prevention of maladjustment and that he will establish close relations with the other agencies and services working in this field.

(iv) *Consultant paediatric services*

499. Since the inception of the national health service, a Consultant Children's Physician with regional responsibilities has been appointed in several cities and larger towns as part of the hospital service. By virtue of their training and experience, these doctors are particularly well fitted to recognise not only frank maladjustment but also the early evidence that a child's behaviour is moving towards serious disharmony with his circumstances, and their advice to the parents or school will often right the situation. In common with consultants in other branches of medicine they are in close touch with the general practitioner service, while in addition they are closely linked with the neonatal, infant welfare and school health services of the local health and the local education authorities ; indeed they are often in the employ of the local authority as well as of the hospital service. In this way they are in a unique position to foster co-ordination between the child's home and the family doctor on the one hand, and the health and education services on the other. We consider it essential that paediatricians should be in the closest touch with the child guidance clinics, for the child psychiatrist and the children's physician have much common interest in any child. Although the detection, treatment or referral of maladjusted children is but one facet of the work of a paediatrician, it is clear that further development of this service must react to the advantage of these children.

(v) *Health visitors and school nurses*

500. Of all the workers in the health services who can help in the work of prevention, none is better placed than the health visitor. We have already mentioned in Chapter V that school nurses are now normally required to hold the health visitor's certificate, and in fact some 75 per cent. of them do so. Usually school nurses holding the health visitor's certificate are employed part-time in the school health service and part-time in the other health services of the local authority, including the maternity and child welfare service. Health visitors thus tend to know the children of the families they visit both as young infants and as school children.

501. The health visitor's contacts with a child in its family begin in the first month of its life. When a baby is about a fortnight old, a health visitor generally visits the home and afterwards will visit as needed until the child reaches the age of five, in addition to seeing the mother and child when they visit the child welfare centre. Health visitors are increasingly asked by parents for advice on general questions of upbringing as well as health, and they are thus in a position to help in the detection of maladjustment in its early stages. More than any other type of welfare worker, health visitors have the entry into homes ; this is an incalculable asset in all their work and makes them, apart from the parents, potentially the most important agents for discovering maladjustment in children of pre-school age.

502. Health visitors who are also school nurses will continue to visit the family as necessary when the children are of school age, as part of their duties under the school health service. The continuity of the work of school nurses who are also health visitors, which may extend for 15 years in relation to a child, enables them to gain a much deeper knowledge of children and

also increases the confidence of the family in them. Parents in general are ready to ask for—and act on—their advice in matters of physical health, and we think that their training might help them to understand more about nervous behaviour and other difficulties in children so that they can be of help to parents on this side also. If parents feel that they can turn to somebody they already know when they are anxious about any aspect of their children's development, they will be more likely to ask for advice sooner rather than later. In this way a large number of small troubles can be dealt with which, if unrevealed and untreated, may lead to maladjustment.

503. We are encouraged to suggest this extension in the work of the health visitor by some remarks in the Ministry of Health's report for 1953, to which we have already referred (page 169 of Part II): " . . . . the time has arrived when medical officers, health visitors and midwives should take a more comprehensive view of their responsibilities as educators. Hitherto, they have been occupied, for the most part, with the physical health and care of the individual mother and child ; now the wider social sphere of family health must also be their interest and concern ". The significance in public health of harmonious family relationships is emphasised. The report goes on : " Maternal and child health workers must become teachers and protagonists in the field of mental hygiene if they are fully to maintain their place and function as creators and preservers of health ".

504. We do not, however, consider that the present training of health visitors entirely fits them for the extension of their work which we have in mind. Although we understand that the syllabus of training for the health visitor's certificate has been broadened in recent years and now includes some instruction in the general development of children, we feel that even more attention should be paid to emotional and mental development and that the teaching should be made more practical. In addition to giving the health visitor the wider understanding of children needed for this work, her training should help her to adopt the right approach to the whole family. The first aim is to win the parents' confidence ; to achieve this the health visitor must, as her training already recognises, be able to listen patiently and sympathetically to all that they have to say and be prepared to give support and advice rather than directions. She must also know the limitations of what she can do on her own and be ready to call in outside help if it is required. It is not for us to suggest how a re-orientation of the health visitor's training should be brought about, but this is essential if health visitors in general are to play the part we have in mind for them. A working party on the proper field of work and training of health visitors was set up by the Ministers of Health and Education in 1953, and we have brought to its notice our views on this matter. We also commend the points we have made to the attention of any other bodies which have the functions or training of health visitors under review.

(vi) *Doctors in child welfare centres, school medical officers and family doctors*

505. In Chapter XIV we suggested that all medical students should be taught something about the emotional development of children. This seems to us essential if doctors are to make full use of their special opportunities, whether they work in the maternity and child welfare service, the school health service or as family doctors, to advise on and encourage the healthy emotional development of children and to notice the earliest signs of deviation from the normal. In addition to the need for more basic knowledge, there is a need for more advanced courses in emotional and mental health at a later stage when some cross-fertilisation between theory and experience

is possible. Doctors in child welfare centres, school medical officers and family doctors do not all work only in one of these capacities; many work part-time in more than one, and this should make it easier to arrange courses in which all three groups can take part.

The schools

(a) *Nursery schools and classes*

506. We have considered carefully the question whether nursery schools and classes* have a contribution to make to the prevention of maladjustment among children below the age of five. Attendance at a nursery school or class is the only means for some children of providing companionship with others of the same age or space to play freely; these are two of the most important requirements between the ages of two and five. The teachers in a nursery school or class have the skill and the equipment needed to introduce children to a widening range of experiences, which their homes are unlikely to provide. Parents find talks with the teachers helpful, and nursery schools and classes can also provide a valuable meeting-ground for parents. Mothers' clubs have already been established in connection with some nursery schools, e.g. in Liverpool. One of the witnesses for the Nursery School Association told us that parents find the atmosphere of nursery schools conducive to the sharing of experience and advice.

507. In our view, by supplying the stimulus and outlet required at this age for children who would not otherwise obtain them, nursery schools and classes can make a large contribution to the prevention of maladjustment. They should be especially beneficial for only children and for those living in overcrowded dwellings or in flats where the neighbours object to the noise made by children. The number of nursery schools and classes is at present insufficient to meet the demand for places; and some people believe that a whole day away from home is too long for many very young children and that the essential benefits of a nursery school or class could be secured by half-day attendance. Experiments on these lines are being tried in London and Bristol. We hope that this possibility of using some nursery schools and classes for a considerably larger number of children will be carefully considered.

(b) *Primary and secondary schools*

508. The principal contribution to the prevention of maladjustment which may be expected from teachers is the encouragement of the healthy mental and emotional development of children. A great responsibility rests on the schools in this way. Some children are not obtaining at home the love and care, the discipline or the stimulus which they need, and the school inevitably has to try to make good some of the home's deficiencies. The school too is constantly demanding fresh adjustments from its pupils; and if they are to make these without strain, the school must in its turn be capable of a certain degree of adjustment and flexibility in its handling of individuals.

509. All children are exposed to portrayals of violence and evil in some of the reading matter and films which they may come across. These need not of themselves cause maladjustment, but they may confirm and encourage tendencies to cruelty, sensuality, anxiety or, indeed, cynicism; when sensitiveness and sympathy are blunted, a balanced personal and social life becomes

* Nursery schools (for children aged 2–5) are organised separately, but nursery classes (for children aged 3–5) form part of primary schools.

impossible. Schools can do much to counteract these tendencies if they set high standards and ideals before children and provide a stable environment for them.

510. We are conscious of the serious handicaps under which many schools labour at the present time. If the educational difficulties mentioned in Chapter IV are to be avoided and if all children are to gain confidence in their ability to learn and get on in school, teachers should be enabled to give individual attention to any children who are, or show signs of becoming, out of step with the rest. This is very difficult when classes are large and when free movement in the classroom is impeded by lack of space. Even under these conditions, however, it often proves possible to help individual children with educational difficulties, which might otherwise develop into maladjustment, by making special arrangements for teaching them in smaller groups within the ordinary schools.

511. The schools, like the child welfare centres, can encourage the formation of parents' clubs and discussion groups. We have already spoken at length of the value of these (cf. paragraphs 490-492 above), and need not enlarge further on this subject.

(c) *Teachers*

512. In Chapter XV we spoke of the special training for work with maladjusted children which teachers should have after they have completed their general training. Teachers in ordinary schools have an important part to play in the discovery and prevention of maladjustment. Since children above the age of five spend five or six hours a day at school for over nine months of the year, teachers have better opportunities than anybody, except the parents, of getting to know the children in their school. They can view children more objectively and compare them more easily with other children than the parents can ; at the same time, unless teachers get to know a child's parents and his home background, they may easily make a false judgment about him. They should be able to appreciate the significance of a child's behaviour which is outside the ordinary range, does not respond to their ways of handling children and calls for specialist advice ; and should be aware that some children who are very emotionally disturbed may give no trouble in school, and learn how to pick them out. Teachers, however, may without guidance not be aware of the facilities which are available for providing advice and help, and the way to obtain these. We recommend that local education authorities should take steps to ensure that this information is brought to the notice of all the teachers in their schools.

513. To equip teachers for preventive work it is clear that their initial training should include instruction about the emotional development and needs of children, and that this instruction should be based on the direct observation of children by the students. We are glad to learn that a growing number of training colleges adequately prepare their students in this way, and we hope that this practice will extend. Intending teachers should also be told about the variations to be expected within the range of normal behaviour. In all training the approach should be through the normal ; students still in their teens are not likely to be mature enough to take in the emotional implications of maladjustment. If however they gain a good grasp of what is normal, they will later find it less difficult to pick out children who are outside that range and who may in fact be maladjusted. Further, much more can be done for a child who is maladjusted by a teacher who is warm-hearted and loving than by one who approaches maladjustment through the abnormal and broods over him as a problem child.

514. Many teachers with some years' experience would find refresher courses in child development of value to them. Their experience and greater maturity will have given them a deeper insight into the emotional development and needs of children, and they will thus be more ready to profit by a special refresher course. We hope that more such courses will be arranged, and that local education authorities and other employing bodies will encourage teachers to take part in them.

The child guidance service

515. We have already dealt in Chapter VI with the main preventive aspects of this service, with its roots both in the schools and in the health services. It is essential that the staff of the service should not allow themselves to become clinic-bound if they are adequately to fulfil their preventive rôle. They can and should be associated with many of the activities and developments suggested in the previous paragraphs of this chapter, such as talks to parents' associations and discussion groups, and should work in co-operation with the ante-natal clinics and child welfare centres, with the school health service and, in particular, with the health visitors. They can also help with refresher courses for health visitors, for teachers and for doctors working in the local authority services or general practice. The educational psychologist can advise teachers on the problems of individuals and organise remedial teaching; the psychiatric social worker may be called upon to visit families which the health visitor has reported as raising difficult problems likely to lead to maladjustment in the children; the psychiatrist may be consulted by his medical colleagues in the local authority and general practitioner fields. It is important that workers in the child guidance service should be accessible and known to their colleagues working in other services, and that no formalities should be allowed to stand in the way of co-operation between any or all of the available services.

Other agencies

516. There are many parents who will not be reached or helped through the services which we have so far described in this chapter. Often those parents who most need help will not join a group based on a clinic or school. It is therefore essential to try and reach these parents through any other social groups to which they may belong, e.g. a community centre or a club. Efforts should be made to arouse the interest of these organisations, with offers to provide speakers or run discussion groups.

517. More might be tried in the way of wireless talks, television features, films or pamphlets. Some stimulating film strips about common problems have been produced by the Central Council for Health Education; and some films dealing with problems of mental health have been produced in Canada, which are available in this country from the Central Film Library. The National Association for Mental Health have produced a series of most attractive pamphlets for the guidance of parents, each about a single topic*. These pamphlets are priced at 1s. 3d., but the Canadian Department of National Health and Welfare has published free of charge some even simpler leaflets on aspects of child training; and we think there is a place in this country for a cheaper series which would be more likely to reach some of the mothers who most need help with the upbringing of their children. We suggest for consideration the possibility of the Ministry of Education and the Ministry of Health sponsoring some pamphlets or leaflets for the guidance of parents, for which at most a nominal charge should be made. The value however of

* e.g. there are pamphlets on habit training, temper tantrums, children's fears and children's jealousies.

pamphlets, as of all material which reaches people through the other impersonal media mentioned, is limited unless they can be used as a basis for a talk or a discussion, e.g. at a parents' club.

518. There is no more important aspect of prevention than action designed to keep the family together. For this reason the work of bodies such as Family Welfare Associations, Marriage Guidance Councils and Family Service Units is of great importance. There is obviously room for strengthening work of this kind. We also welcome the recent initiative of the Ministry of Health in issuing a circular to local health authorities* encouraging them to use the domiciliary services, which they provide under the National Health Service Acts, to help to prevent the break-up of families. The circular lays stress on the part which the health visitor can play in this work.

Conclusion

519. In this chapter on prevention, as in the earlier chapters on treatment, we have been mainly concerned to suggest ways in which the existing services should be more fully utilised and in which co-operation between them could be better secured. We have made some recommendations in our report of ways in which the existing services should be strengthened or developed ; and in our view progress is to be sought by strengthening and developing rather than by thinking in terms of a radical change or of the setting up of entirely new services. We should like, therefore, to conclude this chapter and our report by emphasising once again the need for full understanding and co-operation between the staff of the various services. Neither personal misunderstandings nor patterns of administrative responsibility should be allowed to stand in the way of this or to prevent the various services from offering the best possible help to children and their parents.

Recommendations

We recommend that

(1) child guidance clinics should work in close co-operation with child welfare centres in their area.

(2) consideration should be given by the appropriate bodies to extending the functions and adapting the training of health visitors, so that they can advise parents on behaviour, nervous and other difficulties in children, as well as on matters of physical health.

(3) short advanced courses on the emotional development of children should be arranged for school medical officers, doctors working in child welfare centres and general practitioners.

(4) in view of the contribution which nursery schools and classes can make to the prevention of maladjustment, consideration should be given to the possibility of increasing the number of children who can be admitted to nursery schools and classes by using some as part-time nursery schools and classes.

(5) more clubs and discussion groups for parents should be established by schools, including nursery schools.

(6) local education authorities should take steps to ensure that the attention of all teachers in their schools is drawn to the facilities which are available for obtaining advice and help over children with behaviour or other difficulties.

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* Circular 27/54, of 30th November, 1954.

(7) all initial courses of training for teachers should include instruction about the emotional development of children and about variations within the range of normal behaviour.

(8) more refresher courses in child development should be arranged for teachers.

(9) consideration should be given by the Ministries of Health and Education to sponsoring a series of simple pamphlets for the guidance of parents on the upbringing of children and common problems which arise.

(10) the fundamental importance of the family as a whole should be borne in mind by those responsible for strengthening and developing the social services, and action designed to keep the family together should be regarded as one of the most important aspects of prevention.

CHAPTER XVII

SUMMARY OF RECOMMENDATIONS

(At the end of each recommendation will be found in brackets the chapter or chapters from which it is taken.)

A. The child guidance service

1. There should be a comprehensive child guidance service available for the area of every local education authority, involving a school psychological service, the school health service and child guidance clinic(s), all of which should work in close co-operation. (VI)

2. Local education authorities and regional hospital boards should plan their provision of child guidance clinics in consultation. (VI)

3. Paragraph 18 of Ministry of Education Circular 179 should be withdrawn. (VI)

4. The pattern of provision most likely to lead to an effective and well-integrated child guidance service is for the local education authority to provide the clinic and to employ the educational psychologist(s) and psychiatric social worker(s), and for the regional hospital board to provide and pay for the psychiatrist. (VI)

5. Where the services of the psychiatrist are provided by the regional hospital board and the local education authority employ the rest of the clinic staff, there should be full consultation between the two employing bodies about appointments to the clinic staff by either of them. (VI)

6. All child guidance clinics, whether provided by local education authorities or regional hospital boards, should have close links with both the education and health services. (VI)

7. Child guidance clinics should work in close co-operation with child welfare centres in their area. (XVI)

8. All child guidance clinics, whether provided by local education authorities or regional hospital boards, should normally be open to all boys and girls in the area up to the age of 18, whether they are at school or not; and the law should, if necessary, be amended to allow direct access to clinics for children attending schools not maintained by a local education authority. (VI)

9. Parents should have direct access to clinics. (VI)

10. All clinics should have a clear policy over treatment. (VI)

11. A reasonable ratio between psychiatrists, educational psychologists and psychiatric social workers in a team working in a child guidance service is 1 : 2 : 3. (VI)

12. The educational psychologist in the child guidance service should work part-time in the child guidance clinic and part-time in the school psychological service, and should be the main link between the schools and the clinic. (VI)

13. The educational psychologist in the school psychological service should, when possible, try to help within the setting of their school individual children who have learning or behaviour difficulties; when this is not possible, he should refer children without delay to the clinic for investigation by the whole team. (VI)

14. The basic child guidance team, consisting of a psychiatrist, educational psychologist(s) and psychiatric social worker(s), should be able to call on a consultant paediatrician and other workers and specialist services as required. (VI)

15. The staffing of a child guidance service should provide for adequate secretarial and clerical assistance. (VI)

16. As a means of increasing mutual understanding, meetings should be arranged between magistrates of juvenile courts and the staff of child guidance clinics. (XII)

17. All clinics should have premises which are suitable and easily reached. (VI)

Expansion of child guidance services over the next decade

18. Local education authorities should plan on the assumption that a child guidance team, consisting of the equivalent of one full-time psychiatrist, two educational psychologists and three psychiatric social workers, can adequately serve 45,000 school children. (XIII)

19. The objective should be to increase the number of child guidance staff to the equivalent of approximately 140 full-time psychiatrists, 280 educational psychologists and 420 psychiatric social workers. (XIII)

Training and supply of child guidance staff

(i) *Child psychiatrists, educational psychologists and psychiatric social workers:*

20. Candidates should not be accepted for child guidance training unless they are judged to have the right personal qualities for work with children. (XIV)

21. As a means of attracting more recruits and improving the distribution of trained staff, the number of centres outside London where training can be obtained should be increased. (XIV)

22. Training should be arranged in association with a university; and, in order to allow some of the training to be shared, facilities for training all three professions should be provided by some universities. (XIV)

23. More child guidance clinics should be provided with the staff and the space to enable them to undertake practical training. (XIV)

(ii) *Child psychiatrists:*

24. All medical students should be given lectures on general and child psychology and should attend a child psychiatric department. (XIV)

25. All medical schools should have links with a child guidance clinic, which could be used for the training of medical students and of doctors preparing for the Diploma in Psychological Medicine, as well as for the post-diploma studies of intending child psychiatrists. (XIV)

(iii) *Educational psychologists and psychiatric social workers:*

26. The Minister of Education should have power to make arrangements to ensure that there are sufficient facilities available for training and for the provision of financial assistance during training. (XIV)

27. A clear policy should be drawn up and made known about the sources and extent of grants which are available for staff in training. (XIV)

28. Knowledge about educational psychology and psychiatric social work as careers, and about work in a child guidance service, should be spread both in the field from which recruits are at present drawn, including the centres where basic qualifications are obtained, and further afield. (XIV)

(iv) *Educational psychologists:*

29. Where possible, a newly-trained psychologist should work in a child guidance clinic where he would for the first year be under the supervision of a more experienced psychologist. (XIV)

30. A Training Council should be set up to be the recognising body for training courses and to advise on their content and standards. (XIV)

31. The Minister of Education should keep under review the effect which the introduction in the national health service of the grade of Psychologist has on the number and quality of applicants for training as educational psychologists. (XIV)

32. In increasing the number of training courses, some priority should be given to the establishment of additional two-year courses for those who have graduated in subjects other than psychology. (XIV)

33. Consideration should be given to the establishment of a form of training on the lines of the Scottish system, whereby graduates who intend to become educational psychologists, after one year's full-time training (which includes their training as a teacher), can complete the rest of their training while they are holding salaried posts. (XIV)

34. Consideration should be given to the possibility of arranging for a degree in psychology to be taken through part-time study in some universities outside London and for the course of study to be completed in a minimum of three years. (XIV)

(v) *Psychiatric social workers:*

35. If a greatly increased flow of recruits is to be secured, the salary scales need to be attractive to young men and women who do not at present take up any form of social work. (XIV)

36. More opportunities should be provided for married psychiatric social workers to return as part-time workers. (XIV)

37. In order to effect economies in the use of psychiatric social workers, other less highly trained workers in the education and health services should be trained to detect and handle minor troubles of children which either are referred at present to child guidance clinics or, if they remain undetected and untreated, may develop into maladjustment. (XIV)

B. Other forms of day treatment, and residential treatment

38. Local education authorities should make more use of day treatment for maladjusted children, particularly special schools and part-time special classes. (VII)

39. A child should be given residential treatment only if there appears to be no hope of treating him successfully while he remains at home; and, where it is given, the aim should be to prepare the way for his return home as soon as possible. (VIII)

Part-time special classes

40. Children should be admitted and discharged on the recommendation of the child guidance service, and in consultation with the teacher of the special class and the head of the child's ordinary school. (VII)

41. Teachers should be allowed sufficient time for keeping in touch with the parents, the child guidance service and the ordinary schools from which the children come. (VII)

Day special schools

42. Children should be admitted and discharged on the recommendation of the child guidance service and in consultation with the head of the school. (VII)

43. A school should contain not less than about 20 children, and ordinarily not more than about 50. (VII)

44. Staffing should be based on the principle that ordinarily a teacher cannot satisfactorily meet the needs of more than 10 maladjusted children, and that for some purposes a group may need to be considerably smaller. (VII)

45. Adequate arrangements should be made for keeping in close touch with the parents. (VII)

Residential treatment

46. Where children are deemed to need a period under observation away from home before a recommendation can be made about their treatment, consideration should be given to the practicability of sending some of them for a few weeks to selected reception centres provided under the Children Act. (VIII)

47. In reaching and carrying out a decision to provide residential treatment for a child, a local education authority should act in close consultation with the child guidance clinic ; and they should together make a plan to suit the individual child, which covers his home and his education as well as his treatment for maladjustment, and is flexible enough to allow for possible developments. (VIII)

48. The local education authority should make every effort to ensure that a child has a satisfactory home base before he leaves school, if necessary through the local authority taking him into care under the Children Act. (VIII)

49. In general, every child appearing before a juvenile court who is so handicapped as to need special educational treatment in a boarding school should be provided with residential treatment by the local education authority rather than be sent by the court to an approved school. (XII)

50. Consideration should be given to the question whether Section 33 (2) of the Education Act, 1944, covers all forms of special educational treatment suitable for maladjusted pupils which can be combined with attendance at an ordinary school ; and, if necessary, the law should be amended. (V)

51. Hostels and boarding special schools should continue to be the main forms of residential provision for maladjusted children. (X)

Hostels and boarding special schools

52. Children should be admitted only on the recommendation of a child guidance clinic and with the agreement of the warden or the head of the school. (IX, X)

53. In order to avoid unnecessary moves before treatment is completed, the age-range of boarding special schools and hostels should be sufficiently elastic to enable children to be retained at establishments for juniors until the age of 13 and to be admitted to establishments for seniors at the age of 10 (or exceptionally 9). (VIII)

54. Adequate arrangements should be made for maintaining contact between parents and their children and between parents and the hostel or school staff; and for securing treatment, where necessary, for the parents. (IX, X)

55. Children should be allowed—and encouraged—to take as full a part as possible in the life of the community and, where they go out to a local day school, in its activities. (IX, X)

56. Arrangements should be made for schools and hostels to be visited regularly by a psychiatrist and to keep in close touch with a child guidance clinic. (IX, X)

57. Where a local education authority maintain a hostel or a special school, the Principal School Medical Officer should be responsible for the health and general well-being of the children. (IX, X)

58. A hostel or school should remain open in the holidays if it is in the best interests of any child that he should stay there; but, normally, local education authorities should arrange for children to go away for at least part of the holidays. (IX, X)

59. Before any child is discharged, there should be consultation between the local education authority, the parents, the child guidance clinic which recommended treatment, the special school or hostel, any other clinic providing supervision or treatment while the child has been there, and the head of the local day school if the child has attended one. (IX, X)

60. The premises should provide a standard of comfort similar to that of an ordinary home; and equipment and materials should be supplied for a variety of crafts and hobbies. (IX, X)

61. Adequate accommodation should be provided for staff, married and single. (IX, X)

Hostels

62. A child should not be admitted to a particular hostel unless there is a day school suitable for him within reach. (IX)

63. The warden should work in co-operation with the school which a child attends, and should give the school any information which may be of help to it in handling the child. (IX)

64. A larger measure of regional co-operation should be developed in the use of hostels. (IX)

Boarding special schools

65. A school should contain not less than 20 children, and ordinarily not more than about 50. (X)

66. Staffing should be based on the principle that ordinarily a teacher cannot satisfactorily meet the needs of more than 10 maladjusted children, and that for some purposes a group may need to be considerably smaller. (X)

67. Even where house-staff are employed, the teachers should take some responsibility for the children in the evening and at week-ends. (X)

68. The system should be generally adopted whereby children, when they are fit to attend an ordinary school and it can be arranged, go out for their education to a suitable day school in the locality. (X)

69. Local education authorities within a region should consult each other and any voluntary bodies concerned, to see whether a scheme can be worked out whereby each school for maladjusted pupils in the region meets a particular need, with the ultimate object of enabling authorities to place nearly all their maladjusted boys and girls inside the region. (X)

70. The Minister of Education and local education authorities should keep under review the need for more places for maladjusted pupils over the age of 11, in particular boys with I.Q.s below 85-90 and children suited to a grammar or a technical school course. (X)

Foster-homes

71. A child should not be placed with foster-parents unless he can tolerate the tensions of intimate relationships inside a family. (IX)

72. Foster-parents should be chosen for a child only if it appears that they can deal with his difficulties and, without becoming possessive, satisfy his emotional demands. (IX)

73. The local education authority should arrange for regular visits to be paid to the foster-home, and advice and help should be available to the foster-parents when required. (IX)

74. Foster-parents taking maladjusted children should receive adequate remuneration. (IX)

Independent schools

75. As from an appropriate date as soon as possible, local education authorities should be permitted to maintain maladjusted pupils only in those independent schools which are recognised by the Minister of Education as efficient. (X)

After-care

(a) *Children attending school after their treatment as maladjusted pupils has ceased :*

76. Local education authorities should provide, where appropriate by arrangement with voluntary bodies, a comprehensive service of personal help ; and, if necessary, the law should be amended to enable authorities to do this. (XI)

(b) *Boys and girls up to the age of about* 18 *who are no longer at school and who were during their school-days treated as maladjusted pupils :*

77. Local education authorities should provide, where appropriate by arrangement with voluntary bodies, a comprehensive service of personal help ; and the law should be amended to enable authorities to do this. (XI)

78. Consideration should be given to the question whether local education authorities should be given power to provide accommodation, either in hostels or lodgings or both, at least for those who finished their school-days at a special school or hostel for maladjusted children. (XI)

79. Any power given to local education authorities to provide accommodation should include a power to make a charge for it which is in relation to earnings and so calculated as to leave boys and girls with adequate spending money. (XI)

Training and supply of teachers and house-staff

80. Special training should be provided for teachers and house-staff in special schools and classes and hostels for maladjusted children. (XV)

(i) *Teachers :*

81. Special training should be provided within the framework recommended by the National Advisory Council on the Training and Supply of Teachers in their recent report on the training and supply of teachers of handicapped pupils. (XV)

(ii) *House-staff :*

82. The Minister of Education should have power to make arrangements to ensure that there are sufficient facilities available for training and for the provision of financial assistance during training. (XV)

83. Consideration should be given by the Home Office and the Ministry of Education to extending the scope and membership of the Central Training Council in Child Care to cover the educational field, with the object that the Council should arrange courses which will cater for all those intending to undertake the residential care of children in special schools or boarding homes, and lead to an appropriate national qualification. (XV)

84. Shorter courses providing more specialised training should be arranged by the Central Training Council, which students intending to work with maladjusted children should be encouraged to take after their initial general training. (XV)

85. Advanced training should be available for staff with suitable experience who show promise of being fit to hold the more responsible posts. (XV)

86. Refresher courses should be arranged by the Central Training Council which existing staff should be encouraged to take. (XV)

87. The Minister of Education should keep under review the salaries paid to all staff, with the aim of ensuring, so far as possible, that salaries are commensurate with their qualifications and responsibilities. (XV)

88. Staff should derive some financial advantage from obtaining the qualification to which the initial general training leads. (XV)

C. Other measures of prevention

89. Consideration should be given by the appropriate bodies to extending the functions and adapting the training of health visitors, so that they can advise parents on behaviour, nervous and other difficulties in children, as well as on matters of physical health. (XVI)

90. Consideration should be given by the Ministries of Health and Education to sponsoring a series of simple pamphlets for the guidance of parents on the upbringing of children and common problems which arise. (XVI)

91. In view of the contribution which nursery schools and classes can make to the prevention of maladjustment, consideration should be given to the possibility of increasing the number of children who can be admitted to nursery schools and classes by using some as part-time nursery schools and classes. (XVI)

92. More clubs and discussion groups for parents should be established by schools, including nursery schools. (XVI)

93. Local education authorities should take steps to ensure that the attention of all teachers in their schools is drawn to the facilities which are available for obtaining advice and help over children with behaviour or other difficulties. (XVI)

94. All initial courses of training for teachers should include instruction about the emotional development of children and about variations within the range of normal behaviour. (XVI)

95. More refresher courses in child development should be arranged for teachers. (XVI)

96. Short advanced courses on the emotional development of children should be arranged for school medical officers, doctors working in child welfare centres and general practitioners. (XVI)

97. The fundamental importance of the family as a whole should be borne in mind by those responsible for strengthening and developing the social services, and action designed to keep the family together should be regarded as one of the most important aspects of prevention. (XVI)

APPENDIX A

LIST OF WITNESSES

The following bodies submitted evidence to the Committee. Those marked with an asterisk submitted written evidence only and the one marked with a dagger gave oral evidence only; the rest gave both oral and written evidence. Oral evidence was given through the representatives named:

Association of Children's Officers	Mr. E. Ainscow Mr. K. Brill Mr. I. H. D. Brown Miss J. Cooper
Association of Education Committees	Dr. W. P. Alexander Dr. E. Thomas Mr. Martin Wilson
Association of Education Officers	Mr. W. J. Deacon Mr. V. H. Hoskin Dr. E. Thomas
Association of Headmasters, Headmistresses and Matrons of Approved Schools.	Miss A. Brown Mr. H. Chamberlain Mr. J. Gittins
Association of Municipal Corporations	Councillor Mrs. W. Beer Mr. J. Gardiner Mr. A. Greenough Mr. E. Healey Alderman Professor F. E. Tylecote.
Association of Psychiatric Social Workers	Miss D. E. Brown Miss M. Irvine Miss M. Opie
Association of Managers of Schools approved by the Secretary of State.	Mr. F. R. Groom Rev. Dr. Healy Alderman R. G. Robinson Mr. T. F. Tucker
Association of Workers for Maladjusted Children...	Dr. Portia Holman Miss L. Rendel Mr. O. L. Shaw
*Birmingham Society for the Care of Invalid and Nervous Children.	
British Medical Association	Dr. S. J. Hadfield Professor D. R. MacCalman Dr. A. A. E. Newth Dr. Doris Odlum Dr. J. G. Thwaites
British Paediatric Association	Dr. A. White Franklin Professor A. Moncrieff Dr. C. T. Potter Professor J. M. Smellie
British Psychological Society	Dr. E. Balint Sir Cyril Burt Mr. H. A. T. Child Miss M. Davidson Dr. K. Soddy
Child Guidance Training Centre	Dr. M. Collins Dr. G. R. Debenham Miss N. L. Gibbs Miss H. Horder Dr. W. Moodie

County Councils Association	Dr. H. K. Cowan Mr. J. L. Green Miss M. O'Conor Mr. H. Martin Wilson
Howard League for Penal Reform	Miss W. A. Elkin Dr. Marjorie Franklin Mrs. M. C. Strand
Institute for the Study and Treatment of Delinquency	Dr. J. W. D. Pearce Dr. P. D. Scott
Joint Committee of Four Secondary Associations...	Miss A. Catnach Mr. A. J. Doig Mr. H. V. Loseby Miss N. W. Wooldridge
London County Council	Sir Allen Daley Dr. M. MacGregor Miss D. A. Plastow
London Society of Juvenile Court Probation Officers	Miss M. E. Dawkins Miss R. N. Nowell Mr. R. S. Wright
*Magistrates Association	
National Association of Approved School Staffs ...	Mr. F. O. Bevan Mr. T. W. J. Hurley
National Association for Mental Health	Miss R. S. Addis Dr. R. F. Barbour Dr. A. Bowley Dr. A. Maberly
National Association of Probation Officers... ...	Mr. F. Dawtry Mr. G. W. Foster Miss M. E. Routh Miss W. M. Simpson
National Association of Remand Home Superintendents and Matrons.	Mr. J. Connolly Miss J. Drury Mr. A. Pegg Mr. J. Tonks
National Marriage Guidance Council	Mr. A. J. Brayshaw Mrs. R. Hacker Mr. A. Ingleby Dr. R. Shields
*National Society of Children's Nurseries	
National Union of Teachers	Mr. E. L. Britton Mr. F. D. Powell Davies Miss G. Thomas Davies Mr. W. Griffith Mr. J. G. Millard
Nursery School Association	Dr. E. Balint Miss J. Cornish-Bowden Dr. E. Davies Miss D. E. M. Gardner Dr. I. Hellman
Royal Medico-Psychological Association	Dr. J. Bowlby Dr. K. Cameron Dr. Portia Holman
Society of Medical Officers of Health	Dr. C. W. Anderson Dr. J. Maddison Dr. J. B. S. Morgan Dr. A. A. E. Newth

Special Schools Association	Mr. W. J. Carman Mr. J. G. Millard Mr. G. M. Williams
Welsh Joint Education Committee	Councillor Mrs. R. Cross Alderman Mrs. F. R. Davies Mr. H. Wyn Jones Dr. W. Evan Thomas
†Women Public Health Officers' Association ...	Miss K. M. Avis Miss S. Briggs Mrs. B. Greenmon

The following Local Education Authorities gave evidence on the incidence of maladjustment through the representatives named:

Berkshire	Miss M. M. G. Ewart Dr. E. C. H. Huddy
Birmingham	Mr. W. J. Bannon Mr. R. M. Marsh
Bristol	Dr. R. F. Barbour
Essex	Dr. H. M. Davy
Leicester	Dr. G. Randall Miss O. C. Sampson
Nottingham	Mrs. J. Fry Dr. J. E. Greener Dr. A. A. E. Newth
Sheffield	Mr. N. E. Whilde
Somerset	Dr. F. Bodman Dr. J. F. Davidson Mr. W. J. Deacon Mr. W. Robertson

The following individuals submitted written evidence:

Mrs. Dockar-Drysdale ...	Principal of the Mulberry Bush Special School for Maladjusted Children, Standlake, near Witney, Oxfordshire.
Mrs. T. Hornik	Lincombe Lodge Research Library, Oxford.
Dr. W. L. Neustatter ...	Physician in Psychological Medicine, Royal Northern Hospital, London.
Dr. T. A. Ratcliffe	Consulting Psychiatrist, Nottingham Children's Hospital.

The following individuals submitted oral evidence:

Miss A. M. Bickersteth ...	Welfare Officer for Handicapped Children, Essex Local Education Authority.
Miss Clare Britton	Lecturer, Child Care Course, London School of Economics and Political Science.
Dr. Mary Capes	Psychiatrist, Southampton Children's Hospital and Director of Southampton Child Guidance Service.
Mr. H. A. T. Child ...	Educational Psychologist, London County Council.
Miss R. M. Druce	Personnel Manager, C. & J. Clark, Ltd., Street, Somerset.
Miss E. Gibbs	Head of Staff Training, Selfridges, London.
Mrs. E. E. Irvine	Psychiatric social worker, Tavistock Clinic, London.
Miss M. Irvine	Tutor, Course for Psychiatric Social Work, Manchester University.

Miss K. B. Lade ...	...	Principal, Staff Training Centre, Dr. Barnardo's Homes.
Miss A. E. Lewis ...	...	Teacher in charge, special class for maladjusted children, Greenwich, London.
Mrs. K. F. McDougall	...	Tutor in charge, Mental Health Course, London School of Economics.
Mr. J. G. Millard ...	...	Headmaster, East Quinton Special School for Maladjusted Children, Seaford.
Miss D. A. Plastow	...	Assistant Education Officer, London County Council.
Miss G. Rawlings	...	Part-time Lecturer at University College, London, and consultant clinical psychologist at University College Hospital.
Miss L. Rendel ...	...	Hon. Director, Caldecott Community, Mersham-le-Hatch, Kent.
Mr. E. R. C. Roberts	...	Superintendent, Wood Vale Reception Centre, West Norwood, London.
Dr. Flora Shepherd	...	Paediatrician and psychologist, Welwyn Garden City, Herts.
Miss M. K. Smith...	...	Teacher in charge, special class for maladjusted children, Stepney, London.
Sister Teresa ...	...	Headmistress, St. Peter's Special School for Maladjusted Girls, Horbury, Yorks.
Miss F. E. Waldron	...	Senior psychiatric social worker, Midland Nerve Hospital, Birmingham, and former Tutor to the Course in Psychiatric Social Work, Edinburgh University.
Rev. J. Waterhouse	...	Principal, National Children's Homes.
Mr. D. Wills ...	...	Warden of Bodenham Manor Special School, Hereford.
Dr. F. D. Wride ...	...	Psychiatrist, Child Guidance Clinic at Holborn and West End Hospital for Nervous Diseases, London.

APPENDIX B

A GROUPING OF SYMPTOMS WHICH MAY BE INDICATIVE OF MALADJUSTMENT

(See Chapter IV, para. 96)

N.B. (i) This follows, except at a few points, the lines of a classification in use in child guidance clinics in this country.

(ii) For many of the symptoms listed, any and every manifestation does not indicate maladjustment, but only manifestations that are excessive or abnormal.

1. **Nervous Disorders :**

   Fears—anxiety, phobias, timidity, over-sensitivity.
   Withdrawal—unsociability, solitariness.
   Depression—brooding, melancholy periods.
   Excitability—over-activity.
   Apathy—lethargy, unresponsiveness, no interests.
   Obsessions—rituals and compulsions.
   Hysterical fits, loss of memory.

2. **Habit Disorders :**

   Speech—stammering, speech defects.
   Sleep—night terrors, sleep-walking or talking.
   Movement—twitching, rocking, head-banging, nail-biting.
   Feeding—food fads, nervous vomiting, indiscriminate eating.
   Excretion—incontinence of urine and faeces.
   Nervous pains and paralysis—headaches, deafness, etc.
   Physical symptoms—asthma and other allergic conditions.

3. **Behaviour Disorders :**

   Unmanageableness—defiiance, disobedience, refusal to go to school or work.
   Temper.
   Aggressiveness—bullying, destructiveness, cruelty.
   Jealous behaviour.
   Demands for attention.
   Stealing and begging.
   Lying and romancing.
   Truancy—wandering, staying out late.
   Sex difficulties—masturbation, sex play, homosexuality.

4. **Organic Disorders :**—Conditions following head injuries, encephalitis or cerebral tumours ; epilepsy, chorea.

5. **Psychotic Behaviour :**—Hallucinations, delusions, extreme withdrawal, bizarre symptoms, violence.

6. **Educational and Vocational Difficulties :**

   Backwardness not accounted for by dullness.
   Dislikes connected with subjects or people.
   Unusual response to school discipline.
   Inability to concentrate.
   Inability to keep jobs.

7. **Unclassified.**

APPENDIX C

FORM 1 H.P.

(see Chapter V, para. 142)

MINISTRY OF EDUCATION

CERTIFICATE PRESCRIBED BY THE MINISTER OF EDUCATION UNDER SECTION 34 (5) OF THE EDUCATION ACT, 1944

Name, date of birth, and address of child submitted for medical examination under Section 34 of the Education Act, 1944:—

.....

.....

.....

Having examined the above-mentioned child in pursuance of Section 34 of the Education Act, 1944, I hereby certify that he/she is suffering from a disability of mind/body of the following nature and extent:—

.....

.....

.....

.....

.....

In my opinion the nature and extent of the child's disability is such as to cause the child to fall within the following category/categories of pupils requiring special educational treatment as prescribed by the School Health Service and Handicapped Pupils Regulations, 1953:—

Signed.....

Medical Officer of the
Local Education Authority.....

Dated.....

NOTE.—On Form 1 H.P. the categories of handicapped pupils prescribed by the above-mentioned Regulations are given overleaf. Extracts from these Regulations are reproduced as Appendix D, and the categories will be found in Regulation 14.

APPENDIX D

EXTRACTS FROM THE SCHOOL HEALTH SERVICE AND HANDICAPPED PUPILS REGULATIONS, 1953

(See Chapter V, paras. 144, 152, 154)

STATUTORY INSTRUMENTS

1953 No. 1156

PART II.—SCHOOL HEALTH SERVICE: CONDUCT OF MEDICAL EXAMINATIONS AND INSPECTIONS; CONDITIONS FOR RECOGNITION OF EXPENDITURE ON MEDICAL INSPECTION AND MEDICAL AND DENTAL TREATMENT.

3. The provisions of this Part of these Regulations—

(*a*) in so far as they are made under Section 69 of the Act, prescribe the conduct of medical examinations and medical inspections for the purposes of the Act; and

(*b*) in so far as they are made under Section 100 of the Act, prescribe the conditions to be fulfilled and the requirements to be complied with in order that expenditure incurred by Authorities in the exercise of their functions relating to the medical inspection and medical and dental treatment of pupils may be recognised.

4. With a view to the performance of their functions with respect to the medical examination, medical inspection, and medical and dental treatment of pupils, every Authority shall establish for their area a service, hereinafter called "the School Health Service".

5. The Authority shall appoint an officer to be called "the Principal School Medical Officer" who shall be responsible to the Authority for the efficient discharge of their functions in relation to the health and well-being of the pupils who are within the scope of the School Health Service.

7. The Authority shall also appoint to the staff of the School Health Service such other medical officers, nurses, and other persons as may be necessary for the efficient conduct of that Service.

8.—(1) The Authority's arrangements for their School Health Service and the premises used for that Service shall be open to inspection by any person appointed for that purpose by the Minister.

(2) When making their arrangements aforesaid, the Authority shall have regard to other services in their area relating to health and education and shall secure that their School Health Service is in harmony with such other services.

9. Premises used for the School Health Service shall be kept in a proper state of repair, cleanliness and hygiene.

10.—(1) The arrangements made by the Authority for the medical..... inspection of pupils attending schools maintained by the Authority shall ensure—

(*a*) a general medical inspection of every pupil on not less than three occassions at appropriate intervals during the period of his compulsory school age and other medical inspections of any pupil on such occasions as may be necessary or desirable:

Provided that there may be fewer than three general medical inspections for any pupil who attends schools maintained by the Authority for less than the period of his compulsory school age or, if the Minister approves, for all pupils; .....and

(*c*) that the attention paid to the general health and welfare of any pupil who is suffering from a disability of mind or body shall include particular attention to his disability.

(2) So far as practicable, the parent of every day pupil shall be given the opportunity of being present at any general medical inspection ..... of his child.

(3) Medical ..... records in approved form shall be kept for every pupil attending a maintained school.

12. Every nurse employed by the Authority for the purposes of the School Health Service shall possess the qualifications prescribed for a Health Visitor .....

(Here follow provisions for certain exceptions)

13. As soon as possible after the end of each calendar year the Authority shall submit to the Minister in respect of that year a report by their Principal School Medical Officer on the health and well-being of pupils in his care and of the work of himself and his staff in relation thereto, ...

PART III.—CATEGORIES OF HANDICAPPED PUPILS AND SPECIAL EDUCATIONAL TREATMENT

14. The several categories of pupils requiring special educational treatment are hereby defined as follows:—

(*a*) Blind Pupils, that is to say, pupils who have no sight or whose sight is or is likely to become so defective that they require education by methods not involving the use of sight.

(*b*) Partially Sighted Pupils, that is to say, pupils who by reason of defective vision cannot follow the normal regime of ordinary schools without detriment to their sight or to their educational development, but can be educated by special methods involving the use of sight.

(*c*) Deaf Pupils, that is to say, pupils who have no hearing or whose hearing is so defective that they require education by methods used for deaf pupils without naturally acquired speech or language.

(*d*) Partially Deaf Pupils, that is to say, pupils who have some naturally acquired speech and language but whose hearing is so defective that they require for their education special arrangements or facilities though not necessarily all the educational methods used for deaf pupils.

(*e*) Educationally Sub-Normal Pupils, that is to say, pupils who, by reason of limited ability or other conditions resulting in educational retardation, require some specialised form of education wholly or partly in substitution for the education normally given in ordinary schools.

(*f*) Epileptic Pupils, that is to say, pupils who by reason of epilepsy cannot be educated under the normal regime of ordinary schools without detriment to themselves or other pupils.

(*g*) Maladjusted Pupils, that is to say, pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social or educational readjustment.

(*h*) Physically Handicapped Pupils, that is to say, pupils not suffering solely from a defect of sight or hearing who by reason of disease or crippling defect cannot, without detriment to their health or educational development, be satisfactorily educated under the normal regime of ordinary schools.

(*i*) Pupils suffering from Speech Defect, that is to say, pupils who on account of defect or lack of speech not due to deafness require special educational treatment.

(*j*) Delicate Pupils, that is to say, pupils not falling under any other category in this Regulation, who by reason of impaired physical condition need a change of environment or cannot, without risk to their health or educational development, be educated under the normal regime of ordinary schools.

PART IV.—BOARDING ARRANGEMENTS FOR HANDICAPPED PUPILS OTHERWISE THAN IN BOARDING SCHOOLS

17. An Authority shall not, without the approval of the Minister, establish any maintained boarding home for handicapped pupils or discontinue the maintenance of such a home.

18. The Minister may approve for the accommodation of handicapped pupils any non-maintained boarding home conducted by persons other than an Authority and any fees to be charged to Authorities in respect of handicapped pupils sent by them to the boarding home.

19. The Minister, when approving any maintained or non-maintained boarding home, may impose conditions as to the number, age-range, sex or category of handicapped pupils to be boarded therein, or otherwise.

20. Every approved maintained or non-maintained boarding home shall be open to inspection by an Inspector and its premises shall conform as closely as the Minister thinks practicable with the Regulations made from time to time by the Minister under Section 10 of the Act.

21. Proposals to provide new premises for an approved maintained or non-maintained boarding home, or to alter, add to, or enlarge the existing premises of such a home shall require the approval of the Minister unless the Minister otherwise directs.

22. An Authority who are responsible for boarding a handicapped pupil in a non-maintained boarding home which has not been approved or in the residence of a foster parent shall satisfy themselves that the home or residence is suitable for the child and make satisfactory arrangements for visits to be made to the home or residence before the admission of the child and regularly thereafter.

23. The Authority shall ensure that adequate arrangements are made for the medical ..... care of any handicapped pupil boarded by them in a maintained or non-maintained boarding home or in the residence of a foster parent.

24.—(1) Provision shall be made for every pupil, for whom boarding arrangements are made under this Part of these Regulations, so far as practicable, to attend religious worship and receive religious instruction in accordance with the wishes of his parent.

(2) No such pupil shall be required to attend such worship or receive such instruction contrary to the wishes of his parent.

PART V.—CONDITIONS AS TO APPROVAL AND RECOGNITION TO BE FULFILLED BY MAINTAINED SPECIAL SCHOOLS

25. The provisions of this Part of these Regulations prescribe the conditions to be fulfilled by any maintained special school (in this Part called " the school ") in order that it may be approved for the purposes of Section 33 of the Act and recognised for the purposes of payment of grant under Section 100 of the Act.

26. The school shall comply with the requirements imposed on it by or under the Act and if it does not so comply approval or recognition may be withdrawn.

27. An Authority shall not, without the approval of the Minister, establish a school or discontinue the maintenance of a school.

28. The school shall be kept on a satisfactory level of efficiency.

Premises and Organisation

29. Proposals to provide new premises for the school or to alter its existing premises and the plans and estimates of the cost thereof shall require the approval of the Minister before work is begun unless the Minister otherwise directs.

30. Without prejudice to the general requirement of Regulation 26, the premises of the school shall be kept in a proper state of repair, cleanliness and hygiene and adequate arrangements shall be made for the safety of the pupils and staff in case of fire.

31. The school shall be organised for the purpose of providing special educational treatment suitable for handicapped pupils of such number, category, age and sex as the Minister may approve, and for the purpose of such approval the Minister will consider whether the number of pupils will ensure economical and effective organisation and whether the school shall provide for one or more categories of pupils, for the whole or part of their school life, and for either sex or both sexes.

32. The curriculum of the school shall be suited to the age, ability and aptitude of the pupils in attendance thereat, with particular regard to their disability of mind or body.

33.—(2) The number of pupils on the register of the school shall not exceed the number for which the school is approved.

Size of Classes

34. The number of pupils on the register of any class shall not exceed the maximum herein prescribed for that class, that is to say—

(*b*) for a class of blind, partially sighted or maladjusted pupils, fifteen pupils ;

Admissions, sessions and attendances

35. A pupils shall not be refused admission to or excluded from the school on other than reasonable grounds.

36.—(1) The educational year shall be divided into terms being not more than three in number in the case of a boarding school and not more than four in number in the case of a day school, and amounting in the aggregate, except for some unavoidable cause, to a period of not less than 200 days:

Provided that the Minister may in exceptional circumstances approve more than three terms or four terms as the case may be in the educational year.

Other Conditions

40.—(1) Provision shall be made for every pupil, so far as practicable, to attend religious worship and receive religious instruction in accordance with the wishes of his parent.

(2) No pupil shall be required to attend such worship or receive such instruction contrary to the wishes of his parent.

41. Whenever a pupil ceases to attend the school and becomes a pupil of some other school or place of education or training, adequate medical and educational information concerning him shall be supplied promptly to that other school or place.

42. Adequate provision shall be made for the medical ..... care of boarders.

PART VI.—CONDITIONS AS TO APPROVAL AND RECOGNITION TO BE FULFILLED BY NON-MAINTAINED SPECIAL SCHOOLS

44. The provisions of Part V of these Regulations except Regulation 27 and Regulation 42 shall apply to any non-maintained school ; and accordingly—

(*a*) for the reference to any maintained special school in Regulation 25 there shall be substituted a reference to any non-maintained special school ; and

(*b*) for the reference to the Authority in the proviso to Regulation 34 there shall be substituted a reference to the managers of the school.

45.—(1) The school shall be under the direction of a suitably constituted body of managers.

(2) No member of the staff may be a manager or have any financial interest in the school.

(3) The school shall not be conducted for profit.

46.—(1) Adequate arrangements shall be made under Section 78 (2) of the Act or otherwise for the medical ..... care of pupils, and for their periodical medical ..... inspection, and such arrangements shall include provision for their examination and treatment by a medical practitioner possessing special experience of the particular disability from which the pupils suffer.

(2) Medical ..... records in approved form shall be kept for every pupil attending the school.

47.—(1) The accounts of the school shall be kept and audited in accordance with approved arrangements.

(2) Copies of the accounts shall be sent to the Minister and, on request and subject to any requirements of the said arrangements as to a reasonable copying charge, to all Authorities and other bodies by whom pupils are sent to the school.

48. The school premises shall conform as closely as the Minister thinks practicable with the Regulations made from time to time by the Minister under Section 10 of the Act.

49. Any fees charged to Authorities in respect of pupils sent by them to the school shall be such as may be approved for the school from time to time.

APPENDIX E

RULES 16: RECOGNITION OF SCHOOLS, ETC., AS EFFICIENT

(See Chapter V, para. 148)

Revised May, 1953.

Statement of the conditions upon which the Minister of Education will recognise certain schools and other educational establishments as efficient but not for the payment of grants.

These Rules apply to:—

(*a*) Primary and Secondary Schools,

(*b*) Establishments of Further Education,

(*c*) Training Colleges.

General Conditions for all Schools, etc.

1. In order to be recognised as efficient, a school or other educational establishment must comply with any requirements of the Education Act, 1944, as amended by any subsequent enactments, and with the requirements of paragraph 2 and of such other paragraphs of these conditions as may be applicable. If it does not so comply, recognition may be withheld or withdrawn.

2.—(*a*) A school or educational establishment must be kept on a level of efficiency which is satisfactory, regard being had to the purposes for which it is conducted and to the level of efficiency which would be required in the case of any similar school or establishment aided by grant.

(*b*) The instruction must be efficient and suitable and must be adequate in scope and character for the whole age-range of pupils.

(*c*) The number of pupils must be sufficient for economical and effective organisation.

(*d*) The teaching staff must be suitable and sufficient in number and qualifications for providing adequate instruction at each stage of the course. No teacher who has been, or is at any future time, declared to be unsuitable by the Board of Education or the Minister for employment on medical grounds or on grounds of misconduct or grave professional default shall be employed. If a teacher's engagement is terminated, whether by dismissal or resignation, on account of misconduct, grave professional default, or conviction of a criminal offence, the Governors or the proprietors shall report the facts to the Minister. Before taking action to declare a teacher unsuitable, the Minister will use every available means of informing the teacher of the grounds of the proposed action and, if such has not already been done, of giving the teacher an opportunity for explanation or of making representations on the subject.

(*e*) The accommodation provided must be adequate and suitable and properly equipped having regard to the number, ages and sex of the pupils.

(*f*) Such registers and records must be kept and such information and returns must be furnished from time to time as the Minister may require.

Special conditions in respect of particular types of Schools, etc.

Primary Schools

3. In order to be eligible for recognition as an Efficient Primary School, a school must provide a progressive general education of a kind and amount suited at all stages to an age-range of not less than three years between the ages of 2 and 12. Schools such as " Preparatory Schools " which contain pupils over the age of 12 will be regarded as primary schools if the majority of the pupils are transferred to secondary schools; but it will be a condition of the recognition of such a school that provision for the older pupils is efficient and suitable in accordance with paragraph 2.

Secondary Schools

4. In order to be eligible for recognition as an Efficient Secondary School, a school must provide a progressive general education of a kind and amount suitable at all stages to an age-range of not less than three years between the ages of 12 and 17. Schools which contain pupils below the age of 12 will be regarded as secondary schools if the majority of the pupils complete a secondary course ; but it will be a condition of the recognition of such a school that the provision for pupils under 12 is efficient and suitable in accordance with paragraph 2.

Primary and Secondary Schools

5. In order to be eligible for recognition as a primary and secondary school, a school must provide a progressive general education of a kind and amount suitable at all stages to an age-range of 9 or less to 15 or more.

Establishments of Further Education

6. In order to be eligible for recognition as efficient an Establishment of Further Education must provide a course of education or training suitable at all stages for pupils over the statutory school leaving age.

Training Colleges

7.—(*a*) In order to be eligible for recognition as an Efficient Training College, a college must provide a course of educational and professional training suitable at all stages for students of 18 years of age or more who are preparing to become teachers, and there must be adequate provision for their practice in teaching in accordance with approved arrangements.

(*b*) Suitable arrangements must be made for the examination or assessment of the students at the end of their course.

N.B.—A student intending to follow a course entitling him to the status of qualified teacher for the purpose of Regulation 11 (2) of the Schools Grant Regulations, 1951, must comply with the conditions of admission contained in sub-paragraphs (*a*), (*b*) and (*c*) of Regulation 17 (1) of the Training of Teachers Grant Regulations, 1950, as amended by any subsequent Regulations.

Notification to Local Education Authority

8. The Minister will notify the Local Education Authority and, where appropriate, the Divisional Executive of the recognition of a school or other educational establishment and also of the withdrawal of any such recognition.

G N Flemming

APPENDIX F

THE WORKINGS OF A CHILD GUIDANCE CLINIC

(See Chapter VI, footnote to heading above para. 174)

1. We give a brief description of the workings of a child guidance clinic, since many people are ignorant and apprehensive about what goes on there, regarding its procedures as more akin to magic than to medicine.

2. A clinic is usually a building containing a number of rooms suitable for private interviews with members of the staff, with larger rooms serving as playrooms, waiting rooms, etc. A number of clinics are situated in adapted houses, where it is easier to secure the homely atmosphere which helps to give confidence to parents and children.

3. A child referred to a clinic is given an appointment and comes with one or both of his parents—usually with his mother. The psychiatric social worker may have already visited the child's home, to obtain information about his early history and home background; if not, she will probably take the opportunity of the first visit to interview the mother. The psychologist will have a report from the child's school and may already have visited the school and seen him there. He assesses through tests of various kinds the child's intellectual capacity and attainments.

4. The psychiatrist will have available to him, from the school health service, the child's medical record with details of his last physical examination. A further physical examination will probably be carried out at the clinic by the psychiatrist or school medical officer, though not necessarily on the occasion of the first visit.

5. The psychiatrist's aim in talking to children is to uncover the emotional problems in their lives. In dealing with older children, he may discuss with them directly the reasons for the behaviour which has led to their being sent to the clinic, or he may approach their problems indirectly by getting them to act out or discuss some imaginary situation. Younger children will usually accept some of the toys left about for them to play with, and in their play may act out some part of their problems. This often reveals much about their temperament, fears and family relationships.

6. A conference of the clinic staff follows, at which a diagnosis is made and the treatment decided on. Perhaps what is required is advice to the mother, admission to a day special school or class (if one is available) or psychological treatment in the clinic; or it may be found at a later stage that a period away from home in a boarding hostel or special school is advisable.

7. Treatment in the clinic will be given through private interviews, the child seeing the psychiatrist perhaps once a week and the mother seeing the psychiatric social worker or the psychiatrist perhaps less often. The psychiatrist will use the same approach which he used in investigation. The child will be encouraged to express his feelings through the ways natural to him, in drawing, painting, miming and other play, and as the psychiatrist comes to be accepted as an ally he will talk more to the child about what lies behind his play. Gradually the child is helped to bring his problems to the surface and face them, and through his relationship with the psychiatrist he gains the confidence needed to go forward to meet whatever the future has in store for him. The psychiatric social worker in the meantime helps the mother to unburden herself and arrive at a better understanding of herself in relation to her children.

APPENDIX G

THE FUNCTIONS AND PROCEDURE OF JUVENILE COURTS, AND SOME METHODS OF TREATMENT

(See Chapter XII, paragraph 347)

1. There are four reasons for which children* may be brought before a juvenile court:

(i) for offences against the law (children aged 8 and below 17) ;

(ii) as in need of care or protection (any age below 17) ;

(iii) as beyond control of parents or guardians (any age below 17) ;

(iv) for truancy, or failure of parents to send child to a school for which a school attendance order has been made (children aged 5 and below 15, or below 16 if attending a special school).

2. The governing consideration in the treatment of the young offender is education and training, not punishment. Every court in dealing with a child brought before it is required to have regard to his welfare : and in a proper case to take steps for removing him from undesirable surroundings and for securing that proper provision is made for his education and training (Children and Young Persons Act, 1933, Section 44).

3. Children under 8 years old are presumed to be incapable of crime. For a child aged below 14 it is an old presumption of common law that he has not reached the age of discretion and is *doli incapax,* but this presumption may be rebutted if the court is satisfied that he knew he was doing wrong.

4. Once a case has been proved and before a decision is reached on the action to be taken, under the rules governing juvenile court procedure the court, except in dealing with offences which appear to it to be of a trivial nature, has to " obtain such information as to the general conduct, home surroundings, school record and medical history of the child or young person as may enable it to deal with the case in his best interests ". If such information is not fully available, the court has to consider the desirability of remanding or adjourning the case for such enquiry as may be necessary. The court can, for example, request the local authority under the Children Act to arrange for a child guidance report on a child.

5. When a child is remanded or his case is adjourned, he may, unless he is aged 12 or more and charged with an offence, be sent to a " special reception centre " instead of a remand home. Reception centres have to be provided by local authorities under the Children Act for the temporary reception and observation of children coming into their care ; and any centre made available by the children's authority for the custody of children sent by a juvenile court in a specified area is known as a " special reception centre ". There are comparatively few of these.

6. When a case has been found proved, the court has, broadly speaking, three courses to choose between: (i) to leave the child to the guidance of his parents ; (ii) to provide him at home with some form of outside supervision ; or (iii) to take steps to arrange that for a period he is boarded away from home.

7. Without any claim that the list is complete, the following are some of the possible ways of providing supervision or boarding and/or procuring special education or child guidance treatment:

(i) a child left to the guidance of his parents may attend a child guidance clinic, a day special school or class (if available), or both.

---

* In this appendix, as in Chapter XII, "child" and "children" are used to mean boys and girls of any age below 17, i.e. covering "young persons" as defined in the Children and Young Persons Act, 1933,

(ii) Outside supervision may be provided through a probation order (for a child charged with an offence) or a supervision order (for a child brought before the court as in need of care or protection, as beyond control or for truancy). In some cases, as a condition of probation or supervision, arrangements may be made for a child to live with relatives or friends or in an approved probation home or hostel. A child on probation or under supervision may also, of course, attend a child guidance clinic or day special school or class.

(iii) (*a*) Where there is agreement that a child should attend a boarding hostel or special school, he may be left at home while awaiting a vacancy. When that is not possible, the court may make periodic orders for his care until there is a place available.

(*b*) A child may be committed to the care of a Fit Person, usually the local authority, in order to enable suitable treatment and placing to be arranged.

(*c*) A child may be sent to an approved school.

8. Six classifying approved schools have been established to which boys and girls may be sent on committal for a period not normally exceeding two months. The purpose of this is to determine, after suitable tests, to which approved school they should be sent to complete training. The classifying schools for boys do not yet cover the whole country, but most areas are now served by such a school. Where one is available, courts are required to send a child first to it unless there is a special reason which makes this undesirable.

9. The period for which a child may be detained in an approved school is prescribed by Section 71 of the Children and Young Persons Act, 1933, and is not determinable at the discretion of the court. This period is three years, except that children under the age of 12 at the time of committal may be kept until the age of 15 years 4 months; children over 16 on committal form another exception. It is however not usual for boys and girls to be detained for the full legal period. The school managers are under obligation to review the progress of each child in their school towards the end of the first year of detention, and thereafter as often as may be necessary and at least quarterly, with a view to releasing him on licence as soon as he is fit to go out.

APPENDIX H

SUMMARIES OF THE REPORTS OF THREE PILOT SURVEYS ON THE INCIDENCE OF MALADJUSTMENT; COMPARISON OF THE RESULTS OF THE THREE PILOT SURVEYS WITH CERTAIN ESTIMATES OF INCIDENCE; OTHER ESTIMATES OF INCIDENCE.

(See Chapter XIII, paras. 375, 377 and 378)

(a) *Summaries of Reports of Three Pilot Surveys on the Incidence of Maladjustment*

1. In all three surveys, the children seen were divided into the following five categories:

Category A—very maladjusted (but excluding advanced phychosis or mental deficiency), needing special treatment by a child guidance clinic team.

Category B—probably maladjusted, diagnostic clinic interview desirable, though not necessarily requiring treatment other than environmental.

*Category C*1—not maladjusted, but needing some modification of school situation through a psychologist.

*Category C*2—not maladjusted, but where conditions in the home were adverse (e.g. illness or unemployment, poor living accommodation, isolated situation, over-anxious parents) and needing some modification through welfare or health agencies.

*Category C*3—not maladjusted, needing no further attention.

Somerset Survey, 1952

2. *Children investigated.* Out of a school population of 57,000, a sample of 883 was taken. In selecting schools due weight was given to the number of schools of different types (e.g. infants only, all-age, secondary modern) in the county and to urban and rural areas. The final selection of a school was often made because the head teacher was likely to be co-operative and interested in the survey. From the schools chosen, a random sample of 883 children was taken according to the number allocated to each school. The children were taken from three age-groups (6, 9 and 13 years, representing the infant, junior and secondary stages) in roughly equal proportions and slightly more were boys than girls (471: 412).

3. *Method of investigation.* A questionnaire was filled in by the head teachers for each of the children in the sample. On the basis of this report one of the three educational psychologists carrying out the survey discussed with the staff, and interviewed individually, all the children considered as possibly maladjusted by either the school staff or psychologists, together with some children who did not appear maladjusted. The psychologists visited the parents of as many as possible of the children seen individually (215 out of 261), in order to obtain some light on the child's personality as seen in the home situation. After the home visit the psychologist completed a separate questionnaire, and then on the basis of all the information available from school and home placed each child in one of the five categories.

4. *Results*:

(i) General.

Category	A	B	C1	C2	C3
Number	24	80	47	49	683
Percentage	2·7	9·1	5·3	5·6	77·3

(ii) Distribution by age and sex.

Age-group	Sex	A	B	C1	C2	C3
6 years old ...	% Boys ...	1·7	4·2	2·1	3·2	22·7
	% Girls ...	0·7	4·6	1·0	1·2	27·9
9 years old ...	% Boys ...	1·1	3·4	2·5	1·9	24·4
	% Girls ...	0·7	2·2	2·2	1·9	26·7
13 years old ...	% Boys ...	0·8	2·5	1·3	0·6	27·4
	% Girls ...	0·2	0·9	1·5	1·7	26·0
TOTALS ...	% Boys ...	3·6	10·1	5·9	5·7	74·7
	% Girls ...	1·7	7·7	4·7	4·8	81·1

5. *Special points.* Teachers were asked at the end of the school questionnaire to say whether they thought each chld was maladjusted or not and to what extent. They classed as maladjusted 75 per cent. of those finally placed in categories A or B, and also 10 per cent. of those finally placed in category C3, i.e. not maladjusted and not needing attention either at school or home.

Birmingham Survey, 1953

6. *Children invesigated.* Out of a school population of 170,000, a sample of 2,264 was taken. In selecting schools, due weight was given to different types of area (slum, artisan, municipal and residential). From the 76 schools chosen, a random sample of 2,264 children was taken, the children being divided into three age-groups (6, 9 and 13 years) in proportion to the total number of children of those ages on the rolls of schools in the city (giving 830, 788 and 646). The numbers of boys and girls were equal.

7. *Method of investigation.* The aim was to secure a picture of children both in their home and in their school environment. Questionnaires were first sent to the schools to be filled in by the member of the staff likely to know each child best. When they had been returned, another questionnaire was sent to the parents of all children, and 60 per cent. of these (1,364) were completed and returned. All questionnaires from schools and parents were first assessed by the senior educational psychologist. School questionnaires were then assessed independently by another psychologist, and home questionaires by one of three phychiatric social workers. The independent findings on each pupil were then examined and final assessments made, according to the evidence of the teachers only, of the parents only (for 60 per cent. of the sample) and of both together. Where opinions of the assessing staff varied, agreement was reached by consultation.

8. *Results.*

(i) Classifications based on school reports (complete sample—2,264).

	A		B		C1		C2		C3	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Infants (6–7 yrs.) ...	4	1	63	42	20	19	8	4	320	349
Percentage	**0·6%**		**12·7%**		**4·7%**		**1·4%**		**80·6%**	
Juniors (9–10 yrs.) ...	1	4	77	56	49	26	8	10	259	298
Percentage	**0·6%**		**17%**		**9·5%**		**2·3%**		**70·7%**	
Sec. Mod. (13–14 yrs.)	4	4	57	39	27	9	6	5	191	228
Percentage	**1·4%**		**16·8%**		**6·3%**		**1·9%**		**73·5%**	
Grammar (13–14 yrs.)	0	0	1	5	0	2	1	2	36	29
Percentage	**0**		**8%**		**2·6%**		**4%**		**85·5%**	
Totals	9	9	198	142	96	56	23	21	806	904
Percentage	**0·8%**		**15%**		**6·7%**		**1·9%**		**75·5%**	

(ii) Classifications based on parents' reports.

	A		B		C1		C2		C3	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Infants (6–7 yrs.) ...	22	13	70	71	1	1	7	4	163	185
Percentage	6·5%		24·4%		0·3%		2%		64·8%	
Juniors (9–10 yrs.) ...	4	6	71	47	3	9	8	13	156	167
Percentage	2%		24·4%		2·5%		4·3%		66·7%	
Sec. Mod. (13–14 yrs.)	3	2	37	37	1	2	3	2	94	111
Percentage	1·7%		25·3%		1%		1·7%		70·2%	
Grammar (13–14 yrs.)	0	1	8	4	0	0	0	3	16	19
Percentage	2%		23·5%		0		5·9%		68·6%	
Totals	29	22	186	159	5	12	18	22	429	482
Percentage	3·7%		25·3%		1·2%		2·9%		66·8%	

(iii) Classification based on agreement between parents' and school reports (38 per cent. of sample—870).

N.B.—The senior educational psychologist considers that this is probably the most reliable table (but see para. 9 (*a*) below).

	A		B		C1		C2		C3		Agreed on		Disagreed	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
Infants ...	2	0	17	14			1	0	141	158	161	172	102	102
Percentage	0·4%		5·8%				0·18%		55·7%		62·08%		37·92%	
Juniors ...	0	1	26	20	1	6	2	1	115	139	144	166	98	76
Percentage	0·2%		9·5%		1·4%		0·6%		52·5%		64·2%		36·8%	
Sec. Mod.	1	0	13	7			1	0	73	94	87	101	51	53
Percentage	0·3%		7%				0·3%		57·1%		64·7%		35·3%	
Grammar			1	3			0	1	16	16	17	20	7	7
Percentage			7·8%				2%		62·7%		72·5%		27·5%	
Totals ...	3	1	57	44	1	6	4	2	345	407	410	460	257	237
Percentage	0·3%		7·4%		0·5%		0·4%		55·1%		63·8%		36·2%	

9. *Special Points :*

(*a*) The last question parents were asked about their child (and the only one which could not be answered by underlining words in the questionnaire) was: "Is there anything about his/her attitude, behaviour or habits that worries you, and about which you would like some advice? If so, state what it is here and we will do what we can to help." About 200 of the 1,364 parents answered this question. In the following few months 60 of these were invited to come to the clinic, and 30 came. The psychiatric social worker thought that there was no need for 6 of the children to come to a clinic at all, but she reached the conclusion that 16 of the others required to be seen by a psychiatrist. Of these 16, 11 had been classified on the basis of the report from their school as "not maladjusted, needing no further attention" (category C3); 2 of the 11 were considered to be extremely serious cases of maladjustment. None of the 11 children were of course included in table (iii). As there might be a considerable number of children needing treatment who were regarded as maladjusted by their parents only and not by their school, it means that table (iii) can only be regarded as a minimum estimate.

(*b*) Assessments based on the school evidence about the children whose parents replied, and about the children whose parents did not, show almost exactly the same proportions in categories A and B. The chances are therefore great that the 60 per cent. of parents who replied constituted a representative sample of all the parents involved.

Berkshire Survey, 1953

10. *Children investigated.* Out of a school population of 39,000 in this area, which is regarded as about half urban and half rural, a sample of 992 children was taken. Out of 255 schools in the area, excluding nursery schools, children were drawn from 222 schools, the numbers from each school being in proportion to its size. Inside schools children were chosen who were alphabetically first or last in a class or the school. No attempt was made to confine the children to particular age groups or to control the proportions of boys and girls.

11. *Method of investigation.* A questionnaire was completed by teachers for each child. On the information obtained, the two psychiatrists of the Berkshire child guidance service divided children up into two groups, those presumably normal and those possibly maladjusted, i.e. where the questionnaire "gave the smallest evidence of doubt as to the normality of the child". The homes of 96 of the 110 "possibly maladjusted" children were then visited by one of three psychiatric social workers, who also visited the school if this was thought necessary. The psychiatric social worker then filled up a separate questionnaire. The final placings were made by the two psychiatrists in consultation with the Principal School Medical Officer and the three psychiatric social workers.

12. *Results:*

Category	A	B	C1	C2	C3
Number	8*	46*	13	18	907
Percentage	0·8	4·6	1·3	1·8	91·4

* The numbers of boys and girls in A and B were roughly equal.

13. *Special points:* The senior psychiatric social worker reported that, where schools reported any aggressive or bullying behaviour, parents usually denied it. On the other hand, a child reported to be shy, inhibited and sensitive at school was usually declared to be the same at home.

(b) *Comparison of the Results of three Pilot Surveys with certain Estimates of Incidence* (*see Chapter XIII, paragraph* 377)

14. Any attempt to compare the results of the three pilot surveys with the estimates given in the Ministry of Education's pamphlet on "Special Educational Treatment" and in Dr. C. P. Blacker's book, "Neurosis and the Mental Health Services", can only be made with the greatest caution, since the two sets of figures are expressed in ways which are different and of uncertain relation. The estimates from the three surveys also cover a wide range (5·4 to 11·8 per cent.). It may however be worth attempting a comparison in order to provide pointers for further research:

The Ministry's pamphlet suggested that 1 per cent. of school children need treatment *in any one year.* Assuming that this figure relates to new cases, it follows arithmetically† that, in an area with no treatment facilities, the

† If the school population is taken to comprise ten age-groups and if 1 per cent of each age-group come each year to need treatment for the first time, at the end of any year the proportion of children in need of treatment will amount to 1 per cent in the first year, 2 per cent in the second, 3 per cent in the third and so on up to 10 per cent in the tenth year, with an average of 5½ per cent.

accumulation of children needing treatment *at any given moment* would be just over 5 per cent., less the unknown (but perhaps considerable) percentage whose difficulties had cleared up without treatment.

In areas such as those where the three pilot surveys were conducted, with treatment facilities which are well-developed though not completely adequate, the proportion needing treatment *at any given moment* would be well below 5 per cent.

But the average of the estimates from the three pilot surveys is that about 8 per cent. need treatment *at any given moment.*

Therefore, this would indicate that in an area with fully developed treatment facilities the proportion of children needing treatment *in any one year* should be higher than 1 per cent. and round about the top of the range suggested by Dr. Blacker (1-2 per cent.). This however ignores the effect of preventive measures which would naturally accompany the development of treatment facilities.

(c) *Other Estimates of Incidence* (*see Chapter XIII, para.* 378)

15. Some people may consider that the estimates of incidence from the three pilot surveys are exaggerated. For purposes of comparison the results of three surveys carried out in the 1940s will be given. Only the first relates to school children, but all three indicate that mental ill-health affects in some degree about one person in every three of the population ; and the first two are expressed in directly comparable terms, i.e. the number found to be maladjusted at a given moment. The results of the three surveys are taken from the report of the study group set up in 1953 "to investigate the possibility of increasing preventive mental health work in the maternity and child welfare services", which is mentioned in paragraph 494 of Chapter XVI:

(i) In 1949 a survey (unpublished) was made by a psychiatrist on the staff of the Tavistock Clinic of all the eight-year-old boys in a primary school in a borough of outer London. Of a total of 40 boys, the parents of 33 co-operated fully. Of these boys 14 were judged to be maladjusted—or 42 per cent. (Even if it is assumed that the 7 who did not co-operate were all stable, the percentage remains as high as 35.)

(ii) Dr. R. S. L. Logan and Miss E. M. Goldberg carried out a study of the physical, mental and social health of the 18-year-old males who registered for National Service in a borough of outer London in May, 1949*. Of the total of 85 youths, 74 co-operated fully. Of these 74, 12 were found to be severely maladjusted and another 19 mildly disturbed. Expressed as percentages these represent 16 and 26 respectively—or a total of 42 per cent. (Even if all the 11 youths who failed to co-operate are assumed to have been stable, the percentages remain as high as 14 and 22—with a total of 36 per cent.)

(iii) Dr. Russell Fraser, in the survey among 3,000 factory workers referred to in Chapter I (para. 15), found that 9 per cent. of the men and 13 per cent. of the women had suffered from definite disabling neurotic illness during the six months prior to the examination, and that a further 19 per cent. of men and 23 per cent. of women had suffered from minor degrees of neurosis during the same period. The totals are 28 per cent. of men and 36 per cent. of women.

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* Rising eighteen in a London Suburb (British Journal of Sociology, 1953, 4, pp. 323–345).

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(Arabic numerals refer to paragraphs, Roman numerals to Chapters, numbered recommendations to the summary in Chapter XVII.)

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