

Autumn NewsLetter No 16

“Belonging Matters”

SEBDA Conference 2025. Dr Amanda Barrie

A sunny day in early July saw more than 100 professionals and pupils attend the SEBDA National Conference in Catford in South East London.

The theme of the conference was Belonging Matters and was inspired by the work of two SEBDA members, Liz Key and Emma Foinette, who have established an alternative provision in Bromley, Kent for SEMH young people who are at risk of exclusion from mainstream settings. Roots for Learning is still in its infancy but is already showing successes for the young people who previously felt lost in a mainstream school.

Delegates were enthused by keynote speaker Harry Daniels who opened the conference sharing his work on Excluded Lives (Daniels, 2024), a research project looking at the difficulties young people experienced following the Covid 19 pandemic. Ellie Costello (Square Pegs, 2024) was the afternoon keynote speaker who spoke of her own personal challenges with school for her two young children. Her focus was on attendance and how the schools approach to supporting young people finding going to school difficult isn't always productive, focusing on high expectations and fines for parents whose children don't attend consistently. Suggesting that there will always be some need underlying the 'poor attendance'.

There were a range of interactive workshops throughout the day covering a range of topics related to the theme of 'Belonging'. Presenters were professionals working in the fields of SEMH, parents and students. One of the most powerful presentations was from a student at Roots for Learning. She shared how she has struggled in mainstream due to her neurodiversity and was failing in all areas of school life. Since accessing Roots for Learning she has successfully gained GCSEs and learned how to crochet.

Everyone left the conference with a powerful feeling of belonging to a collegial group of adults and young people. We were ready to go out into the world to make it a better place for young people with SEMH needs.

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Belonging by Steve Russell

Each year it seems that there are new buzzwords that enter into the world of schools and education. Currently, one that seems to be particularly prominent is 'belonging'. Driven in no small part by the ever increasing number of children and young people who, for a variety of reasons, are not in school full-time, school leaders are turning their attention to how they can foster cultures that promote belonging for all their pupils.

To belong is a fundamental human need. Our brains are hard-wired for connection, going right back to prehistoric times when to belong to a group was essential for survival. Belonging also has huge psychological importance - indeed, Maslow placed it third in his hierarchy of needs, coming just above physiological needs and safety needs. When it comes to schools, the research points to how a sense of belonging fosters motivation and engagement (1). There are also significant benefits when pupils feel connected with their peers, including a greater willingness to engage in collaborative learning, as well as providing support for others.

For those of you who are interested in, or already engaged in, developing this critical aspect of your school culture, the National Children's Bureau has produced a very useful report - 'Nurturing a sense of belonging at school' (2). Drawing on case studies, it offers the following key prompts for promoting belonging:

- It requires a sense of intention, purpose and a commitment to connectedness.
- For pupils to experience connectedness, they need to perceive the school, and what goes on in it, as being important and meaningful to them.
- Staff and pupils share a mutual understanding as to what matters - and have a shared language to be talking about it.
- Technology offers much in the way of providing potential connectedness for pupils who are prone to prolonged absences.

References

1. **and (2)** 'Place and Belonging in School : Why it matters today' : Riley, Coates and Allen. Nov 2020. Available for download from neu.org.uk under 'Advice' - 'Classroom behaviour'. <https://neu.org.uk/sites/default/files/2023-04/Belonging%20research%20booklet.pdf>

Mental Health and Children with Complex Learning Difficulties and Disabilities (CLDD) by Dr Rob Long

The mental health difficulties that children and young people with CLDD are frequently under reported. The number of children considered to have CLDD is difficult to ascertain. This is due in part to increased survival rates of premature babies and those with severe illnesses and different definitions being used (Carpenter et al, 2015). In England it was estimated that there were some 10,000 children with a severe learning disability (Health & Social Care, 2018).

It is generally accepted that children with CLDD have some or all of the following:

Cognitive impairments
Communication difficulties
Sensory and physical disabilities
Emotional, behavioural and social difficulties

Co-occurring conditions

The term CLDD reflects the possibility that a child may have more than one disorder that exists independent of another. Such co-occurring conditions can make diagnosis difficult as well as the best form of support for the individual. How the different conditions interact can exacerbate symptoms and make for a child having a very unique learning profile.

Learning profile

The best way to understand how a child with CLDD learns is to get to know each child. However a framework which can give some general insights to the differences in learning style comes from Zigler's 2 Structure Model (1977). Ziegler proposed that there were two discernible and distinct learning profiles.

1. CLDD children with global learning delay. These children had no recognised syndrome or chromosomal abnormality. They would progress through the same cognitive stages of development for other children but at a much slower rate and their achievement level would be lower.
2. CLDD children who have learning difficulties caused by either a recognised syndrome or chromosomal abnormalities. These children are likely to have a peaky learning profile. That is, there will be areas of definite strengths and areas of marked weaknesses. They may reach the same milestones as everyday children or not reach them at all. Teaching support for these children is much more complicated.

In addition there can be CLDD children who have some communication skills and use speech but lack an understanding of what may be said to them. Adults may assume that what they have said, a request for example, has been understood by the individual. The adult can wrongly interpret the lack of response as 'defiant behaviour'. This ability to communicate but lacking understanding can mask underlying SEMH issues. Professionals that support CLDD children learn to make structured observations under such circumstances which enables simplistic assumptions to be avoided and a more thorough analysis made.

CLDD, Evolution and Social, Emotional and Mental Health (SEMH)

Reframing mental illness

From an evolutionary point of view, the brain is designed to adapt to the environmental context in which it finds itself. Bowlby (1969) wrote of 'Environmental Evolutionary Adaptedness'. Defined as:

“A compound idea representing the sum of a population’s exposure, over a given time frame, to external conditions and stimuli threats and opportunities, including nutrients, social pressures, threats from parasites, predators and competitors as well as climate and general habitat.” (P. 7 Abed and John-Smith, 2022).

This suggests that there are SEMH difficulties faced by children that are their response to stressful environmental conditions.

CLDD & SEMH

The mental health difficulties that children and young people with CLDD have are frequently under reported. This is often because the problematic behaviours, such as aggression, self-harm and rocking are attributed to their learning or medical difficulty. This can result in prolonged distress for the individual.

Studies have shown that children with an IQ below 70 are at an increased risk of mental disorders (National Library of Medicine). In fact some 40% of children with an intellectual disability will have a diagnosable mental disorder (Totsika, 2022).

An IQ score gives no information as to what an individual child’s social, educational or medical needs are. While every child inherits unique genetic information from their parents, their lived experiences are unique. Their environment and experiences will help shape and determine their hopes, ambitions, fears and personality. When you meet one child with Down’s syndrome you have met one child with Down’s syndrome. The level of support a child will need depends on their adaptive functioning in different contexts, not their IQ score.

How to know if a child has SEMH difficulties

1. Know the child - what is their normal functioning, their idiosyncrasies
2. Monitor and assess changes in behaviour. An increase or decrease.
3. Liaise with family/carers to compare behaviour in different contexts.
4. Be aware of uncharacteristic extreme behaviours, self harm, obsessive or compulsive behaviours, running away.
5. Physical changes, weight gain or loss, incontinence.
6. Loss of existing skills, communication, personal care, physical pain with no obvious cause.
7. Behaviour changes are long term (over 2 weeks) and occur in different contexts.

With regard to behaviour, as Imray (2008) explains:

There is no such thing as behaviour without reason (all behaviours have a reason behind them) and that reason always has a meaning. (P1)

Seeing behaviour as a form of communication means that professionals understand that problematic behaviour displayed by a CLDD child may be a sign of distress or indicating

that some basic needs are not being met, for example safety or hunger. Punitive responses, sanctions, to such behaviours serve no purpose. They will not work and are more likely to worsen the situation, causing distress to the child and frustration for the adult.

The brain, SEMH and CLDD

A very basic model can throw light on why children who face CLDD are more likely to experience SEMH issues. Simply put, we can use the 'upstairs down stairs model' (SEL Sketches). Upstairs is where thinking processes occur. Namely:

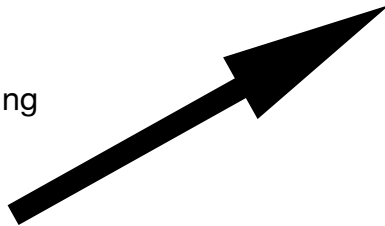
- Decision making
- Planning
- Emotional regulation
- Empathy
- Self-awareness



We know that these are processes that our children struggle with.

And down stairs is where:

- Flight, fight, freeze
- Autonomic responses - breathing
- Strong emotions
- Sensory memories
- Action before thought



Are children with CLDD more likely to experience trauma?

Yes. There are many inter-related reasons for this.

Developmental differences

- Emotional regulation
- Communication
- Sensory processing
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Adverse Childhood Experiences

- Neglect or abuse
- Medical trauma (painful/invasive procedures)
- Bullying or social exclusion
- Family stress (parental mental health issues, etc.)
-

Communication Challenges

Limited or atypical communication which can make it harder to report abuse or seek help

Cumulative Impact

The interplay between disability & trauma is often cyclical. For a child with CLDD trauma can be confusing and scary because:

- No control over their environment
- Not able to make sense of what has happened
- Fear over it happening again

A trauma informed approach is a positive way to support children who have experienced trauma of some sort. Such support will involve:

1. Psychological Safety - Routines/visual timetable/ calm down spaces/ reduce sensory overload
2. Sensory integration support - Tailoring surroundings to the child's sensory profile.
3. Supportive communication
4. Build emotional regulation skills - Visual aids, social stories, calming techniques.
5. Strong, attuned adult relationships to help co-regulate the child.

Children with CLDD rely on trusted adults to co-regulate before they begin to self-regulate, that is able to manage their own emotional states. Co-regulation involves an adult being in an attuned relationship with the child. There are two excellent approaches to achieve this. Briefly, they are, P.A.C.E (Hughes, 2012) which is an educational therapy tool standing for Playfulness, Acceptance, Curiosity and Empathy. The other is W.I.N.E. Wonder, Imagine, Notice and Empathy (Davies.)

Anxiety

Children who have CLDD are especially susceptible to anxiety for many reasons. While their level of understanding may vary, their innate emotional responses are controlled by their lower brain and will respond to external stresses as dangers in the same way as other children. Common causes of anxiety in children with CLDD are:

Limited ability to cope with negative feelings
Communication difficulties making it difficult to explain
Anxiety triggered through being sensory sensitive - hyper or hypo.
Experiencing bullying or peer exclusion
Medical treatments.
Lack of, or changes in, routines.

Indicative signs of anxiety

Stimming (self-stimulating behaviour) for example rocking or hand flapping
Acting out (aggression), acting in (avoidance), an increase or decrease in any behaviour, including eating more or less, sleeping more or less
Physical complaints (headaches, stomach aches)

What can be done?

There are many support strategies, here's a few examples from Rees (2024) adaptable to individual children:

Regular check-ins with a key member of staff
Create a calm box with personally meaningful activities that aid self regulation
Use intensive interaction to help children engage and be able to co-regulate to self-regulate
At signs of stress introduce simple sorting activities
Provide frequent opportunities for breathing relaxation and movement
Develop ways to support transitions to reduce anxiety level.

This is an abridged version of the full article available with references on the SEBDA web site at <https://sebda.org/>

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