VOLUME 1- PUPIL AND STAFF VIEWS ON SUCCESSFUL REINTEGRATION TO A PERMANENT EDUCATION SETTING FROM ALTERNATIVE MEDICAL EDUCATION PROVISION

By

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ABSTRACT

The focus of this research is exploring the views of pupils and medical education provision staff about what factors make a reintegration to a permanent education setting from alternative medical education provision successful. The views were gathered from pupils who have been supported by the alternative medical education provision and have then reintegrated back into a school or post-16 setting within the last 3 years. Views were gathered from staff within the alternative medical education provision about what they believe supports pupils to reintegrate back into permanent education settings. Through a mixed methods approach using Q methodology with pupils, and semi structured interviews with staff that were analysed using thematic analysis, factors were identified that supported successful reintegration including relationships with staff, planning, individual support, and communication. The implications of the findings are discussed in relation to the role of school staff and educational psychologists.

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LIST OF ABBREVIATIONS

AP- Alternative Provision

CFA-Centroid Factor Analysis

CYP-Children & young people

EVs-eigenvalues

IPA- Interpretative phenomenological analysis

LA- Local Authority

MET-Medical Education Team

PRU-Pupil Referral Unit

PCA-Principal Component Analysis

SEMH-Social Emotional Mental Health

1. INTRODUCTION

The focus of the research is exploring the views of children and young people (CYP) and staff about what factors make a reintegration to a permanent education setting from alternative medical education service provision successful. The views have been gathered from pupils who have been supported by the alternative medical education provision (also referred to as the medical education team MET) and have then reintegrated back into a permanent education setting within the last three years. Views have also been collected from staff who work closely with these pupils in alternative medical education provisions.

Pupils supported by the MET are referred if a medical condition (physical or mental health condition) has been affecting their attendance at mainstream school, supported by evidence from medical professionals who are working with the pupil. The aim of the MET is to provide short term education while the pupil recovers and to support them to reintegrate into a permanent education setting. This short-term education takes place in a pupil referral unit (PRU) specifically for those with medical needs.

1.1 Justification for the research

This research aims to provide knowledge about what factors contribute to a successful reintegration to a permanent education setting from alternative medical education provision. Previous research has explored the factors that contribute to successful reintegration from alternative provision where CYP have been excluded from their mainstream provider (Atkinson & Rowley, 2019; Pillay et al., 2013; Thomas, 2015). However, factors for successful reintegration with CYP who have medical needs has not been explored fully. This population of CYP are different to others who attend alternative provision as they have not been formally excluded due to behavioural issues and they are not able to access education in

mainstream due to either physical or mental health needs. Therefore, the factors that support successful reintegration to mainstream education may be different to the factors that support previously excluded CYP. Research has been completed on supporting those with medical needs in education both physical health needs (Datta et al., 2006; Hinton & Kirk, 2015; Lum et al., 2019) and mental health needs (Carroll & Hurry, 2018; Finning et al., 2020; Mansfield et al., 2021). As well as research exploring what supports pupils reintegration from hospital or home settings with physical health needs (Tresman et al., 2016; Vanclooster, Bilsen, Peremans, Van Der Werff Ten Bosch, Laureys, Paquier, et al., 2019; Young et al., 2017) and mental health needs (Marraccini et al., 2019; Savina et al., 2014; Tougas et al., 2019). However, research on reintegration from medical pupil referral units (PRUs) is limited.

Within research often the views of professionals working with CYP rather than the CYP themselves are explored. CYP with medical needs are often not given the opportunities to share their views or their views are represented by the professionals working with them rather than given by the CYP directly (Seymour, 2004). This research gives CYP who have medical needs the opportunity for their voices to be heard. As well as being able to compare the views of the CYP to what professionals who work closely with them feel is important to a successful reintegration. The factors that professionals believe are important to a successful reintegration may not be important to the CYP or may be important but for different reasons than those that have been considered by professionals.

It is anticipated that this research will have an influence on the practice of school staff and educational psychologists who support and advise school staff with reintegrating pupils back into a permanent education setting from an alternative medical education provision. Having a better understanding of the factors that support CYP with medical needs to

successfully reintegrate into a permanent education setting should enable future provision to be better informed.

1.2 Researcher Position

My interest in the area of supporting pupils with medical needs and allowing their voices to be heard developed through my role as a trainee educational psychologist, as well as my previous experience working as a children and family support worker and a teacher in a secondary school. During my previous work as a teacher, I would teach pupils with medical needs and became interested in how best to support them in the classroom and the adaptions I could make. When I worked as a children and family support worker, I worked supporting children at home and in the community whose medical needs impacted their attendance at school. My interest particularly developed around what schools could do to help pupils with medical needs to attend.

During my role as a trainee educational psychologist my interest was further developed in this area working with alternative education settings that were specifically for pupils with medical needs. Within the local authority where I was completing my placement, a research priority for the service was responding to medical needs of pupils and finding out about reintegration after pupils had received support from the medical education service. My work as a trainee educational psychologist in this alternative provision and with schools who were trying to support pupils to reintegrate from the alternative provision to their school led me to feel that this is an important area to research. An additional factor influencing my desire to conduct research was that there seemed to be a lack of representation of the view of pupils who had medical needs and I wanted to enable their voices to be heard.

1.3 Research Questions

The research questions were developed from my reading for my literature review. This research is designed to answer the following questions:

1. What are the views of children and young people who have received support from alternative medical education provision, and have reintegrated back into an education setting regarding the factors that supported their successful reintegration into the education setting?

2. What are the views of staff from alternative medical education provision, regarding the factors that supported pupils' successful reintegration into an education setting following support from the medical education provision?

3. How do professionals' views about what supports reintegration to an education setting following support from the medical education provision compare to the views of the pupils themselves?

2. LITERATURE REVIEW

2.1 Introduction

This literature review will examine the knowledge base on supporting pupils with medical needs, including the relevant legislation in England on supporting pupils with medical needs, as well as reintegrating pupils who have spent time in alternative provisions. Then the review will consider the research of how best to support pupils with physical and mental health needs, before moving on to consider the barriers and facilitators to reintegrating those with medical needs back into education where their medical needs have meant they have been absent or out of school for an extended period. The literature review will conclude by considering the research on reintegrating those with medical needs from medical pupil referral units back into permanent education settings and identifying research questions emerging from the literature review process.

Although the literature explores pupils reintegrating from AP, pupils with physical health needs and pupils with mental health needs separately, the pupils within these populations are not comparable. Within the different populations of pupils studied there is a wide range of health conditions and needs that cannot be grouped together. For example, the research on pupils with physical health needs includes pupils with cancer, concussion, brain injuries and burns. In the literature on supporting pupils with mental health needs it includes pupils with anxiety, depression, psychosis and eating disorders. This makes it clear that CYP with medical needs are not a homogenous group and the different populations within the existing literature are not comparable with each other. Therefore, the barriers and facilitators to reintegration back into education for one group of CYP may be different to other groups with different medical needs.

2.2 National Policy Supporting Pupils in England with Medical Needs

This section will briefly consider statutory guidance and government policy which influences how pupils with medical conditions are supported at both a local authority (LA) and school level in England. Following this guidance on medical pupil referral units (PRUs) and the need for reintegration into a permanent school setting from medical PRUs are addressed.

The Children and Families Act (2014) places a duty on schools to "make arrangements for supporting pupils at school with medical conditions". Statutory guidance from the Department for Education (2015) make clear that pupils with medical conditions need to be supported to have access to a full education and curriculum that includes physical education and inclusion in school trips and visits. It explains governing bodies must plan for pupils with medical conditions to take a full and active role in education so that they are supported to achieve their academic potential. This means that pupils with medical conditions should have the same opportunities at school as other pupils. Under the Equalities Act (2010) LAs and schools must make reasonable adjustments and have a duty to ensure equality of opportunities for all pupils.

The Education Act (1996) states that LAs have a duty to provide education for pupils who are excluded, unwell or otherwise not in school. For those pupils who cannot attend school due to health problems the LA must arrange an alternative education provision. This provision might be home tuition, hospital school or a medical PRU. Statutory guidance from the Department of Education (2013b) states that LAs have to provide education to pupils once it is clear that they will be absent from school due to health problems for 15 days or more and that the days do not need to be consecutive. The provision that LAs provide should be equivalent to the education they would receive in school. Where reintegration into school is

anticipated the LA should plan for provision to be as consistent as possible for the pupil, by accessing the curriculum they would have access to in school. Reintegration plans should be tailored to the needs of the individual pupil and LAs should work together with schools to arrange this.

NASEN (2018) produced a guide for schools and other educational settings about supporting children with medical needs, including statutory guidelines and practical advice for supporting pupils and their families. The key principles of positive communication, positive relationships, encouraging pupil independence, and positive outcomes for all are highlighted throughout the guide and support with reintegration to school from alternative education settings is included. They explain that central to successful reintegration and outcomes for pupils with medical needs is communication with both the pupil and the family, ensuring that their voices are heard. They also highlight the importance of individual healthcare plans and the need for them to be reviewed regularly. The individual healthcare plan is an agreement between parents/carers, school, and healthcare professionals about the care the pupil needs and how the care will be delivered. Every pupil with a medical condition needs an individual healthcare plan.

2.3 Reintegration from Alternative Provision

The LA has a duty to provide education to "permanently excluded pupils, and for other pupils who – because of illness or other reasons – would not receive suitable education without such arrangements being made" (Department for Education, 2013a, p. 5). These pupils will often be placed in alternative provision (AP). Previous research has explored the factors that contribute to successful reintegration to mainstream from AP where CYP have been excluded from their mainstream provider. Thomas (2015) studied education practitioners views of what were the barriers and facilitators of a successful reintegration from AP for

excluded pupils in key stage 1-3. This study found that parental support was considered the most important factor for successful reintegration, school ethos was considered the second most important, followed by the length of time the pupil had been out of mainstream education, staff training, support from PRU, pupil perceptions and learning support assistant support. The factors that education practitioners considered to be the least important were pupil literacy, pupil numeracy, school size, pupil key stage, pupil special educational need (SEN) and class size. This suggests that despite reintegration being unique to each pupil there are common barriers and facilitators to successful reintegration (Thomas, 2015). Although Thomas' (2015) research is useful as it suggests there are common factors to successful reintegration, it did not include the views of pupils and what they consider as important for successful reintegration may be different to staff working in education.

Conversely Atkinson and Rowley (2019) explored the views of pupils about what supported their reintegration to mainstream education following an exclusion and a placement in AP. This research found that although there were individual differences in pupil views some common themes about what made reintegration successful emerged. The common factors for successful reintegration were the pupils having a desire to succeed, support from the key systems surrounding the pupil (family support, peer relationships, key adult in school, school ethos etc), having good connections between the pupil, family and the school and having a gradual and timely reintegration and these overlap with the factors that school staff believed to be important (Thomas, 2015). Although the use of Q-methodology in Atkinson and Rowley's (2019) research allowed for the views of pupils to be shared they did not complete a post-Q interview with pupils and instead gave them a short questionnaire to fill out to support their factor interpretation. Using an interview rather than a questionnaire may have led to a deeper understanding of why the pupils sorted the statements in the way that

they did, as follow up questions could not be asked. The questions on the questionnaire were already fixed and decided prior to the sorting of the statements and this may have meant that the views of the pupils were not fully explored or understood. This could have led to some of the views of the pupils being misinterpreted.

Pillay et al. (2013) also found that there were factors that promoted successful reintegration for pupils. The promotive factors were emotional experience (feeling pride etc), good relationships (family, peers, and adults in school), gradual reintegration and good communication between home and school. Pillay et al. (2013) studied reintegration to mainstream education for pupils with social, emotional, and behavioural difficulties and as well as promotive factors also looked at risk factors for reintegration. The risk factors were emotional experiences (anger and anxiety etc), poor relationships (family, peers, and adults in school), a long time spent outside of a mainstream setting, volume of work, and the emphasis on academic attainment within the mainstream education provider. Both Atkinson and Rowley (2019) and Pillay et al. (2013) gained the views directly from the pupils who had reintegrated from AP. Pillay et al. (2013) supports the view that pupils who are reintegrating from AP should have access to resilience-based reintegration programmes that involve developing emotional competence, supportive relationships and implementing promotive reintegration practices within the setting.

Moore et al. (2020) conducted a case study in the USA that focused on a solution focused brief therapy reintegration programme for a pupil reintegrating from AP. They suggested that interventions to support pupils reintegrating from an AP were absent and their case study indicates that solution focused brief therapy interventions can help pupils to recognise strengths, build solutions and reintegrate successfully.

A common theme throughout the research on reintegration from AP is that support from the systems around the pupil and not just within child factors are vital for a successful reintegration (Atkinson & Rowley, 2019; Moore et al., 2020; Pillay et al., 2013; Thomas, 2015). However, this research focuses on those pupils who have been excluded or are placed in AP because of behavioural difficulties in school. There is much less research on pupils reintegrating from AP where they have been placed in AP due to medical needs. Some factors that contribute to successful reintegration may be relevant to all pupils leaving AP but there may also be factors that are specific to those with medical needs. Although there is less research exploring the reintegration of those pupils with medical needs from AP there is more research on supporting pupils with medical needs in school.

2.4 Supporting Pupils with Medical Needs in Education

Pupils with medical needs refers to both pupils with physical health needs and pupils with mental health needs. Schools have a duty to support pupils with medical conditions in school and ensure they have an individual healthcare plan in place whether there medical needs are related to their physical or mental health (NASEN, 2018). Schools need to ensure these pupils are supported throughout their education including during the primary to secondary transition (Department for Education, 2015). Much of the research exploring supporting pupils with medical needs in education separates those with physical health needs and those with mental health needs. The things that are needed to support those pupils with physical health needs in school may differ in some ways from the things that would support those pupils with mental health needs. However, there may also be a crossover of support that works for all pupils with medical needs and those with physical health needs may also have mental health needs and vice versa. Although there may be some overlap with support for physical and mental health needs most of the research studying support for these pupils

clearly separates the two. Therefore, this section discusses the research for supporting pupils with medical needs in school transition, before focusing on supporting pupils in school with physical health needs and mental health needs separately.

2.4.1 Transition from primary to secondary with medical needs

CYP will change to a new education setting through the transition from primary to secondary school. It is important that all CYP are supported through this transition as this may be challenging and it is a pivotal point in their education (West et al., 2010), but particularly for pupils with medical needs. Despite this there is limited research on how best to support pupils with medical needs through their transition from primary to secondary school. In the available research on transition for this group of pupils Moore et al. (2021) found that the primary to secondary transition is more difficult for those with mental health difficulties and suggests interventions need to be sensitive to those with mental health difficulties, but it does not explain what factors support with successful transition for those CYP.

Grant (2020) completed a doctoral thesis studying the experiences of transition to secondary school for pupils with SEMH needs and found factors that contribute to successful secondary school transition for these pupils include having early intervention that supports the development of trusting relationships and a sense of belonging, having a sense of choice and agency within the school, having academic aspirations, and being able to distance from negative views of school from primary school. However, pupils with SEMH needs encompass a wide range of needs and may not all have specific medical needs and therefore the findings in this study may not be applicable for CYP with medical needs.

2.4.2 Pupils with Physical Health Needs

Research on supporting pupils with physical health needs covers a wide range of medical conditions from long term health conditions (Datta et al., 2006; Lum et al., 2019) such as cancer and acquired brain injury (Stevens et al., 2021) to acute conditions such as concussion (Davies et al., 2020; Kasamatsu et al., 2016). Those pupils with long term health conditions will need the support put in place throughout the duration of their medical condition, but it is important that pupils with acute conditions are also supported when needed.

Hinton and Kirk (2015) carried out a review of the literature on supporting pupils with long term health conditions in mainstream schools but they focused solely on teacher views. The found that teachers felt there were key barriers and facilitators within schools to supporting pupils with long term health conditions. These were: level of formal training of teachers of the long-term health condition, communication between school, home and health and social care services, education programmes developed with or by healthcare professionals and pupils receiving care and support to integrate with their peers in school. This review suggests similar factors are involved in supporting pupils with medical needs as those reintegrating from AP such as communication and support (Atkinson & Rowley, 2019; Pillay et al., 2013; Thomas, 2015), but it only focuses on the perspective of the teachers and not the pupils themselves. Pupils with long term health conditions may feel that there are different facilitators and barriers to supporting them in school.

A large scale study for the National Children's Bureau on meeting medical needs in mainstream education was carried out by Datta et al. (2006) who gained pupil views through a survey of over 6,500 young people and completed case studies of 19 young people, their families, and professionals both from schools and health services. They found important

factors to supporting pupils with medical needs in mainstream settings were: having a positive school ethos (similar to Thomas' (2015) findings for those reintegrating from AP), having a school policy that covers how to support and the inclusion of pupils with medical needs, training of staff to support pupils with medical needs, staff having an awareness of the impact of the medical needs on the pupil, pupils having a key adult in school who they can go to for support with their medical needs, having good communication between pupils, school, families, external services and school staff and supporting pupils who are absent by maintaining contact with the pupil during periods of absence from school due to medical needs. This study had a large sample size and explored the views of pupils themselves with all the case studies being pupils with long term health conditions.

Support for pupils with acute or short-term medical conditions has also been studied in the research. In the USA pupils with concussion are often supported primarily by their athletics trainers and Davies et al. (2020) found that athletics trainers who had frequent communication with teachers were better at supporting pupils with concussion and ensuring they were given cognitive rest to recover. Similarly in interviews with pupils who had experienced concussion Kasamatsu et al. (2016) found that while supportive and well-informed parents, friends, school staff and athletics staff made things better, those who did not understand the pupils' experience made things worse. Both Davies et al. (2020) and Kasamatsu et al. (2016) suggest the importance of communication between school staff and home to ensure that pupils are supported in their recovery post-concussion.

Collaboration and communication between home, health and school has been highlighted as vital to supporting pupils with other physical health needs (Finch et al., 2015; McClanahan & Weismuller, 2014; Selekman & Calamaro, 2014) as well as pupils with concussion (Davies et al., 2020; Kasamatsu et al., 2016). Finch et al. (2015) found that

although school psychologists and school nurses felt that they worked well with each other they still believed that they needed to improve communication between schools and hospitals to better support pupils with medical needs. School nurses and school psychologists suggested that they felt trained to support pupils with medical needs in school (Finch et al., 2015), however research with teachers suggests that unlike school nurses and school psychologists they do not feel they are adequately trained to support pupils with medical needs (Stevens et al., 2021).

Pupils with acquired brain injury need supportive school environments to adapt to the classroom and have their needs met (Parkin et al., 1996). However, research suggests that school staff do not have opportunities to gain knowledge about acquired brain injury (Briesch et al., 2019; Mansfield et al., 2021) and lack resources needed to accommodate pupils' learning needs (Ettel et al., 2016; Linden et al., 2013; Mealings & Douglas, 2010; Mohr & Bullock, 2005). As well as finding that school staff felt unprepared to support pupils with acquired brain injury Stevens et al. (2021) also found that families felt unprepared to support their children with the school environment following an acquired brain injury.

The wellbeing of pupils with chronic illness in school is vital to facilitate engagement with school (Lum et al., 2019). Pupils with chronic illness were found to have lower school wellbeing than pupils without chronic illness and parents of pupils with chronic illness reported that higher levels of school wellbeing led to higher levels of school engagement (Lum et al., 2019; Pini et al., 2016). Lum et al. (2019) suggest that preventative and early intervention school based mental health promotion may help to increase school wellbeing in pupils with chronic illness. By increasing school wellbeing pupils with chronic illness are more likely to have higher levels of school engagement (Forrest et al., 2011; Pini et al., 2016).

2.4.3 Pupils with Mental Health Needs

While some of the support needed for pupils with mental health needs differs to those with physical health needs some key themes are found in both areas of the literature such as the importance of collaboration and working together for the people and systems around the pupil including home and school (Finning et al., 2020). School staff identified anxiety as being a risk factor for school non- attendance but they felt that school factors were less important than individual factors in relation to anxiety leading to attendance problems (Finning et al., 2020). School staff in this study did not identify other mental health issues as having an impact on attendance, however depression has been found to be a bigger risk factor for attendance than anxiety in quantitative studies (Egger et al., 2003; Finning et al., 2019). Finning et al. (2020) suggest that staff are best placed to make changes to those school factors to support pupils whose mental health needs are impacting their attendance and there is a need to increase awareness of the impact of school factors and to promote positive relationships between the pupil and staff as well as collaboratively working with the pupil, school and home.

Carroll and Hurry (2018) carried out a literature review that focuses on supporting pupils in mainstream and specialist settings with social, emotional, and mental health needs (SEMH). The results suggested that factors that supported pupils with SEMH in schools were teachers and school leaders having a positive approach to SEMH, using approaches that avoided deficit models and fostered good relationships between pupils and teachers. They found essentials of good SEMH provision included: qualified and committed professionals, practical and functional environmental supports, effective behaviour management plans, relevant and effective social skills programmes, and good academic support systems. This

study is useful for considering factors that support pupils with mental health needs, but this focuses specifically on the effectiveness of interventions used within school settings.

School staff beliefs about supporting pupils' mental health needs in schools is highlighted by Briesch et al. (2019) and Mansfield et al. (2021). Briesch et al. (2019) found that school staff believed that pupils' social, emotional, and behavioural problems should be monitored in school, but they felt a pressure to change screening procedures for these pupils. They found that staff wanted to move to a more proactive approach to support the mental health needs of pupils by identifying students who may be at risk by identifying their risk and resilience factors and not just focusing on those pupils who already exhibit mental health problems. Mansfield et al. (2021) found that school staff believed that the biggest barriers to supporting pupils with mental health needs was the lack of capacity both in school and children and adolescent mental health services (CAMHS), and the communication difficulties between agencies. The training offered by schools significantly predicted the staff awareness of mental health issues and the process for supporting pupils (Mansfield et al., 2021). The importance of school staffs' approach to supporting pupils with mental health needs was emphasised by Carroll and Hurry (2018) who found that a positive approach by staff underpinned all of the successful mental health programmes used in schools that they reviewed.

As well as support from school support from home needs to be considered when helping pupils with mental health needs to ensure all of the people around the pupil can work effectively together (Finning et al., 2020). Kjellström et al. (2017) found that parental support was more important than teacher support in outcomes for pupils with psychosomatic health needs. Parent support was more significant for younger girls with psychosomatic health complaints compared to older girls, with the opposite pattern found for school staff support

(Kjellström et al., 2017), highlighting again the importance of collaboration and communication needed between home and school.

Luthar et al. (2020) studied teacher responsibilities for pupils' mental health in nine high achieving cohorts where anxious- depressed symptoms in pupils were six to seven times the national norms in the USA. They found that schools needed to ensure support for staff, so they were able to effectively support pupils' emotional needs without it leading to burnout for the staff. This study highlights the importance of ensuring the wellbeing of those who are involved in supporting pupils with mental health needs in schools is also addressed, for them to support those pupils effectively and continually. Carol and Judith (2013) and Lorraine et al. (2013) studied the support school counsellors could offer to pupils with mental health needs as a specific role in schools, rather than it being teachers or teaching assistants who support these pupils. As well as providing direct support to pupils Carol and Judith (2013) suggest that school counsellors are well placed to build alliances with pupils, parents, teachers and other members of the pupil's community to coordinate mental health support for the pupils in their school. Lorraine et al. (2013) suggest that school counsellors need knowledge of education, and their role should be both considered as an education leader and a mental health professional in order to address and respond to the mental health needs of all pupils in school. This stresses the need for an understanding of the systems that the pupils exist within including the school system to be able to fully support them. A wider systemic view of how best to support pupils' mental health, thinking about the environment and systems they exist within, as well as the personal-social factors that impact the pupil all need to be considered to enable people around the pupils to support them best.

However, sometimes support in school for those with mental health or physical health needs may not be enough and pupils may have a period of non- attendance due to ill health or

need to spend an extended period in hospital due to medical needs. For these pupils it may be that additional support or alternative support is required to get the pupil back into school and fully reintegrate after an extended period not in the school environment. In the next section I will explore the literature around supporting reintegration to education for those pupils with medical needs who have not been able to attend school due to their medical needs and consider facilitators and barriers to a successful reintegration to education for these pupils.

2.5 Reintegration to Education with Physical Health Needs

Research on reintegration to education for children and young people with physical health needs includes those who suffer with long term health conditions such as cancer (Harris, 2009; Kesting et al., 2016; Soejima et al., 2015; Tresman et al., 2016) and physical injuries (Wilson et al., 2014; Young et al., 2017). The importance of communication and collaboration between professionals (health and education) and families has been identified as vital to supporting pupils with physical health needs return to school (Psihogios & Baber, 2017; Tresman et al., 2016; Vanclooster et al., 2018; Vanclooster, Bilsen, Peremans, Van der Werff Ten Bosch, Laureys, Willems, et al., 2019; Wilson et al., 2014). Vanclooster et al. (2018) reviewed the literature in Belgium, on the communication and collaboration after school reintegration of a seriously ill pupil and found the main topics discussed during consultations were the pupil's condition, education, and support, but the practices of communication and collaboration were variable, and most stakeholders viewed them as inadequate. This research suggests the need for a school liaison officer to provide a connection between families, education, and healthcare to enable them to work together effectively. Similarly, Psihogios and Baber (2017) suggested a likely barrier to reintegration in the USA, was that the partnership between medical and school stakeholders was not strong enough in their research on a family based cognitive behavioural intervention on a single case

study to support school reintegration, following a period of absenteeism due to irritable bowel syndrome. Again, this is highlighting that good communication and joint working with all stakeholders is needed for a successful school reintegration.

Likewise, research in England has also found communication between stakeholders to be vital to a pupil's successful return (Tresman et al., 2016; Wilson et al., 2014). Wilson et al. (2014) interviewed teachers who were involved in reintegration for a pupil in their class following a burn injury and found teachers suggested one area that needed to be improved was better communication before the pupil returned to school so they felt better prepared to protect them from additional harm. However, this study did not consider the perspectives of other involved such as healthcare professionals or the family of the pupil. Tresman et al. (2016) on the other hand collected data from parents, teachers and healthcare professionals involved in school reintegration for pupils following medulloblastoma treatment. After exploring reintegration experiences the study aimed to create a structured reintegration protocol to support return to school for these pupils. Tresman et al. (2016) proposed a reintegration passport with multiple stages of information sharing including ensuring multidisciplinary cooperation, establishing an early relationship with the special educational needs coordinator (SENCo) and families having an active role in supporting their child's return to school to ensure that communication is consistent across all stakeholders. Harris (2009) suggests school psychologists' role in successful school reintegration for pupils with cancer is to facilitate consultation between the pupil, parents/carers, school professionals and health professionals to bring all involved together. In the UK, this may not always be possible as educational psychologists (EPs) do not usually work with and in just one school in the same way that school psychologists do in the USA, but it highlights the importance of bringing everyone involved together to facilitate successful school reintegration.

Vanclooster, Bilsen, Peremans, Van der Werff Ten Bosch, Laureys, Willems, et al. (2019) conducted a qualitative study with parents and teachers of pupils who had reintegrated after receiving treatment for a brain tumour at both the start and end of a one- year period following the school return. Similar themes on reintegration facilitators emerged from this research including communication and working together but also two other main themes: the child's performance and wellbeing, and the school's attitude and approach to reintegration. Children's wellbeing in school can be closely related to the social support they have and their friendships (Holder & Coleman, 2015). Social support from peers for pupils with cancer has been related to the peers understanding of hospital experiences (Soejima et al., 2015). Friendships and peer support are suggested to be the most important motivating factor to pupils with serious physical health conditions for returning to school (Soejima et al., 2015; Vanclooster, Bilsen, Peremans, Van der Werff Ten Bosch, Laureys, Willems, et al., 2019). These studies suggest that social contact and relationships established before returning can help to facilitate a successful reintegration to school.

Other things that schools need to consider for pupils returning with physical health needs are more focused on specific aspects of the school day. Once in school pupils who are reintegrating may need support focused around taking part in lessons such as physical education (PE) (Kesting et al., 2016). In the survey of pupils who had returned to school following cancer treatment Kesting et al. (2016) found that one in four reported not taking part in PE. Kesting et al. (2016) emphasised that reintegration to PE for these pupils needs to be continuous and they should be encouraged to take part in adapted sports activities throughout their treatment to make the reintegration to PE on their return to school easier.

Often studies focus on individual factors relating to the pupil's medical condition when considering reintegration (Georgiadi & Kourkoutas, 2010; Lindsay et al., 2015), but

Worchel-Prevatt et al. (1998) argue that it is better to take a systems approach when supporting school re-entry for chronically ill children. Worchel-Prevatt et al. (1998) stress the importance of the child's environment including home, school, and the relationships within these with family, peers, and teachers.

Most research available on supporting pupils' reintegration following physical illness or injury focuses on the views of the people around the child including families and professionals rather than the views of the pupils themselves about what has supported their return to school. There is also a lack of research about reintegration for those with mental health conditions which I will explore in the next section. Interestingly, the research for those reintegrating with mental health needs is similar to those with physical needs in that often the research only explores the views of the professionals.

2.6 Reintegration to Education with Mental Health Needs

The research on reintegration for pupils with mental health needs explores those who have spent time in hospital for their mental health or attended hospital schools, those who have been absent and at home because of their mental health, and those who have attended alternative medical education provision such as a medical pupil referral unit (PRU). I will discuss those who have reintegrated from a medical PRU separately to those who have come from home or hospital as the medical PRU is a specific type of education setting where the aim is to support pupils to eventually reintegrate to another education setting. Pupils reintegrating with mental health needs includes those with anxiety (Kljakovic & Kelly, 2019; McKay-Brown et al., 2019), depression (Preyde et al., 2017) and other mental health conditions (Marraccini et al., 2019; Savina et al., 2014; Tougas et al., 2019).

Some of the research explores the view of professionals working with children and young people with mental health needs (Kljakovic & Kelly, 2019; Marraccini et al., 2019). Marraccini et al. (2019) gathered the view of school psychologists in USA about what influences reintegration for pupils leaving mental health hospitals. They identified several factors including communication with the hospital, meeting the family before the pupil returns and developing an individual re-entry plan for the pupil. The factors identified are supported in reviews of research by Savina et al. (2014) and Tougas et al. (2019) who both identify collaboration between health and family as a key theme in the research on reintegration of pupils with mental health needs. Savina et al. (2014) suggested that a lack of inter disciplinary collaboration and negative perceptions and attitudes of peers, teachers, parents, and the pupil are barriers for successful reintegration from a mental health hospital. They suggest that there is a need for high levels of collaboration with professionals and family to help identify shared priorities for the pupil and work together to create a manageable transition plan. The idea of a manageable transition plan is similar to the factor of developing an individual re-entry plan that Marraccini et al. (2019) suggests. Although Savina et al's (2014) review aimed to study school reintegration following hospitalisation for mental health reasons, the review covered a much wider scope than this. Within Savina et al (2014) the review explored pupil and parental experiences of hospitalisation and the impact of the child being in hospital on families, and this may not be relevant to the review area of school reintegration. Even though Savina et al's (2014) review focuses on different areas to school reintegration the parts of the review that did focus on school reintegration identified several factors that could support pupils, however, it could be argued that this review was not systematic in its inclusion and exclusion criteria for research.

However, Tougas et al. (2019) criticises Savina et al. (2014) because their review was not systematic and many of the research articles they included went beyond the objective of school reintegration and studied areas such as hospital experience. Despite this criticism, Tougas et al. (2019) found similar themes in the research evidence about what is needed for a successful reintegration from a mental health hospital, with communication, collaboration and coordinating all involved in the reintegration being crucial for success.

Similarly, McKay-Brown et al. (2019) found collaboration aided successful reintegration through a study on a multidisciplinary 'In2School' programme that promotes collaboration and working partnership between mental health clinicians, teachers, and home. Although, this was a small-scale pilot study 6 out of the 7 pupils on the programme successfully reintegrated to mainstream schools follow a period of absence from school due to mental health conditions. However, this study did not have a comparison group who were not following the In2School programme, so it is difficult to know if it was the collaboration and working partnerships that the In2School programme had promoted that led to the success of the pupil's reintegration or if there were other factors involved. The other support that was given to these pupils outside the In2School programme was not discussed or measured and it may have been other things that led to the pupil's successful reintegration and the other support they received cannot be separated from the support received through the In2School programme.

However, most of the literature in these reviews focuses on views of health professionals, school professionals and families, rather that the pupils themselves. Where the research considered the views of pupils themselves it was usually before the return to school had taken place. One piece of doctoral research that did consider the views of pupils themselves after they returned to school was Iverson (2018) who carried out interviews with 8

pupils who had returned to school after being in a mental health hospital. Iverson (2018) found that pupils felt the support from school staff, peers and family made the biggest impact on their successful return to school. Although, this research has considered the views of pupils after they have returned to school there is still minimal published research that focuses on the pupils' view. However, Iverson's (2018) research is still limited as the interviews with some of the pupils were very short and ranged from 20 to 60 minutes in length. Iverson (2018) shared that some pupils did not want to discuss their return to school in detail and therefore the things that were identified as being important to pupils returning to school may only have been important to one or two of the pupils in her research. Pupils were also recruited to the research by being referred by their school counsellor. This may mean that the pupils who were referred were more likely to have had a good return to school and they may have been more likely to say positive things about their return to school, as the school counsellors are less likely to refer a pupil if they feel their view may reflect negatively on them or the school. Therefore, the views of the pupils in Iverson's (2018) research about their return to school are limited to their individual experiences about their return from hospital.

Published research that does consider the perspectives of the pupils seems to focus solely on their concerns before they reintegrate to school such as Preyde et al. (2017). They found the children and young people in inpatient mental health hospitals were most concerned about social situations, being behind academically and feeling overwhelmed and not able to manage big emotions at school. Although these concerns can help us to identify the needs of individual pupils that need to be considered on a reintegration plan it does not inform what works for a successful reintegration to school from the pupil's perspective.

Overall, what supports successful reintegration for pupils with mental health needs seems to be much less widely research than reintegration for those with physical health needs,

particularly when pupils are returning after time in hospital (Savina et al., 2014). The majority of research in this area also comes from USA (Iverson, 2018; Marraccini et al., 2019; Preyde et al., 2017; Savina et al., 2014) and little from the UK. Kljakovic and Kelly (2019) did examine the views of professionals in England about what helps young people reintegrate, but the young people with mental health conditions were grouped with a wider population of school non-attenders and included those who did not attend due to educational needs (SEN) and behavioural difficulties. This may explain part of the reason less research exists in the UK about reintegration to school for these pupils as they are often categorised with other populations including those with SEN and behavioural difficulties, rather than viewed as a distinct group of pupils who need support reintegrating with mental health needs.

Some pupils with mental health or physical health conditions will reintegrate from other short stay education settings that support with their education while they are unable to attend school due to their medical needs. These short stay settings focus on support while recovering and their aim is to reintegrate back to a school setting as soon as possible. Things that support these pupils may be different to those coming from hospital or reintegrating after a period of recovery at home. In the next section I will explore the research on reintegration from these short stay settings (medical pupil referral units).

2.7 Reintegration from Medical Pupil Referral Unit

Research on reintegration from medical pupil referral units (PRUs) is limited. Some local authorities have separate medical PRUs while others have PRUs where both those pupils with medical needs and those who have been excluded from their school attend. This may be one reason why there is limited research focusing on reintegration from medical PRUs as some local authorities do not have these as separate from other PRUs and research on reintegration from PRUs usually focuses on the pupils who were excluded from school

(Atkinson & Rowley, 2019; Pillay et al., 2013; Thomas, 2015). However, research still needs to explore what makes reintegration from a medical PRU successful, as pupils with medical needs may need different support to make a reintegration successful to what those who have previously been excluded need.

Medical PRUs support pupils with physical health needs and mental health needs. It is also important to recognise that there are pupils in medical PRUs who have chronic or acute physical health conditions and they will also have mental health needs, as there is an association between physical illness and mental health conditions (Clarke & Currie, 2009). Rohrig and Puliafico (2018) suggest that in research studying pupils' reintegration we may not be able to separate those with mental health conditions and those with physical conditions because of the levels of comorbidity that occur with adolescents who have chronic illnesses. Grandison (2011) conducted a case study on five pupils who had reintegrated into mainstream school following time spent at a PRU for key stage 3 and 4 pupils with mental health and medical needs. She found the top five facilitating factors to reintegration for those pupils were: individual approach to reintegration, phased reintegration, collaboration between parents, school and PRU, positive attitude of the pupil to reintegration, and the pupil was helped to understand and cope with their emotions. These facilitating factors are similar to the factors identified in research when pupils with medical needs reintegrate from other settings (Kesting et al., 2016; Preyde et al., 2017; Savina et al., 2014; Vanclooster, Bilsen, Peremans, Van Der Werff Ten Bosch, Laureys, Paquier, et al., 2019). Although Grandison (2011) interviewed the pupils who were the focus of the case studies as part of this research, the views of the pupils were muted, as she found that four out of the five CYP could not engage in interviews with the researcher. Therefore, although this research is framed as five case studies it is limited to the views of some of the adults around the CYP. The group of CYP

who were the focus of the case studies in this research had mental health needs that led to them spending time in a PRU for CYP with mental health needs. However, during the research it became clear that one pupil did not have a diagnosed mental health condition and the reason for her being in the PRU was shared as truancy from school. This makes it difficult to think of this small group of CYP as a homogenous group as they all have different needs and not all the case studies had a mental health condition. This research was not published and there is a clear lack of research studying reintegration of pupils from medical PRUs.

2.8 Conclusions

Although the research into reintegration of pupils from AP and research supporting medical needs in education settings suggest similar factors are involved, (communication, collaboration, school ethos, training of staff, relationships etc) the research has not yet studied the impact of both things together i.e., the successful factors of reintegration for those who have had a placement in AP due to medical needs. Also, more research has studied how to support pupils with physical health needs and often does not include those with mental health needs. The medical PRUs support those with physical and mental health needs (or a combination of both physical and mental health needs) and so research needs to consider the factors that impact successful reintegration of pupils with both physical and mental health needs. The research studying pupils with medical needs lacks representation of the views of the pupils themselves and it is vital that the views of pupils with medical conditions are 'heard' as what may be important to professionals and education staff may not be considered important to their successful reintegration by the pupils themselves.

Following this literature review I am interested to find the factors that support successful reintegration specifically for pupils with medical needs who are reintegrating from medical PRUs and if the views of pupils about what supported their reintegration differ from

what professionals believe supports successful reintegration for pupils with medical needs. Therefore, the research questions I have identified are:

1. What are the views of children and young people who have received support from alternative medical education provision, and have reintegrated back into an education setting regarding the factors that supported their successful reintegration into the education setting?
2. What are the views of staff from alternative medical education provision, regarding the factors that supported pupils' successful reintegration into an education setting following support from the medical education provision?
3. How do professionals' views about what supports reintegration to an education setting following support from the medical education provision compare to the views of the pupils themselves?

3. METHODOLOGY & PROCEDURE

3.1 Design

3.1.1 Philosophical Assumptions

All research that is conducted is underpinned by assumptions that influence the way data is collected and analysed. Philosophical assumptions differ according to the ontology and epistemology. Ontology is the study of 'being' and is concerned with our beliefs about the nature of reality and what exists in the social world (Thomas, 2017). Epistemology is concerned with how knowledge is obtained (Thomas, 2017).

The philosophy underpinning this research is pragmatist. Pragmatism is focused on the consequences of the research and is oriented to real-world practice with what works being central to the approach taken (Creswell & Plano Clark, 2018). For pragmatists the importance is about the research questions being asked rather than the methods used (Creswell & Plano Clark, 2018). Pragmatism underpins this research as it is oriented to provide practical implications for educational psychologists and staff working with pupils who are reintegrating from alternative medical education provision to help support them with their reintegration. The relationship between myself and what is being researched is focused on practicality and the data has been collected by using what works in order to address the research questions.

3.1.2 Mixed Methods design

Pragmatism as a worldview allows for flexibility in the research methods in order to answer the research questions (Creswell & Plano Clark, 2018). Pragmatism and mixed methods research have been linked by Tashakkori and Teddlie (2003) and they argue that this is because both quantitative and qualitative methods can be used in a study, the research question is the most important thing, and methodological choices should be guided by a

practical research philosophy. Tashakkori and Teddlie (2003) believe that forced choice between positivism and constructivism should be discarded as well as the use of concepts such as truth and reality.

In this research I have collected both qualitative and quantitative data. Q methodology represents an approach that has characteristics of both qualitative and quantitative data (McKeown & Thomas, 1988). Semi structured interviews were used with alternative medical education provision staff to gather qualitative data. I have justified my reasons for choosing each of these methods later in this chapter.

3.2 Participants

3.2.1 Q-methodology

The participants who completed the Q-sort were a purposive sample of pupils from permanent education settings within the focus local authority who have reintegrated after a period of support from the medical education AP within the last 3 years

Gatekeepers (medical education alternative providers within the local authority) were approached in the first instance and given letters (appendix 1) to seek approval from the headteachers or special educational needs coordinators (SENCos) of the settings where pupils had successfully reintegrated to. The headteacher or SENCos then shared information about the research with parents or carers and pupils (who reintegrated from medical education provision) in their setting. The pupils who expressed an interest in taking part in the study informed the headteacher or SENCo in their school. The headteacher or SENCo then contacted me directly via a council email or telephone number and a meeting was set up at the setting for the pupil to complete the Q-sort and post-sort interview.

3.2.2 Semi-structured Interviews

The participants who completed the semi-structured interviews were a purposive sample of staff from alternative medical education settings within the focus local authority. Senior teachers within the settings were contacted and sent information sheets (appendix 2) about the research. These were then shared with staff within the alternative medical education settings and staff who expressed an interest in taking part in the study contacted me directly via a council email or telephone number. A meeting was then set up through Microsoft Teams with the staff member to complete the semi-structured interview.

3.2.3 Recruitment

It needs to be highlighted that all the participants were recruited from one local authority in the West Midlands. This was in part because the focus of the research was about pupils' reintegration from a specific type of setting, an alternative medical education provision. This is because the research aimed to give practical implications for educational psychologists and school staff who will be supporting pupils reintegrating from these settings in the future. However, this means that attempting to transfer the results of this research to other local authorities may not be appropriate as there are issues with the transferability of the data collected in this study.

The impact of the COVID-19 pandemic on the recruitment of participants particularly for pupils needs to be acknowledged. Due to the timing of data collection recruitment of participants was difficult as pupils were not reintegrated into other education settings during the COVID-19 lockdowns and remote learning for schools. This led to a small population of pupils who were eligible to take part in the research. It is important to note that none of the participants (pupils) who took part in this research had physical medical needs. A participant was recruited with physical medical needs, but they had to withdraw before data collection.

Therefore, this research is focused on the views of pupils with mental health medical needs only.

3.2.4 Participant Characteristics

The participant characteristics for both pupils who had successfully reintegrated and staff from alternative medical education provision are shown in the tables below.

Participant	Gender	Medical condition disclosed	Other diagnosis	Age	Setting reintegrated into
1	Female	Anxiety	Autism Spectrum Condition	14	Specialist SEMH
2	Female	Anxiety	Autism Spectrum Condition	15	Mainstream Autism Base
3	Female	Anxiety	none	16	Further Education College

Table 1: Participant characteristics for the Q-sort

Participant	Job Role With Alternative Education Provision
111	Senior Teacher
112	Teaching Assistant
113	Senior Teacher
114	Teaching Assistant

Table 2: Participant characteristics for the semi-structured interviews

3.3 Ethics

Ethical approval was obtained from the University of Birmingham's Humanities and Social Sciences Ethical Review Committee. The completed Application for Ethical Review can be found in appendix 3 and the further amendments to the Application for Ethical Review can be found in appendix 4. Ethical considerations were made using the guidance provided by

the BPS Code of Conduct and Ethics (2018) and the British Educational Research Association (BERA) Ethical Guidelines for Educational Research (2018).

Freely given, informed consent was obtained from the pupils who were given an information sheet about the research (appendix 5) and who then signed a consent form (appendix 6). Prior to this the pupils' parents were also sent a letter about the research (appendix 7) and signed a consent form (appendix 8) to allow their child to take part in the research. Alternative medical education provision staff also signed consent forms (appendix 9) prior to taking part in the research.

3.4 Data Gathering

3.4.1 Justification of the use of Q-methodology

Q-methodology was considered a practical method as I wanted to know what the views were for children and young people who had successfully reintegrated from alternative medical education provision. I needed a method that would allow for the pupils' voices to be heard. Although I did consider the use of interviews, I felt that given that the participants were a vulnerable group many who had mental health needs, including anxiety, that talking to a stranger about their reintegration may have been difficult for them. Hughes (2017a) suggests that the sorting of statements allows CYP's voices to be raised in a way that is much less influenced by an adult than other methods such as a semi structured interview.

Q-methodology is viewed as an ethical methodology, as it gives a voice to all participants, including minority voices (Hughes, 2017b). Ravet (2007) explained that an unavoidable power difference exists between children and adults. It was important for me to address the power imbalances that would exist between myself and the participants and therefore I concluded that Q methodology would be an appropriate method to do this as I

would not be imposing my viewpoints on the participants. I hoped my use of Q methodology would empower participants to share their views.

3.4.2 Justification of the use of semi-structured interviews

To gain the views of staff from medical education provision I felt that there was less of a power differential between myself and them as participants. I also felt that as staff often were required to share their views during meetings with other professionals an interview was an appropriate method to use to gather their views. Semi structured interviews were used as there was a need for some structure in order to ensure topics around reintegration were covered, but I also wanted to be able to probe deeper and have the flexibility to be able to ask follow up questions if it was needed. A brief interview schedule (appendix 10) was used with initial questions, possible follow up questions and prompts to help ensure that a wide range of areas on the topic of reintegration were covered. I decided it was most appropriate to carry out the interviews online as it would give more staff from the alternative medical education provision the opportunity to take part in the research as they have limited time and during the time of carrying out the research the settings were limiting the number of visitors in person due to the Covid-19 pandemic.

3.5 Procedure

3.5.1 Q-methodology procedure

Q methodology procedure was completed in person with all the participants. This section will outline the procedure of the Q methodology.

3.5.1.1 Concourse development

I generated a set of statements (the Q-set), which are derived from the 'concourse' (the field of shared knowledge surrounding the topic) (Watts & Stenner, 2012). The concourse for

this Q-study was drawn from a range of research. Initially developing the concourse for this study began by doing a literature search of books and journal articles about what children and young people, professionals and families had suggested had supported their medical needs in different education settings. I used this to develop seven key themes and I initially generated five statements for each theme (see appendix 11). Every statement corresponded to an opinion about reintegration from medical education AP.

3.5.1.2 Developing the Q-set

Before completing the Q-sort with participants the initial Q-set (statements) was shared with staff who work in the medical education AP to ensure the final Q-set was representative of the concourse (the field of shared knowledge surrounding the topic). The staff were asked to read the statements and give any other opinions they thought were missing or not represented about successful reintegration to an education setting from medical education provision. The Q-set was then amended, and the number of statements were reduced to 21 as the feedback from staff was that the CYP they work with would find the number of statements overwhelming. Using the opinions staff about the initial Q-set the final Q-set (appendix 12) had 3 statements for each theme.

3.5.1.3 Q-sort administration

Each of the Q-sorts were completed face to face with me. The 21 statements from the Q-set were written on individual cards of the same shape and size. Participants were first reminded why I was there, including resharing of the information sheet and reading and signing the consent form. Participants were then given an explanation of the task and were shown the Q grid that they would be sorting the statements onto (figure 1).

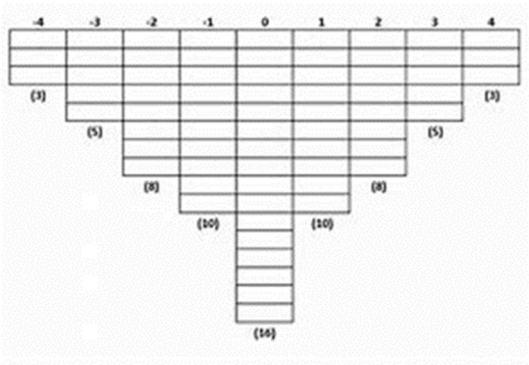


Figure 1: Example Q-grid

Participants were asked to sort the cards, within a fixed distribution. The participants were asked the same question: 'What helped you to settle into your current setting after being at the MET (Medical Education Team) for a while?' It was explained to the participants that the left-hand side of the grid was for unhelpful, and the right had side helpful with the centre of the grid being not helpful, not unhelpful.

To begin the process of sorting, participants were asked to read through the statements and then asked to sort the statements into three piles according to whether they perceive the approach to be 'helpful', 'unhelpful' or 'not helpful, not unhelpful' in supporting their reintegration. When they had sorted all the statements into the three piles the participants were asked to place the statements on the Q-grid from 'most unhelpful' to 'most helpful', beginning with the 'helpful' pile.

3.5.1.4 Post Q-sort interviews

Following the Q-sort the participants were then asked a few questions in the format of a post -Q interview. A brief interview schedule for the post Q-sort interview can be found in appendix 13. The post Q-sort interview helps to support the qualitative interpretation of their views. This interview asked why they decided particular factors were helpful, not helpful and neither helpful nor not helpful in their reintegration to their current setting. At the end of the

interview participants were thanked for their involvement and reminded of their right to withdraw their data and how they could withdraw up to seven days after it had been collected.

4.5.1.5 Semi structured interview procedure

All the semi structured interviews were completed by me via Microsoft Teams. Before each interview began participants were reminded of why I was there through the resharing of the information sheet and the consent forms were discussed and signed. The interviews followed the topics and initial questions on the interview schedule but were flexible in that if a particular topic of interest arose participants were prompted to give more information about the area through probes such as "can you give me an example?". Each interview lasted between approximately 30-45 minutes. At the end of the interview participants were thanked for their involvement and reminded of their right to withdraw their data and how they could withdraw up to seven days after it had been collected.

3.6 Analysis

3.6.1 Q- methodology

3.6.1.1 Factor analysis and Interpretation

The details of the data analysis including both the factor analysis and interpretation are included in Chapter 4. I used PQMethod software (Schmolck, 2014) to analyse the data collected from the Q sorts. I inputted the data from the three completed Q sorts into the PQMethod software. The emerging factors were then extracted and a factor array for the significant factor was used to help explain the participants viewpoint together with the qualitative data gathered during the post Q sort interviews.

3.6.2 Thematic analysis

3.6.2.1 Background and Aims

Reflexive thematic analysis is a method used with qualitative data to analyse and interpret patterns within the data through coding the data in a systematic way to develop themes (Braun & Clarke, 2022). Thematic analysis can be used with many methods and epistemologies. While there are many approaches to thematic analysis this research takes a inductive approach to thematic analysis that allowed for themes to be produced through intense analysis of the data (Braun & Clarke, 2022) Within reflexive thematic analysis, researcher subjectivity is viewed as a key tool for doing data analysis (Gough & Madill, 2012).

The analytical process for reflexive thematic analysis in this research follows the six steps outlined by Braun and Clarke (2022):

1. Familiarisation with the dataset
2. Data coding
3. Initial theme generation
4. Theme development and review
5. Refining, defining and naming themes
6. Writing up

Braun and Clarke (2022) encourage researchers to move flexibly through the process outlined above as it is not rigid or fixed, but reflexive thematic analysis requires meaningful engagement with the data set. An example of the coding of the data is shown in appendix 18. The flexibility of thematic analysis means that the researcher plays an active part in generating themes (Braun & Clarke, 2006). Braun and Clarke (2022) explain that the

subjectivity of the researcher and the practice of reflexivity are vital for reflexive thematic analysis to be successful. I therefore felt it was appropriate to keep a reflective diary throughout the research in order to maintain transparency about how my own biases may be impacting the data.

3.6.2.2 Differing approaches to thematic analysis

Given the philosophical positioning of this research, other approaches were considered such as interpretative phenomenological analysis (IPA) or grounded theory. IPA is a participant orientated approach that seeks to allow the participants to express their lived experience (Alase, 2017). However, as the data gathered was from alternative medical education provision staff rather than the pupils themselves for the semi structured interviews, it was not possible to interpret the data as the lived experience of pupils who have successfully reintegrated from alternative medical education provision. Therefore, it was not considered appropriate to use IPA.

Grounded theory (Glaser, 1998) involves generating theories through analysing the data. Grounded theory combines positivist philosophy and symbolic interactionism (Glaser, 1998). Braun and Clarke (2006) argue that thematic analysis has fewer theoretical assumptions than grounded theory and therefore thematic analysis was considered to be a more appropriate method of analysing for this research, as it was not linked to any pre-existing frameworks.

4. RESULTS

4.1 Introduction to Q- Methodology results

Within this chapter I will provide an overview of the data analysis for both the completed Q-sorts and thematic analysis of the semi structured staff interviews. The first part of the data analysis will focus on the Q-sorts and will follow the following structure:

- Factor Analysis
- Factor Extraction
- Factor Rotation
- Factor Array
- Factor Interpretation
- Consensus Statements
- Non-Significant Q-sorts

4.2 Factor Analysis

Three completed Q-sorts gathered during data collection were analysed using the PQMethod software (Schmolck, 2014). Q methodology uses statistical methods to explore how participants group themselves through the process of sorting Q-sets and these completed Q-sorts allow for the exploration of convergences and divergences in viewpoints (McKeown & Thomas, 1988). The factor analysis process follows the method described in Brown (1980).

4.3 Factor Extraction

The first step in this analysis is to intercorrelate the participants' overall Q-sort arrangements. PQmethod gives two factor extraction methods: centroid factor analysis (CFA) and principal component analysis (PCA) (Schmolck, 2014). I chose to use CFA as it allows for an abductive approach to be taken when analysing the data and it acknowledges the idea

that research occurs in the context of theory, and that this affects the interpretation of results by the researcher (Watts & Stenner, 2012).

The final decision was that the extraction of three factors would be most suitable, as it is theoretically possible to extract as many factors as there are sorts and at this stage I did not want to disregard any potentially useful data (Watts & Stenner, 2012). The results of this process are shown below. The results of the extraction of the three factors, with correlations of each sort to each factor, each factor's Eigenvalue and explained variance are shown in table 3 below.

Sorts	**Factor 1**	**Factor 2**	**Factor 3**
1	0.5068	-0.0055	0.0000
2	0.2009	0.1742	0.0000
3	0.7657	0.0052	0.1656
Eigenvalues	0.8835	0.0304	0.0274
% expl.Var.	29	1	1

Table 3: Unrotated Factor Matrix

The unrotated factor loadings and Eigenvalues were used to help identify which factors would be retained.

4.3.1 Kaiser Guttman Criterion

Eigenvalues (EVs) along with the factor variance can give an indication of the strength and potential explanatory power of an extracted factor (Watts & Stenner, 2012). EVs are calculated by summing the squared factor loadings of all the Q-sorts and this gives an estimate of the factors significance (importance) (McKeown & Thomas, 1988). Factors with EVs above 1.00 are considered to be significant, however McKeown and Thomas (1988)

suggest caution should be used when using only statistical criteria. None of the factors within the uncorrelated matrix had EVs greater than one which would indicate the following the Kaiser-Guttman criterion none of the factors should be extracted. However, McKeown and Thomas (1988) suggest that using statistical criteria only may lead to a factor being overlooked that could hold special theoretical interest.

4.3.2 Significantly Loading Q-Sorts

The next parameter I used involved accepting the factors that have two or more significant factor loadings after extraction (Watts & Stenner, 2012). Brown (1980) gave the equation to calculate a significant factor loading at the 0.01 level as:

$2.58\ x\ (1 \div \sqrt{Number\ of\ Q\ set\ Items})$

2.58 x (1÷ √21) = 0.5630

The significance value within this study was therefore taken as **0.56.**

None of the factors from the unrotated data matrix had two or more Q-sorts that significantly loaded onto them, which indicates that none of the factors met this criterion. However, given there were only three Q-sorts completed I felt it was unhelpful to disregard factors at this point. Factor one had one Q-sort that significantly loaded onto it.

4.3.3 Humphrey's Rule

Humphrey's rule 'states that a factor is significant if the cross-product of its two highest loadings exceeds twice the standard error' Brown (1980, p. 223). The standard error is calculated as:

$1 \div (\sqrt{Number\ of\ Q\ set\ Items})$

1÷ (√21) = 0.2182

Rounded up this produces a value of **0.22**, which when doubled to provide the criterion for this rule is **0.44**. This criterion was applied to each of the factors within the unrotated factor matrix:

Factor 1: 0.7657* 0.5068 = 0.39

Factor 2: - 0.1742 * -0.0055 = 0.17

Factor 3: 0.00 * 0.1656 = 0

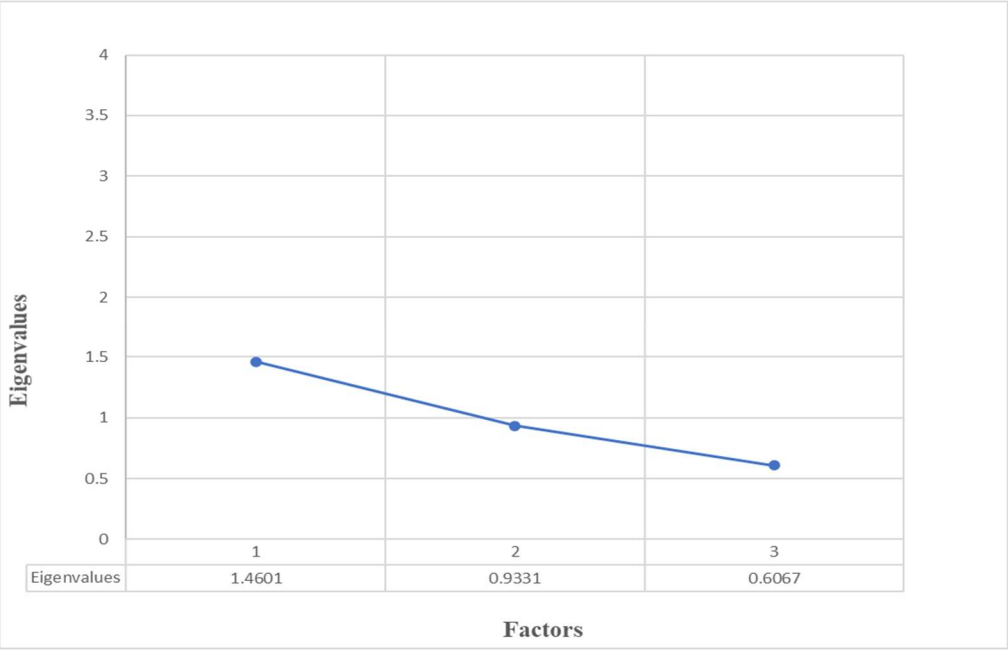
The strict application of Humphrey's rule suggests that none of the factors should be retained. However, Watts and Stenner (2012) explained that Humphrey's rule can be applied less strictly by the product of the two highest factor loadings exceeding the standard error. According to this rule factor 1 should be extracted and retained.

4.3.4 Scree Test

Watts and Stenner (2012) suggest completing a PCA analysis prior to factor extraction. Cattell's (1966) scree test was designed for use with PCA and so PCA extraction using PQMethod to gain the component EVs for the scree plot (figure 2) was carried out. A judgment is made on the scree plot about when the slope of the line changes and levels off (Cattell, 1966; Watts & Stenner, 2012). The factors to the left of where the slope of the line changes should be retained (Cattell, 1966; Watts & Stenner, 2012).

I reviewed the scree plot and in the interest of inter-rater reliability, a trainee educational psychologist colleague who had experience using Q-methodology also reviewed the scree plot. I judged the line to have changed after factor two and the other observer also judged the line to have changed after factor two. This suggested that two factors should be extracted. Noticeably, only the EV of one factor is in excess of 1.00 using the Kaiser-Guttman criterion.

Figure 2: The Scree Plot test graph



In summary the Kaiser-Guttman criterion, significant loading Q-sort criterion and Humphrey's rule indicated that none of the factors should be retained. However, when Humphrey's rule was less strictly applied it suggested that one factor should be extracted and retained. The scree plot suggested two factors should be retained. I judged it most appropriate to proceed with retaining one factor for extraction.

4.4 Factor Rotation

The next step for the Q-analysis is factor rotation. Factor rotation refers to exploring factors from a range of different angles to determine a final factor solution (Van Exel & de Graaf, 2005). Van Exel and de Graaf (2005, p. 9) explain 'rotation does not affect the consistency in sentiment throughout individual Q-sorts or the relationships between Q-sorts, it only shifts the perspective from which they are observed'. There are two approaches typically used for Q methodology factor rotation: Varimax or by hand (Watts & Stenner, 2012). Varimax rotation tries to explain variance by focusing on dominant viewpoints, while by-hand rotation enables the researcher to explore minority viewpoints that may be more

substantive in reality (Watts & Stenner, 2012). Following Watts & Stenner (2012), I used varimax to attain an initial rotation, and then used by hand rotation to support the maximum number of Q-sorts being significantly loaded onto factors. However, the manual rotation did not change the number of Q-sorts being significantly loaded onto factors from what the varimax rotation achieved.

One factor was extracted from the data and rotated using varimax rotation. With the significance value of 0.56, this factor solution had one Q-sort which significantly loaded onto the factor and explained 24% of the study variance with an eigenvalue of 0.71. Two of the Q-sorts were non-significant; however, one Q-sort was identified as a defining sort on the factor although not statistically loaded. Below in table 4 is the final factor solution. The "X" indicates a defining sort for the factor, meaning that it is typical of this factor.

Table 4: The final one-factor solution including the loadings of each Q-sort onto the factor

QSORT	**Loadings** Factor one	**Significantly Loaded**
1	0.4631X	No
2	0.1101	No
3	0.6940X	Yes
% expl.Var.	24	

4.5 Factor Array

The next stage of the data analysis is to produce a factor array for each factor. Watts and Stenner (2012, p. 140) explain that a factor array is 'a single Q-sort configured to

represent the viewpoint of a particular factor'. The array is produced using Z scores for each Q-set item within each factor. A weighted average is used, with participants who correlate more strongly with a factor having a bigger impact on the factor array. I used the factor array to help support the interpretation of the factor.

A table containing each of the Q-set items and the associated rank within the factor array and Z score for each factor can be found within appendix 14.

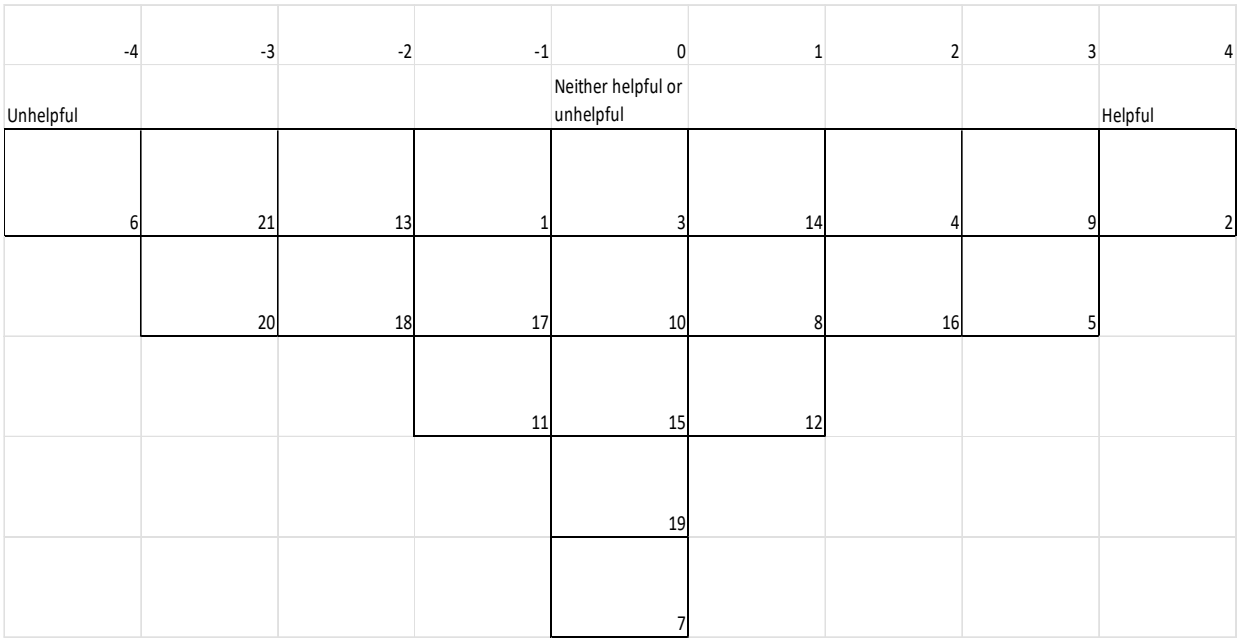
4.6 Factor Interpretation

The final part of data analysis in Q methodology is factor interpretation. I took an abductive approach to the factor interpretation and used the factor array (appendix 15) and qualitative data from the post Q interviews to guide me. Watts and Stenner (2012) suggest that it is important to use a systematic approach in factor interpretation in order to be consistent and transparent. I used elements of Watts and Stenner's (2012) crib sheet approach to support factor interpretation to support a holistic approach to factor interpretation. The crib sheet system involved reviewing the factor array, identifying the items ranked highest and lowest, identifying the demographic information of the participants who significantly loaded onto the factor and finally reviewing the factor array again to decide if any additional or potentially useful items may need adding to the crib sheet. The completed crib sheet for factor one is in appendix 16. As well as using the crib sheet I also used the qualitative data gathered during the post-sorting interviews.

In the next section I will use the terminology viewpoint to refer to the factor extracted, so factor one becomes viewpoint one. I will present the interpretation of this viewpoint alongside supporting evidence from the factor array ratings and direct quotes from the post-sorting interviews.

4.6.1 Viewpoint one- Relationships with staff

Figure 3: The Q-sort factor array for viewpoint one



Viewpoint one explained 24% of the study variance and had an eigenvalue of 0.71.

Two female pupils associated with this viewpoint and one of these pupils Q-sorts significantly loaded onto the viewpoint. Both pupil's medical conditions that led to attendance at the alternative medical education provision was anxiety. One pupil had reintegrated into a further education college and one pupil had reintegrated to a specialist SEMH setting.

Table 5: The demographic information for viewpoint one

Participant	Gender	Medical condition disclosed	Other diagnosis	Age	Setting reintegrated into
1	Female	Anxiety	Autism Spectrum Condition	14	Specialist SEMH
3*	Female	Anxiety	none	16	Further Education College

*** Participant who significantly loaded onto viewpoint one**

Viewpoint one presented strong agreement that it was most helpful to reintegration *when I had a particular member of staff who I could go to in school (2: +4).* It also indicated that participants thought it was helpful to their reintegration when *school staff listened to me and tried to understand me (9: +3).*

Qualitative data indicated that participants with this viewpoint thought that it was important to have a member of staff who understood how they were feeling and who they could talk to when they felt they needed to.

Obviously when I first came here, no one really knew like what I was like in a school environment. So like just having X (staff members name removed) to go to was nice 'cause I knew that she was like in that area of work. She she kind of understood what it was like with mental health and stuff. So it was nice to be able to just go to her specifically and not have to like re explain everything she already know so it was nice to just to be able to go to her and not have to talk about she already knew what was wrong sort of thing.

Participant 3

Like at the start I had different lecturers so we we met different people, but they were all really nice and they I think they adapt to how you behave anyway. So they picked up quite easily, like when I was struggling or not. But yeah, they were they were really understanding of when I'd have to go out of classroom and stuff.

Participant 3

So I could talk about my feelings.

Participant 1 (referring to having a particular member of staff to go to)

This viewpoint suggests that most helpful to reintegration to an education setting from alternative medical education provision is having good relationships with staff in the education setting and that at least one member of staff knowing the pupil well (key adult) is key to a successful reintegration.

Participants with this viewpoint also indicated that it was helpful to their reintegration that *I started school on a part time basis and gradually increased my time here (5:+3).* Qualitative data indicated that participants with this viewpoint expressed that it was important that they felt comfortable in the setting they were reintegrating to and going in on a part time basis helped them with that.

I think it helped with not going full time knowing that I can just go there for an hour. Have a look and then I can go home. I'm not just stuck there and like forced to be there if you get what I mean, but it just helped to fit comfortably into the college.

Participant 3

Other things that participants with this viewpoint still indicated as being helpful were to do with staff believing they could do well (16:+2) and receiving praise when they had done well in school (4:+2). Participants felt it was important that staff recognised when they had achieved something positive for them even when for others it may be easy, and this helped to increase their confidence in what they were doing.

It's it's nice because they they expect something of you.

Participant 3

It's just knowing that I'm doing it right and that I'm not doing it for no reason like just to be complemented on like work that you do, or a nail polish that you've done like it's just. It's just

this they build your confidence up and it's it's help with doing practical work on clients and. Stuff, so yeah, it's nice to be praised.

Participant 3

Participants with this viewpoint indicated that it was somewhat helpful to their reintegration that they received extra support when they needed it from school (14, +1), that they had at least one friend in school when they started (8, +1) and that they could make choices about which lessons they went to (12, +1). Qualitative data suggest that school being able to adapt support was somewhat helpful and having one friend in school was somewhat helpful as they did not want to be on their own when they started at the setting.

So I was given a time out pass and X (staff name removed) who she does like care plans and stuff. So she did a care plan for me. Yeah, if I if I if I said that I needed to talk her like I know that I could see her. I know that I'm not going to be forced to do anything and that I just have to say what I feel and then they they adapt it. So whether I talk to someone, whether I do something, whether I go home, it they just adapted it.

Participant 3

It was, it was well, X (pupil name removed), a girl that I've never met, but we'd talk over social media and then obviously we both found out that we were coming here. So it was like, well, we'll just buddy up together and then just try and get through it. But it was nice to have X because obviously I didn't want to come in on my own I thought it was horrible, so it's nice to have a buddy.

Participant 3

Because I have a person who looks out for me and who is a good friend.

Participant 1

Before we had a plan. Our lecturer that we have now she's obviously set everything out and because I'm more comfortable with it it's not bad, but before because I was just like part time, they didn't really know what was going on like in the college itself so. Yeah, it kind of went on what I was like in the day. Like if I felt something throughout the day then we changed it throughout the day.

Participant 3

Viewpoint one suggested it was less important to their successful reintegration that *I knew what was happening every day and what I should and should not do in school (6:-4).* Qualitative data suggests that this was because they found being in the environment itself difficult and it did not matter if they knew what they were doing or not on any day.

Yeah I I did know but it it didn't make a difference like I think. It wasn't worrying about places where I needed to be. It was just college in general, like being around so it didn't didn't really bother me that I didn't know where I was 'cause I was expecting that, but yeah, but it didn't really bother.

Participant 3

This viewpoint suggests that if they are expecting certain challenges these challenges they face, such as knowing where to go or what they are doing in school have less impact on the success of their reintegration then challenges that were unexpected or that they were not prepared for.

Viewpoint one also indicated that *I took part in activities outside of school hours e.g., after-school clubs or sports team (21: -3)* and *staff in school were aware of the things that I*

need more help with (20: -3) were not very helpful to their reintegration. Qualitative data suggests that any activities outside of school were thought of as extra and participants wanted to focus on been able to complete their work in school without adding to the time they were there. Participants with this view also felt that information was not always passed on to staff and so they rated it as unhelpful because staff were not aware always of their individual needs.

Yeah, I think it was more like them (staff) not fully aware or if someone is aware it's only X (staff name removed) who knows it's not like everyone that has to teach you they don't know like your your signs of you know if your gonna have a panic attack or something. It's things like that like they don't pass on or uhm like needing to go for a breather or things like that. It's just like they don't really get passed on but X (staff name removed). They know that you've got a care plan but they don't know you as in like what can trigger you and things like that.

Participant 3

I just I didn't really want to do activities and stuff like that. I just kind of wanted to do my work and then go home and it was separated so yeah.

Participant 3

Participants with this viewpoint also indicated that it was not particularly helpful to their reintegration that I was asked what I thought about moving here (13: -2). I felt ready to join a school.

I was never asked.

Participant 1

No I wasn't, like no. They obviously they'd say like are you nervous? It's like yeah, I'm excited, nervous but it never like it was just like a brief like yeah, I'm excited. It wasn't really we didn't really talk about it.

Participant 3

Yeah, I think because it was more about making my like, giving myself a date of you know this is when I'm going to go, it was more. It was more just making sure that I was preparing myself for it like I don't know. I didn't really think about it much, it was just. It happened like like that was it just it. Time came to go to college and it was well now you know that you're ready.

Participant 3

Participants with this viewpoint indicated that it was not very helpful to their reintegration to set themselves goals or targets (11, -1), that their parent/carers met with school staff often (17, -1) and that other pupils were kind and welcoming (1, -1). Qualitative data suggests that these things may not have been helpful to their reintegration because they did not happen rather than them been particularly unhelpful.

Everyone just felt awkward and it was like it wasn't. No one would speak to each other, so there wasn't any anything like that going on, like any bitchiness or whatever, but they were they were really. You know you're all new.

Participant 3

There's some nasty ones and some nice ones.

Participant 1

No they didn't meet with staff or anything.

Participant 3

Uh, I didn't find that helpful or helpful like not helpful just because I didn't know where I was anyway and I didn't know uhm, how how I was going to be in college at the start.

Participant 3

Because I don't set targets or goals myself, I just see what happens and that.

Participant 1

Participants with this viewpoint did not indicate strong views on if it was helpful or unhelpful to their reintegration that their parents/carers talked positively about school (10, 0) or that they knew that their parents/carers wanted them to do well in school (3, 0). They suggested that having somewhere to go a break or lunchtimes (7,0) was neither helpful or unhelpful to their reintegration and buddy systems in school (15,0) were not in place when they started. Participants with this viewpoint also felt that preparation to move to their setting by the MET and/or other services (e.g., CAMHS, Family Support, Physiotherapy) (19,0) was neither helpful nor unhelpful to their reintegration.

Summary

Viewpoint one placed significant importance on relationships with staff and having staff who listened and understood how they were feeling. This suggests that having at least one member of staff knowing the pupil well (a key adult) was key to successful reintegration for those who loaded onto viewpoint one. Viewpoint one also indicated that it was helpful to gradually increase time in the setting to help them to feel comfortable in the new setting.

Viewpoint one placed little importance on knowing what was happening in school and what they should or should not do in school and suggested that participants holding this viewpoint felt that it was more the environment itself that they found difficult rather than being unsure about what was happening there at any point. Viewpoint one also indicated that things that were less helpful to their reintegration were because staff were not always aware of their individual needs and participants holding this viewpoint indicated that it would have been helpful if all staff in their new setting knew what their needs were without them needing to explain.

4.7 Non-Significant Q-sorts

Two of the completed Q-sorts did not significantly load onto viewpoint one. However, Q-sort one was still indicated as being a defining sort and therefore was included in the table to show the demographic information for viewpoint one. Q-sort two had not significantly loaded onto viewpoint one; its factor loading and the demographic information for the participant can be found in table 6. I reviewed Q-sort 2 and their qualitative comments to establish if any alternative viewpoints had not been captured within the factor solution.

Participant	Factor Loading 1	Gender	Medical condition disclosed	Other diagnosis	Age	Setting reintegrated into
2	0.1101	Female	Anxiety	Autism Spectrum Condition	15	Mainstream Autism Base

Table 6: The demographic information of non-significant Q-sorts

4.7.1 Q-sort 2

Similar to viewpoint one this Q-sort also identified having a particular member of staff to go to in school (2, +4) as a significant factor in their successful reintegration.

It's really helpful to have someone that I can tell everyone everything to you, and you know, and they'll actually do something about it this week.

Participant 2

This Q-sort uniquely felt that staff being aware of the things they needed more help with (20, +3) was an important factor in their successful reintegration. Unlike viewpoint one this participant felt that staff had a clear idea of the things they needed the most help with and that they were receiving support for those things.

It's all like small things like I hate sitting in the front class 'cause people are behind me and I hate it. So they sat me at the very back, and that's been really great. And also math is the subject I struggle most with and recently a teacher has been in there helping me with it, and that's been really helpful and very understanding. So that's been good.

Participant 2

This Q-sort felt more strongly that other pupils being kind and welcoming was unhelpful (1, -4). Also, unlike viewpoint one this participant disagreed that having at least one friend in school was helpful to their reintegration (8, -3) and indicated that gradually increasing their time (5, -3) was not helpful as they have not been increasing the amount of hours they do in the day, however, they did indicate in the qualitative data that the part time timetable was helpful to their initial reintegration to an education setting.

I just didn't quite happen and actually, I really like that 'cause I didn't I I've got like four friends and that's enough already. Everyone here does their own thing and I really like that there's no like loud talking It's just. It's clearly been in the best way.

Participant 2

Not really friends here.

Participant 2

I don't want to increase hours so it's good.

Participant 2

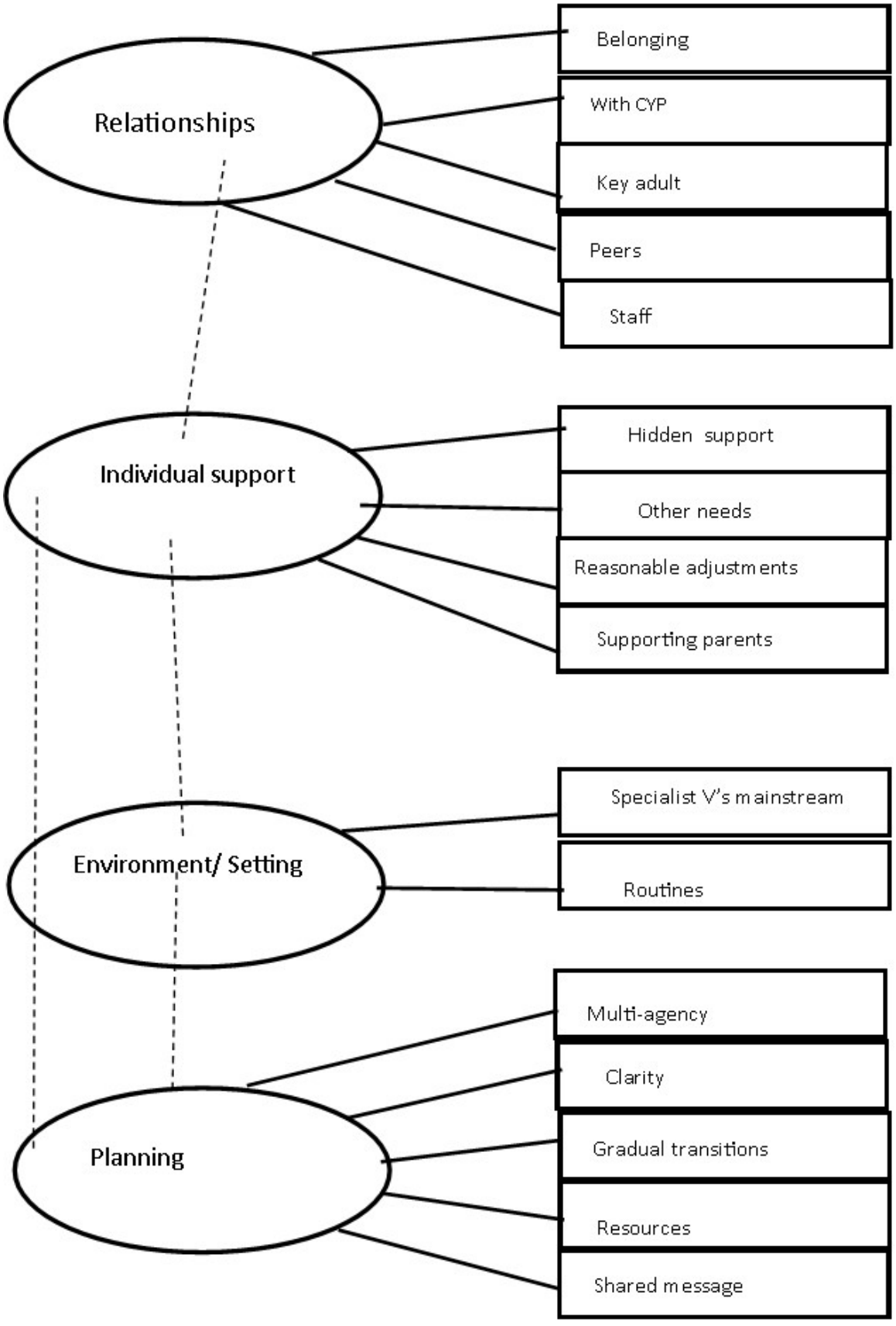
4.8 Introduction to Thematic analysis

This section aims to present key themes and subthemes from the qualitative data gathered through semi-structured interviews with alternative medical education provision staff. Details of the interview participants can be found in Chapter 3 and an example transcript can be found in appendix 17. The themes and subthemes will be presented in a thematic map (see Figure 4), followed by a description and interpretation of each theme.

4.9 Thematic Analysis

Using thematic analysis (Braun & Clarke, 2022) four themes were identified from the data set. In addition, several subthemes were also highlighted. The themes and subthemes and are shown in Figure 4. An example of the coding process is provided in appendix 18.

Figure 4: A thematic map illustrating the themes and subthemes



4.9.1 Individual support

In this theme it was highlighted that there is a need to provide support that is personalised for the individual pupil when reintegrating to an education setting including making adjustments to things such as the timetable or uniform particularly for those pupils reintegrating with mental health needs.

"*Yeah, I mean I, I suppose it would be things like in in terms of, you know, like you said with timetables, but it will be things like perhaps initially getting them to go in just for social times play times, or you know, for the story times if they're little or choose your favourite subject. But there may be some exclusions in the timetable, so for some children, PE, for example, is one of those big no nos, so they may not be required to do PE for example, and things like you know that." (111)*

"Just sometimes, modifications to uniform as well if that is possible and you know sometimes you know to do with particular sensory issues, why I really, really struggle with a tie or shirt or whatever it might be, so it's quite a range of things that can be quite specifically individual to the child that is really important break times as well can be particular stressors." (111)

Participants also suggested that individual support was just as important for those reintegrating with physical health needs to ensure they were physically well enough to attend.

"If it was something like a child returning after you know chemo and again there would need to be certain sort of measures in school in terms of the reduced timetable kind of building up stamina and that kind of thing, but also special considerations if their immunity is compromised in any way and making sure that and you know any concerns of anything that is communicated to parents that may potentially cause an issue for the child should they contract the you know the measles or whatever it is that's going round, you know there."(111)

Emphasis was placed on the need for individual support for pupils reintegrating into a permanent education setting to happen not just at school but also at home and that parents also needed support to help meet the needs of their children and enable them to have a successful reintegration.

"The majority of our work is parents…….I definitely think we need more support for parents 100% and courses line up stuff. We've put things in place and we have offered stuff and X have as well as previously people that ran the X as well before. No, but unfortunately parents that need those courses, opportunities, counselling, are the ones that don't attend or won't meet with people don't really." (112)

It was made clear that the individual support that pupils received needed to not just be focused on their medical needs but also support needed to be more holistic as many of the pupils had a number of other needs that they needed support with such as learning needs to be able to have a successful reintegration.

"Yeah, sometimes there's unmet learning needs as well. You know when they've struggled and struggled and struggled academically with in school. Maybe not had the support that they need really felt like they were failing that they were failures and it's quite difficult once they come to us. You know I've said to schools in the past. I think this child needs, you know, a learning assessment." (113)

Support needing to be hidden from peers was captured in this theme as important to some pupils as participants explained that many pupils were concerned about being perceived as different to their peers so the support that they were given would need to be given in a way where they would not be seen as different from others.

"And and sometimes the children don't want it because the other thing is as well, because they don't want to look different. They don't want to be the new kid who brings their teacher or their TA with them. Sometimes if they're a little more, or you know, sensitive to their, the way that they are perceived. They may not wish to be identified as being any of the any different, because it's their new which is different enough really, isn't it?" (111)

The individual support that pupils needed would need to be explored before the reintegration was due to happen so the individual support they needed could be well planned.

4.9.2 Planning

While planning for a pupil's reintegration the need for a shared vision and expectations of the pupil from all involved was captured within this theme. This included both parents, staff and other professionals involved.

"So it is really important that always the same terminology and have the same vision and have the same expectation as well." (112)

"What has been passed on is passed on to the individual teachers yeah, so that when they are in lessons, they they feel like if they need I don't know turn a card over and walk out or are too shy to ask to go to the toilet or need a little bit of extra support with this you know various things, that they aren't necessarily going to have to explain it every single time." (114)

The subtheme of a shared vision links closely to the subtheme of taking a multi- agency approach to all planning for the pupil's reintegration. Having the right professionals support with the planning of a reintegration to an education setting was viewed as important by participants.

"I mean, the point is whoever is beneficial to the pupil's wellbeing. So it could be a psychiatrist, it could be an ed psych, it's like it could be, you know a SENCO, it could be a

doctor, it could be even be a counsellor, you know depending on you know that persons needs and the nurse if you know if it's diabetes or something like that. Just so we can look at realistic or what measures need to be put in place." (112)

Within the multi-agency subtheme, it became clear that involvement from health professional with education staff is crucial when planning for a pupil's reintegration.

"But yeah, I think the the meeting with the the the school or the OR the setting is really really important and kind of the sharing of that and also as well. You know, in terms of the health input is really important so that we you know the MET are very much steered by health. They tell us what they feel that the child can comfortably do. They tell us to what extent we can, you know, sort of push or encourage the child you know how time might be increased and and that kind of thing" (111)

Emphasis was placed on the need for any plan to be focused on small steps so that the pupil had a gradual transition to their education setting, where they would slowly build up the time they spent there.

"And then perhaps when the child visits that they would offer, you know, a preliminary visit for child and parents and then trial sessions. That there will be a negotiation in terms of the timetable and what the child feels that they can comfortably access with kind of like a stage plan so that they know where there you know where they're going." (111)

Participants felt that it was important for a successful transition that all plans for the reintegration were clear to everyone including parents, staff, and the child. Participants indicated that when there was a lack of clarity in the plan, or someone was unsure this would impact the success of the reintegration. They also suggested that for pupils with additional

needs such as ASC it was very important that they had a clear idea about what was included in the plan and exactly what they should be doing.

"A school being sort of unprepared for the child to come back. Sort of one person hadn't spoken to another person and then their child's not quite sure where they've gotta go or what lessons they're in. You know, a little bit muddled, and that's not what a child needs. A child needs to think that yes, you. you know they're coming in, you know where they've got to go, you know, and there's no stress on their part about that." (114)

"In particular, children that are, you know, have ASD, they they need a plan, and they made very kind of clear parameters." (111)

Participants discussed the importance of schools having available staffing and space to help support the pupil with a gradual reintegration. The subtheme of resources in planning related to the importance of the need to have both space and staffing included in the plan about when, where and how a pupil will reintegrate into an education setting.

"Because we need that space for someone else. But I suppose this you know, the schools just have to manage that really within their resources and everything, it's. Ideally, you know you would hope that every school would have you know some capacity to have smaller groups, wouldn't you? It's it I think you know it varies, doesn't it across schools?... Sometimes you know there there are these places you know like. What what do you call them? Learn learning support bases or whatever within the schools but quite often there's no teaching in there, yeah and and and that's that's tricky. If if they're not ready to go back into their classes, they're not actually having any teaching when they're in there." (113)

The resources an education setting has available including the staffing and where the pupil would be links closely to the next theme of the environment and education setting been central to reintegration.

4.9.3 Environment/setting

In this theme the importance of the environment being appropriate for the individual pupil was highlighted and debate about specialist versus mainstream settings for pupils reintegrating from alternative medical education provision was captured in this theme.

"It wouldn't surprise you to know in terms of kind of resourcing and things that transition in a child with special needs into a specialist setting is a far more successful thing than trying to transition a child back into mainstream when previously mainstream has been unable to kind of meet need." (111)

"Have gone on to specialist provision and and don't like it and want and parents are asking if they can come back to the MET. Because they they were happy at the MET. Uhm, so that's a that's a bit of a difficult situation, really." (113)

Emphasised in this theme was the importance of the pupils being able to become familiar with their new environment and the routines within the education setting they would be reintegrating to as they would likely be very different to the routines, they have in alternative medical education provision.

"Yeah, I suppose it's kind of like, when you go into your new setting, you know phrases like that terminology. Like that and when you are part of your different class or a bigger group, or you know just using familiar language that they'll probably have to get used to, so it's helping them to. You all possibly need to, even the most basic stuff like you may need to stand by your chair before you leave or wait for the bell, things that we don't have in our unit." (112)

"They're in a good place to move on, so all of the things that all of the work that we've done with them on all that preparation that that we do, and sometimes it literally is just the gift of the setting because the setting is small, it's quiet, it's the same people, it's a small number of staff, it's the same people all the time. And so sometimes it is just a matter of reducing that anxiety, getting them back on an even keel, re-engaging them in education in a a different kind of setting. Uhm, that actually is is the the biggest the biggest thing." (111)

Within the settings that participants discussed one of the biggest factors that influenced a pupil's reintegration into the setting was about the relationships pupils had with those within the setting and this is the final theme of relationships.

4.9.4 Relationships

In this theme participants highlighted the importance of pupils feeling like they belong in the setting and staff want them to be there when they reintegrate, and this led to a subtheme of belonging as being key to successful reintegration to an education setting.

"And this so you know, there is a lot of thought that kind of goes into that, but it's also really important, particularly for returning pupil that they feel wanted and welcome and and I have had had experience of children who were obviously extraordinarily challenging within their school settings that have been to us for a period of time, and it was time for them to kind of reintegrate back, and they wanted to go to school."(111)

"So, he did end up trying to transition back to school but there was a feeling that of resistance and reluctance. That certainly would have been communicated within the professionals and meetings and with us sometimes the parents you know we're attending were aware, or you know, or in certain ways aware that the child wasn't really, you know, welcome because they proved difficult previously and staff members were wary." (111)

Emphasis was placed on the need for pupils to have a relationship with at least one member of staff when they started at the new setting who they could go to and who could take the role of a key adult when needed. It was highlighted that this relationship should be built up before the pupil starts at their new education setting.

"Of the things that may not be helpful to start off with, but you know if they've got somebody they can go to, that can be helpful. But if it's not somebody the child met before they go into school, perhaps it takes the time for that to become helpful. So, uhm. That maybe is something that if if they are going to buddy well, give them a mentor somebody at the school. Maybe if they the child could meet them before they go back into school, it would be helpful and and perhaps it's not quite so helpful if they've just gone back and then they're expecting to have somebody they can speak to but if they've never really met them." (114)

"But also that the school then involves themselves wherever possible in transitioning, so coming into the unit and meeting with the child, and so there are some familiar faces and points of connection from from wherever the setting might be and then come in and sort of start to do that handover gradually." (111)

Having positive relationships with staff was captured in this theme as participants indicated relationships with other staff members as well as a key adult such as their tutor or teacher in the new education setting was important for a successful reintegration. A key feature of this subtheme was around pupils needing to feel like they could trust staff to do what they have agreed. Where relationships with staff were not as positive participants indicated this was unhelpful to the reintegration of the pupil.

"Teachers not being there when they promise that they will be. And especially with one chap such severe anxiety and needing to be met outside pupil wasn't there and their teacher wasn't there. And would go home would cry." (112)

"You know, so if we say we are just going to the school and the teachers going to meet you, just show you your classroom and leave. And if the teacher is not there to just do that basic thing, it's kind of like you feel like they feel that they've been tricked or fooled. Or if they do go in and it's a different teacher from what's been promised that can throw them." (112)

"You know I had an example of a child who felt that their particular class teacher had not been sympathetic to their situation prior to them coming to the MET and so did not want to go back with that teacher and needed to avoid that teacher where possible." (111)

As well as participants suggesting that relationships with staff can support a pupil's reintegration but also hinder it if the relationship is negative, relationships with peers were viewed by participants in a similar way, as they were able to have a positive impact in for some pupils but had a negative impact on the reintegration of other pupils.

"Sometimes the children are really keen to go back to school, not necessarily because they they missed school, because often they missed their friends." (111)

"A few of our pupils will still maintain really good friendships within their school and and yeah, that can definitely help them reintegrate." (114)

"Sometimes it's other pupils you know quite often you get relationship, friendship breakdowns and such. And as we know you know children are really sensitive to that sort of thing. Uh, maybe somebody can say the wrong sort of thing and what have you" (114)

One subtheme within the theme of relationships was about doing things with CYP and participants highlighted that it was important that the reintegration was "child led" where the pupil could feel that things were not being done to them by staff but that they were done with them at their pace.

"It is it is child LED and every child is individual and you and you have to take them on on what they're saying to you rather than what you think." (114)

"Uhm, also, as I previously said, some children want you to go you know they'd like you to go back in with them and help them reintegrate back in. Other children don't, then that's where your communication and talking and finding out what they want and what their needs are, rather than anybody just assuming." (114)

4.10 Summary of Thematic Analysis Findings

Overall participants placed a high level of importance on ensuring pupils received individual support to meet their needs when they were reintegrating to a permanent education setting. They perceived that it was most helpful to support the reintegration by ensuring the new setting was supporting all the pupils needs and not just their medical needs, as well as for some pupils, participants felt that it was important for this support to be hidden from their peers. Participants felt strongly that clear planning for reintegration with everyone involved with the pupil was needed to ensure the reintegration was successful. Alongside planning participants highlighted the need for the setting to be the right sort of environment that could meet the individual needs of the pupil when reintegrating. There appeared to be some disagreement over the type of setting that would be best as some participants indicated that specialist settings can often meet the needs of the pupils, but other participants indicated that sometimes reintegration into those settings is not suitable for the pupil. Participants also

emphasised the need for positive relationships with staff and peers as these were considered crucial to pupils being able to successfully reintegrate into the education setting and feel like they belong.

5. DISCUSSION

5.1 Introduction

This chapter will discuss the findings of this research, answering the three research questions by linking the findings to existing literature. The limitations of this research will be discussed and implications for educational psychologists, school staff and future research will be explained.

It needs to be acknowledged that the COVID-19 pandemic had a significant impact on the recruitment of participants particularly for pupils. Due to the timing of data collection recruitment of participants was difficult as pupils were not reintegrated into other education settings during the COVID-19 lockdowns and remote learning for schools. This led to a small population of pupils who were eligible to take part in the research. Initially this research aimed to recruit a broader population of pupils with a wider range of medical needs, however this was not possible. In total only three pupils were recruited to take part in the research. The pupils who were recruited to take part in the research had similar characteristics in that they were all female, aged between 14 and 16 and they all had the same mental health condition of anxiety.

Due to the difficulties with recruitment decisions had to be made about the methods used to gather data and alternatives needed to be considered. Initially the research was focused on gathering the views of pupils with medical needs about what supported their successful reintegration and Q methodology was going to be used to allow pupils to share their views. It was hoped that 10 to 20 pupils could be recruited to share their views using Q-methodology, as this would allow for the full range of viewpoints to be shared. Having only recruited three pupils to share their views, other methods such as interviews were considered.

It would not be possible to explore the full range of viewpoints of pupils with medical needs using Q-methodology with such a small number of participants. Previous research by Grandison (2011) had found the use interviews with CYP with anxiety led to the CYPs voices being muted, as they found it difficult to engage in the interviews and they were not able to answer the questions they were asked. I felt that given that the participants were a vulnerable group who had anxiety, that talking to a stranger about their reintegration may have been difficult for them. Hughes (2017a) suggests that the sorting of statements allows CYP's voices to be raised in a way that is much less influenced by an adult than other methods such as a semi structured interview. Due to this it was decided that it was more important that the method used allowed the pupils to share their views and that they could engage with the method. Therefore, it was decided that Q-methodology should still be used as the method to gather the views of pupils.

The difficulties with recruitment of pupils also led to decisions being made about whether to continue to gather the views of pupils who had already successfully reintegrated into a permanent education setting or whether to ask pupils who were attending the alternative medical education provision what they thought would be helpful to support them with reintegration to a permanent education setting in the future. There was a population of pupils within the alternative medical education setting who could have taken part in this research. However, the Covid-19 pandemic meant that the alternative medical education provision was not allowing visitors into the setting and therefore the Q-methodology would have needed to be completed virtually with the pupils. I felt that this would be challenging for some of the pupils within the setting as it would have been difficult to build a rapport with them virtually. I also had to consider that for many of the pupils withing the alternative medical education provision they may not have been able to answer the question about what they think will help

them when reintegrating to a permanent education setting in the future as they may not be ready to be thinking about moving to a different setting and therefore, they would find it difficult to share their views on the topic. I wanted the research to be focused on what makes a reintegration to a permanent education setting successful and what the pupils felt supported them to make the reintegration successful. This led to the decision to continue to use Q-methodology with those pupils who had successfully reintegrated to a permanent education setting as even though there was a small number their views were still important and central to the research.

The focus of the research on what makes a reintegration to a permanent education setting successful, led to the decision that it would be useful to gather views of staff from the alternative medical education provision, as they have worked with pupils with a broad range of different medical needs. The staff would be able to share their views about what supports pupil's reintegration to a permanent education setting and this would be in addition to gathering the views of the pupils themselves.

5.2 Relating key findings to research questions

Through my analysis of the data, I have answered each of the research questions. The findings of this study align with prior research about what factors both staff and pupils suggest support reintegration to an education setting for those with medical needs from hospital and home settings, as well as the pupils who reintegrate from alternative provisions without medical needs.

Throughout this section I compare the results of the current research to previous literature and discuss the findings. However, the findings of this research have limited generalisability as the CYP who participated in the research were a very small group with a

specific mental health condition (anxiety). This makes it difficult to draw direct comparisons from the current research findings with the findings of previous research. Comparisons with previous research are limited and must be made cautiously, as the CYP in this research have specific needs that are not directly comparable with different groups of CYP with other mental health needs such as depression, eating disorders and psychosis. The findings from the current research can also not be generalised to CYP with anxiety as they are a very specific group of CYP who have other needs as well as anxiety including ASC. It would be inappropriate to view CYP with such a wide range of needs and different mental health conditions as a homogenous group, and therefore it cannot be assumed that they would have similar views about reintegrating to a permanent education setting.

5.2.1 What are the views of children and young people who have received support from alternative medical education provision, and have reintegrated back into an education setting regarding the factors that supported their successful reintegration into the education setting?

Despite this research been open to pupils with a range of physical and mental health needs the three participants who were recruited to take part in the research did share similar characteristics including that all the participants had mental health needs, specifically anxiety. Therefore, I will discuss the findings in relation to the literature focused on supporting pupils with mental health needs.

Viewpoint one indicated that CYP felt that relationships with staff in their current education setting was most helpful at supporting their successful reintegration. However, the views of the CYP did vary as the non-significant Q sort completed by a participant suggested differing views to viewpoint one about:

- Communication of needs
- Peer relationships

Despite this there was consensus between the CYP about:

- Relationships with staff
- Small steps plan

5.2.1.1 Relationships with staff

The literature review highlighted that good relationships were a key factor that helped to promote a successful reintegration for pupils reintegrating from AP, hospital, and home with medical needs (Datta et al., 2006; Iverson, 2018; Pillay et al., 2013). The findings from the current research suggests the same is true for pupils reintegrating from alternative medical education provision. Interestingly this study suggests that pupils feel the most important factor in their successful reintegration was their relationships with staff. Pillay et al. (2013) found that one of the factors that promoted successful reintegration from AP for pupils was good relationships with the adults in school. This is a similar finding to Iverson (2018) who found that pupils felt the support from school staff, peers and family made the biggest impact on their successful return to school following a period in hospital for mental health needs. This suggests that pupils reintegrating from hospital with mental health needs have similar views to pupils reintegrating from medical PRUs with mental health needs about the importance of relationships with staff in school.

Previous research with pupils with mental health needs who reintegrated from AP found that one of the top five facilitating factors was that the pupil was helped to understand and cope with their emotions (Grandison, 2011). Although Grandison (2011) did not directly discuss relationships with school staff, the current research suggests that the relationships

between the staff and pupils are important as the pupils explained they had someone to discuss their feelings with, which is similar to the facilitating factor Grandison (2011) found that the pupil was helped to understand their emotions. It may be that the relationships with staff were important for a successful reintegration so they had someone in school who could help them cope and understand their emotions.

One key finding in the current research was the positive impact on reintegration of having a key adult in the setting that pupils were reintegrating into. This is similar to Atkinson and Rowley (2019) who explored the views of pupils about what supported their reintegration from AP. They found that a common factor was about support from the key systems around the pupil including, having a key adult in school. The large scale study from the National Children's Bureau found that pupils having a key adult in school who they can go to for support with their medical needs was important for supporting pupils with medical needs in school settings (Datta et al., 2006). The current research suggests that this is not just important once in the setting, but the role of the key adult is important from the beginning of the reintegration and the relationship between the pupil and this member of staff should be developed before they reintegrate.

5.2.1.2 Small steps plan

The current research suggests that pupils felt having a reintegration plan that was gradual where they built up time in the setting by starting with small steps supported them when they reintegrated into their current setting. This is similar to the views of pupils reintegrating from AP where they had previously been excluded from school (Atkinson & Rowley, 2019; Pillay et al., 2013). This suggests that having a gradual reintegration is important to pupils who are reintegrating from a different setting whether they are there because of mental health needs or exclusion.

The previous research that highlights the importance of a small steps plan for pupils with mental health needs only explores the views of professionals working with CYP (Marraccini et al., 2019; Savina et al., 2014), rather than the CYP themselves. The current research therefore expands on the current literature as it suggests that a small steps plan is viewed as important to the CYP as well as the professionals supporting them. The current research suggests that pupils felt the small steps plan was helpful to their reintegration because they felt it was supportive for them to be able to choose what lessons they could go to, and that they were able to have an input in the plan where they had been able to have some control around how long they remained in the setting each day during their initial reintegration.

5.2.1.3 Communication of needs

Previous research by Pillay et al. (2013) suggested that CYP felt that communication between home and school was important to their reintegration from AP. However, the current research suggests that some of the CYP felt that staff being aware of the things they needed more help with, and their needs being shared with staff did not support their reintegration and the CYP focused more on the communication within school rather than between home and school. However, the CYP indicated that this could have been useful and supported their reintegration, but they felt that some staff were not aware of their needs.

The views of the CYP in the current research did differ as participant 2 explained that communication between staff did support their reintegration, as staff were all aware of their needs and were able to give them appropriate support as it had been communicated to them. This is similar to Iverson (2018) who found that most of the CYP who reintegrated from hospital due to mental health needs to school settings felt that school staff support was important in their return to school. However, like the current research there were differing

views between the CYP about how well their needs had been communicated and Iverson (2018) explained that one participant had been frustrated that only one member of staff in school gave them the support they needed. Although the CYP differed in their views in the current research about whether this was supportive to their reintegration, those who felt it did not support their reintegration shared that had their needs been passed onto staff it may have made their reintegration easier. This is similar to the views of the CYP in Iverson's (2018) research and suggests that CYP reintegrating from medical PRUs with mental health needs would prefer to have their needs communicated to all staff in school so they can be supported by all staff rather than a small number of staff.

5.2.1.4 Peer relationships

The current research suggests that friendships and peer relationships have a mixed impact on reintegration for CYP from alternative medical education provision. This differs from the views of CYP reintegrating from APs who felt that peer relationships were an important factor that supported their reintegration to school (Atkinson & Rowley, 2019; Pillay et al., 2013). Research focused on those returning to school with mental health needs from hospital settings also differs as Iverson (2018) found that CYP felt that support from peers had a big impact on their successful return to school. This current research may differ in how supportive the CYP found peer relationships to be when reintegrating as unlike Iverson (2018) the CYP in the current research were reintegrating to a new education setting rather than returning to their previous school. The views of the CYP in the current research may also differ in how helpful peer relationships were to their reintegration compared with those reintegrating from APs because of their specific needs, as it may be that their anxiety meant that they did not want to be trying to make friends when they first reintegrated to their new setting. It is also important to consider that in the current research two of the participants also

had a diagnosis of Autism Spectrum Condition, as well as anxiety and their social communication needs related to this may have also impacted their views about how helpful peer relationships were to their reintegration. The current research suggests that for CYP with anxiety reintegrating from a medical PRU peer relationships may or may not be helpful to the reintegration depending on the individual needs and views of the CYP themselves.

5.2.2 What are the views of staff from alternative medical education provision, regarding the factors that supported pupils' successful reintegration into an education setting following support from the medical education provision?

There was a consensus from the views of staff about what supported pupils with their reintegration, however there was some disagreement about whether the type of setting supported their reintegration. All staff agree that individual support, planning and positive relationships with staff and peers in their new setting supported successful reintegration to a permanent education setting.

5.2.2.1 Individual Support

In the current research staff indicated that support for pupils needed to be specific to their needs and making adjustments to things such as the timetable and uniform could really help to support a pupil with their reintegration. This is similar to the views of school psychologists in Marraccini et al. (2019) research as they suggested an individual re-entry plan to support an individual approach to reintegration was important for CYP who were reintegrating with mental health needs following a period of time in hospital.

The staff in the current research also highlighted that they felt it was important for pupils to be supported at home as well as at school. Staff views suggested that parents or carers could help to give support to their children by talking about school positively with

them and this could have a positive impact on their reintegration. Again previous research suggests that school staff have similar views as Finning et al. (2020) found that staff in secondary schools felt that support from home was also important for pupils with mental health needs so that everyone around the pupil can effectively work together at both home and school. The current research suggest that staff felt individual support at home was as important as individual support at school while they were reintegrating to a different setting.

One key thing that was suggested by all staff in the current research was that the individual support that pupils receive in school needed to take a holistic view of their needs and not just focus only on their medical needs, as the factors that impact their reintegration into an education setting are often more complex than just their medical needs alone. Interestingly, previous research suggests that professionals are less focused on the holistic needs of the CYP and more on their individual medical needs when supporting reintegration to school (Savina et al., 2014; Tougas et al., 2019). It may be that staff from the medical PRUs in the current research were more focused on the holistic needs of the CYP because the CYP are reintegrating from an education setting rather than a hospital setting and most of the previous research is focused on pupils reintegrating from hospital settings so professionals involved may be more focused on the health needs of the CYP.

5.2.2.2 Planning

In the current research staff suggested the key factor in the pupils' reintegration was that everyone involved needed to have a shared vision about what will happen for the pupil in the future, and all involved had the same expectations for the pupil. This is similar to the existing literature as the importance of communication and collaboration between professionals (health and education) and families has been identified as vital to supporting

pupils with mental health needs return to school (Marraccini et al., 2019; McKay-Brown et al., 2019; Savina et al., 2014; Tougas et al., 2019).

The current research suggests that the need for multi-agency plans to be developed with health involvement is important for pupils reintegrating from alternative medical education provision with physical and mental health needs. Within the literature collaboration between health and family was also identified as key to supporting pupils' reintegration with mental health needs (Savina et al., 2014; Tougas et al., 2019). This suggests the view of staff is that health input is important as part of the multi-agency planning process before the pupil reintegrates, and it would be expected that the family would be part of those planning meetings alongside education and health staff. There is a clear consensus around staff views about the importance of planning for reintegration of pupils in the current research from a medical PRU and previous research from hospital settings (Marraccini et al., 2019; McKay-Brown et al., 2019; Savina et al., 2014; Tougas et al., 2019).

5.2.2.3 Relationships

In the current research staff indicated that for a reintegration to be successful pupils must feel a sense of belonging in the setting they are reintegrating to and suggested that this came from the relationship they had with staff in school. It was suggested that an important factor for a successful reintegration was that the pupil felt welcomed, and that staff wanted them to be there. This links to the findings of previous research as Savina et al. (2014) found that a key barrier to successful reintegration of CYP from mental health hospitals was negative perceptions and attitudes of teachers. This suggests that staff in school need to have a positive attitude to the CYP who are reintegrating to help them to feel welcomed, so the CYP feel that staff want them to be in school.

One factor that staff viewed as crucial to a successful reintegration in the current research was the pupil was known to at least one member of staff that they could go to who would take the role of the key adult at least during the initial reintegration. Staff in the current research indicated that this relationship needed to ideally be established before the pupil started at the education setting by meeting them while they still attended the alternative education provision, so it was supportive to their reintegration from their first day at the new setting. Interestingly, there was little in previous research about the role of a key adult in school. This may be because the current research focused on reintegration from a type of setting (medical PRU), where many of the CYP reintegrate into new settings and so they do not already know staff and have relationships with staff who they can go to, whereas in previous research most of the reintegration was back into an education setting the CYP had previously attended, whether that was from hospital or home.

Relationships with peers were also discussed as a factor that staff believed could support pupils' reintegration in the current research. However, staff in the current research did explain that when friendships broke down it could hinder the reintegration, so while friendships supported the reintegration for some CYP staff believed that peer relationships sometimes could also have a negative impact on the reintegration. Savina et al's. (2014) research supports the idea that peers can have a negative impact on reintegration as the negative perceptions and attitudes of peers were a key barrier for CYP reintegrating from a mental health hospital. The current research suggests that similar to Savina et al's. (2014) research peer relationships may act as a barrier rather than a factor that supports reintegration of CYP from medical PRUs.

5.2.2.4 Environment/ Setting

In the current research staff views differed when discussing the type of environment or setting that supported the pupil's reintegration. Some staff indicated that often a specialist placement was needed to best support a pupil's reintegration. Other staff indicated that they felt this factor did not always support a pupil's reintegration and they shared experiences of where a specialist setting had not helped to support the reintegration. Interestingly, this factor is different to those found in previous research. This may be because some of the previous research is focused on reintegration into mainstream settings, but it may also be that the views of professionals are that the support the CYP receives is more important to a successful reintegration than the type of setting itself. In the current research staff highlighted that the pupils becoming familiar with the routines, the support that was available in the setting, and the pupils being comfortable in their new environment, was more important to a successful reintegration then whether their placement was specialist or mainstream.

5.2.3 How do professionals' views about what supports reintegration to an education setting following support from the medical education provision compare to the views of the pupils themselves?

There was some consensus between pupil and staff views about what they felt supported a reintegration to be successful about relationships, but pupil and staff views did differ in relation to many other factors. The previous research does not compare the views of professionals and pupils directly on what supports reintegration for those with mental health needs. This section will compare the views of the pupils and staff in the current research and link to previous research on either the views of staff or pupils. Table 7 below show the similarities and differences for key factors in pupil and staff views about what supports a successful reintegration.

Similar	Different
Relationships with staff Relationships with peers	Environment/setting Communication Family/Parental support

Table 7: Similarities and differences in pupil and staff views

5.2.3.1 Agreement between pupil and staff views

In the current research both the pupils and staff felt that positive relationships with staff in schools were vital for a reintegration to be successful. The literature review highlighted that the previous research also suggests that good relationships with staff were a key factor that helped to promote a successful reintegration for pupils reintegrating from AP, hospital, and home with medical needs (Datta et al., 2006; Iverson, 2018; Pillay et al., 2013). Within the current research there was a consensus between staff and the pupils that key adult was an important factor to ensure a successful reintegration. The role of the key adult was not a factor that had been considered before in research on staff views about supporting reintegration of pupils with medical needs, however previous research focused on pupil views on reintegration for AP had suggested that support from the key systems around the pupil including, having a key adult in school helped during their reintegration (Atkinson & Rowley, 2019). It may be that there was little previous research that highlighted the role of the key adult because in previous research most of the reintegration was back into an education setting the CYP had previously attended, whether that was from hospital or home, whereas in the current research the CYP had reintegrated into new settings.

Interestingly, both pupils and staff had mixed views on peer relationships indicating that sometimes peers and friendships in peer groups within the setting can be a supportive factor reintegrating, but both staff and pupil views suggested that this was not always the

case. This view is supported by research from Savina et al. (2014) who found that negative perceptions and attitudes of peers were a key barrier for CYP reintegrating from a mental health hospital.

5.2.3.2 Differences between pupil and staff views

Although staff in the current research discussed the setting itself and suggested that this may be an important factor this was something that pupils did not indicate was an important factor to their reintegration. The pupils in the current research had previously been in mainstream school settings before attending alternative medical education provision. They felt the support from staff and following a gradual plan had more influence than the type of setting on their successful reintegration. This view would align with previous research, as the research on views of professionals does not highlight the type of setting as an important factor to the reintegration of CYP with mental health needs. This may be because some of the previous research is focused on reintegration into mainstream settings, but it may also be that the views of professionals are that the support that the CYP receives is more important to a successful reintegration than the type of setting itself.

The current research suggests that staff view communication between all staff involved in a pupil's reintegration as vital, however the pupils in the research suggested that this was a less important factor. The literature is similar to staff views in this research has also found communication between stakeholders to be vital to a pupil's successful return (Marraccini et al., 2019; McKay-Brown et al., 2019; Savina et al., 2014; Tougas et al., 2019). Interestingly, Wilson et al. (2014) who focused on pupils with physical health needs, found teachers suggested that better communication before the pupil returned to school was needed so they felt better prepared to protect them from additional harm. This is similar to the views of pupils in this study who explained that communication with staff was not an important

factor to their reintegration, because the communication did not always happen, which again suggests this needs to improve when pupils are reintegrating to ensure all staff are aware of their needs. However, previous research on supporting pupils with mental health needs in school does not suggest that communication needs to be improved and this may be because it is assumed that the needs of pupils are communicated to staff in schools. Therefore, the current research adds to previous literature as it highlights that communication between staff could be improved and this may make reintegration from medical PRUs easier for CYP with mental health needs.

The current research suggests that staff felt strongly that parental support was a major factor for successful reintegration of pupils from alternative medical education provision. This view is consistent with research by Thomas (2015) who studied education practitioners views of what are the barriers and facilitators of a successful reintegration from alternative provision for excluded pupils in key stage 1-3. This study found that parental support was considered the most important factor for successful reintegration. However, this differs from the pupils' view in the current research as they shared that parental support was neither helpful nor unhelpful to their reintegration. Previous research that gained professionals views about CYP reintegrating from mental health hospitals suggests that staff shared similar views to the current research that collaboration between health and family was a key factor when returning to school (Savina et al., 2014; Tougas et al., 2019). Interestingly, Thomas (2015), Savina et al. (2014), and Tougas et al.'s (2019) research focused solely on staff views about what impacted on the reintegration of pupils.

On the other hand, Atkinson and Rowley (2019) did explore the views of pupils about what supported their reintegration to mainstream following an exclusion and a placement in alternative provision. This research found that within the common factors they identified for a

successful reintegration family support was one of them. Iverson (2018) also found in interviews with pupils who had returned to school after been in a mental health hospital that the pupils felt support from their family had a big impact on their return to school. The current research differs from the previous research as it suggests that the pupils did not view parental support as highly as previous research had. It may be that although pupils do not view family and parental support to be as important to their reintegration as staff do, they still see that it may still be supportive but that for the participants in the current research they felt other factors were more helpful to their reintegration.

5.3 Research evaluation

Tracy (2010) suggests eight quality criteria for qualitative research. I will consider the strengths and limitations of this research against Tracy's (2010) eight quality criteria.

5.3.1 Worthy topic

Tracy and Hinrichs (2017) explain that a worthy topic in qualitative research is relevant, significant, timely and compelling. This research is able to meet these criteria as I became interested in this particular area of research through my work as a trainee educational psychologist with CYP who were reintegrating to a permanent education setting from medical education alternative provision. Also, the literature review highlighted that the voice of these CYP is underrepresented in the research and what is known about what can support reintegration to a permanent education setting for these CYP often comes from what professionals say is supportive. Therefore, the current research can be viewed as a worthy topic.

5.3.2 Rich rigour

Tracy and Hinrichs (2017) state that rigour is demonstrated in qualitative research by methodological thoughtfulness and attention to detail. Rich rigour is about the research using appropriate procedures for data gathering and analysis and having enough detailed data about the topic being studied (Tracy, 2010). Three pupils and four members of staff gave their views. The use of Q-methodology with post-Q interviews for the pupils provided a large amount of data. This procedure allowed the pupils to share their views with me in a way that was comfortable for them. The use of semi-structured interviews with staff produced a vast amount of data that I became familiar with as I transcribed myself for the thematic analysis.

The research statements that the pupils sorted were shared and discussed with staff prior to the Q-sorts being completed with pupils. However, a piloting of the statements with the CYP themselves may have been more useful, but due to the difficulties with recruitment this was not possible.

5.3.3 Sincerity

Tracy and Hinrichs (2017) explain that sincerity is achieved through self- reflexivity and transparency from the researcher. Throughout the research I kept a reflective diary to help me to consider how my own values may be impacting the data. However, it is important to reflect that the staff participants knew me through my professional role as a trainee educational psychologist, as well as a researcher and they may have been influenced to provide answers to my questions during the semi structured interviews that they felt would be in line with my views. I have endeavoured to be transparent about the difficulties with recruitment and the decisions that were made about the research because of this.

5.3.4 Credibility

In qualitative research credibility comes from the consistency and accuracy of a study's findings (Tracy & Hinrichs, 2017). Tracy (2010) explains that credibility can come from the use of thick description and evidence of multivocality. To gain thick description and multivocality in this research I have included direct quotations from both the CYP and the staff. Although I have interpreted the data and generated themes through my engagement with the data readers are able to view the participant own perspectives through the quotations used.

5.3.5 Resonance

Resonance is the extent to which the research can meaningfully impact its audience (Tracy, 2010). The use of direct quotations from the CYP and staff allow the reader to view the perspectives of the participants and develop an understanding of their individual situations and circumstances.

5.3.6 Significant Contribution

It appears that the current research is the first to gain the views of CYP who have had a successful reintegration to a permanent education setting from alternative medical education provision. The research findings have led to implications for staff working with CYP who are reintegrating from a medical education alternative provision to a permanent education setting. Although this research is not directly transferable to other CYP as the CYP in this research had very specific needs it gives a starting point for future research exploring the voice of CYP in this area of research.

5.3.7 Ethics

Tracy (2010) explains for research to be of high quality it needs to follow ethical guidelines. Ethical approval was obtained from the University of Birmingham's Humanities

and Social Sciences Ethical Review Committee. Ethical considerations were made using the guidance provided by the BPS Code of Conduct and Ethics (2018) and the British Educational Research Association (BERA) Ethical Guidelines for Educational Research (2018).

It was important for me to address the power imbalances that would exist between myself and the participants. I felt that given that the participants were a vulnerable group many who had mental health needs, including anxiety, that talking to a stranger about their reintegration may have been difficult for them. Hughes (2017a) suggests that the sorting of statements allows CYP's voices to be raised in a way that is much less influenced by an adult than other methods such as a semi structured interview. Q-methodology is viewed as an ethical methodology, as it gives a voice to all participants, including minority voices (Hughes, 2017b). Ravet (2007) explained that an unavoidable power difference exists between children and adults and therefore I concluded that Q methodology would be an appropriate method to do this as I would not be imposing my viewpoints on the participants.

5.3.8 Meaningful Coherence

The final criteria is meaningful coherence and this is evident when all sections of the research flow together so that it is both coherent and meaningful for the reader (Tracy & Hinrichs, 2017). The current research identified a gap in the literature through the literature review which led to the development of the research questions. The approaches used for gathering data were justified in order to meet the aims of the research about gathering the views of CYP and staff about successful reintegration from alternative medical education provision to a permanent education setting. The data was then analysed, and the findings were directly discussed in relation to the research questions and previous relevant research. Implications for adults working with CYP who are reintegrating from alternative medical education provision to a permanent education setting came from the findings of this research.

5.4 Limitations of research

I will now consider the strengths and limitations of the research in relation to the methodology and discuss issues related to recruitment of participants, data collection, data analysis and my own influence on the research.

5.4.1 Data collection

Justification for the use of Q methodology and semi structured interviews to collect data can be found in chapter 4.

5.4.1.1 Q methodology

In conducting the factor analysis, I found one factor. However, there was variation within the participant group as there were only three participants. This variation may not have been represented through the one factor. Therefore, I felt it was necessary to highlight the views shared from the non-significant Q sort when they differed from viewpoint one.

5.4.1.2 Thematic analysis

An inductive approach to thematic analysis that allowed for themes to be produced through intense analysis of the data was used in this research (Braun & Clarke, 2022). It may be considered that some of the richness of the data is lost through the process of thematic analysis because things such as tone of voice and body language are not included in the analysis. However, I felt that this was not needed as I was trying to get an overview about the factors supporting reintegration for pupils from alternative medical education provision and this research on reintegration would be the first to focus on successful reintegration from alternative medical education provision.

Thematic analysis could also be criticised as the researcher will always influence the results because the themes are generated through the researcher's engagement with the data. I

attempted to reduce the impact of this by keeping a reflective diary (example entry below) and following the six phase process to thematic analysis (Braun & Clarke, 2022) outlined in chapter 4.

"Phase two- coding (initial) I think I may have moved into phase three while doing coding as I'm starting to think about the initial themes." (Reflective diary entry 24/02/22)

"Need a break from thematic analysis. I've generated initial map but need to step away before reviewing. I'm becoming aware of my own thoughts influencing the parts of transcripts I'm using against the initial themes." (Reflective diary entry 27/02/22)

5.4.1.3 Reflexivity

I was influenced by my own interest in supporting children with medical needs and my previous roles of supporting these children. However, it is important to reflect that the staff participants knew me through my professional role as a trainee educational psychologist, as well as a researcher and they may have been influenced to provide answers to my questions during the semi structured interviews that they felt would be in line with my views. Throughout the research I kept a reflective diary to help me to consider how my own values may be impacting the data. Example entries from my reflective diary can be found in the previous section.

5.5 Implications

The central implication of this research for adults who work with CYP with medical needs who are reintegrating to a permanent education setting, is about supporting CYP to engage with their reintegration and enabling them to share their views. The current research aimed to empower the CYP to share their views about reintegration. The use of Q-methodology to gain the views of CYP and the findings that came from this data highlights

the value of listening to the views of CYP and empowering them to have their voices heard. This implication is significant for all adults supporting CYP with medical needs who are reintegrating to a permanent education setting, because the findings of the current research highlight that each pupil will require different support with their reintegration. The individual differences in the views of the CYP in the current research suggests CYP with mental health needs reintegrating to permanent education cannot be treated as a homogenous group, as there is such a wide range of needs and conditions within this group. Even where CYP have the same medical need such as anxiety, their views about what they need to support may be different and therefore we cannot group all CYP with the same medical condition such as anxiety together.

5.5.1 Implications for educational psychologists

Educational psychologists are well placed to offer support with facilitating consultations within education settings (Meyers, 1973; Wagner, 1995; Wagner, 2000). This research highlighted the importance of multi-agency planning and working collaboratively. Educational psychologists would be well placed to facilitate this consultation with professionals from both education and health as well as families and pupils to help support development of a clear small steps action plan for reintegration. Educational psychologists are also well placed to support with a reintegration plan using person-centred planning tools such as planning alternative tomorrows with hope as this will keep a child or young person at the centre of the reintegration plan (Pearpoint et al., 1993; Sanderson, 2000a, 2000b). Educational psychologists may also be able to support setting staff with ways to support obtaining the views of the CYP who are reintegrating by delivering training to staff who are working closely with the CYP.

5.5.2 Implications for school staff

The most important implication for school staff where CYP are reintegrating following support in an alternative medical education provision is about the need for a member of staff to have already built up a positive relationship with the pupil before they start at their setting so they have someone they can go to who knows them well and understands their needs. This means that schools will need to allow a staff member time to visit the pupil while they are in the alternative medical education provision, in order to begin to build up a rapport and get to know the pupil. Another implication for school staff is about ensuring that messages about the support the pupil reintegrating needs are passed on to all staff who will work with the pupil, so the adjustments and support they need can be made throughout the school day to make their reintegration into the setting easier. School staff also all need to ensure that it is not just the key adult who has a positive relationship with the pupil but that all staff build positive relationships with the pupil and show them that they believe they can do well and give them the support when needed.

5.5.3 Implications for future research

The findings build on the existing body of literature that exists about what supports pupils with medical needs reintegrating into an education setting, but it extends this by focusing on reintegration from an alternative education medical provision. This research also helps to present the voice of children and young people with medical needs and share their views about what they feel supports them with reintegration. However, as this research focuses only on those pupils' views with mental health needs it may be useful to expand this further and future research could study the reintegration for those pupils with physical health needs. It may then be useful to compare the views of what supports pupils' reintegration with physical health needs to what supports pupils' reintegration with mental health needs. This

research also only focused on pupils in key stage four and five and therefore it would be useful to research the views of pupils in key stage one, two and three with medical needs about what supports reintegration into an education setting.

5.6 Conclusions

This research aimed to find out the views of pupils and staff about what supports successful reintegration to a permanent education setting from alternative medical education provision. Through a mixed methods approach using Q methodology with pupils and semi structured interviews with staff that were analysed using thematic analysis, factors were able to be identified that supported successful reintegration including relationships with staff, planning, individual support, and communication. Limitations of this research include the transferability of the data and issues with recruitment. Implications for future practice include the need for a key adult to develop a relationship with the pupil before reintegration and ensuring the needs of the pupil are communicated to all staff. These things need to happen in order to give pupils with medical needs a successful and positive reintegration into a permanent education setting.

6. REFERENCES

Alase, A. (2017). The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach. *International journal of education and literacy studies*, *5*(2), 9. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Atkinson, G., & Rowley, J. (2019). Pupils' views on mainstream reintegration from alternative provision: a Q methodological study. *Emotional & Behavioural Difficulties*, *24*(4), 339-357. https://doi.org/10.1080/13632752.2019.1625245

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2022). *Thematic analysis : a practical guide*. Los Angeles : SAGE.

Briesch, A. M., Cintron, D. W., Dineen, J. N., Chafouleas, S. M., McCoach, D. B., & Auerbach, E. (2019). Comparing Stakeholders' Knowledge and Beliefs About Supporting Students' Social, Emotional, and Behavioral Health in Schools. *School mental health*, *12*(2), 222-238. https://doi.org/10.1007/s12310-019-09355-9

Brown, S. R. (1980). *Political Subjectivity: Applications of Q Methodology in Political Science*. Yale University Press.

Carol, J. K., & Judith, O. R.-T. (2013). Addressing Student Mental Health Needs by Providing Direct and Indirect Services and Building Alliances in the Community. *Professional school counseling*, *16*(5), 323-332. https://doi.org/10.5330/PSC.n.2013-16.323

Carroll, C., & Hurry, J. (2018). Supporting pupils in school with social, emotional and mental health needs: a scoping review of the literature. *Emotional & Behavioural Difficulties*, *23*(3), 310-326. https://doi.org/10.1080/13632752.2018.1452590

Cattell, R. B. (1966). The scree test for the number of factors. *Multivariate Behavioral Research*, *1*(2), 245-276.

Children and Families Act. (2014). HMSO Retrieved from https://www.legislation.gov.uk/ukpga/2014/6/part/5/crossheading/pupils-with-medical-conditions

Clarke, D. M., & Currie, K. C. (2009). Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence. *Med J Aust*, *190*(S7), S54-60. https://doi.org/10.5694/j.1326-5377.2009.tb02471.x

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (Third edition. ed.). Los Angeles : SAGE.

Datta, J., Ryder, N., & Madge, N. (2006). Meeting medical needs in mainstream education. *National Children's Bureau*.

Davies, S. C., Bernstein, E. R., & Daprano, C. M. (2020). A Qualitative Inquiry of Social and Emotional Support for Students with Persistent Concussion Symptoms. *Journal of educational and psychological consultation*, *30*(2), 156-182. https://doi.org/10.1080/10474412.2019.1649598

Department for Education. (2013a). *Alternative Provision Statutory guidance for local authorities* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942014/alternative_provision_statutory_guidance_accessible.pdf

Department for Education. (2013b). *Ensuring a good education for children who cannot attend school because of health needs*. Retrieved from

https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school
Department for Education. (2015). *Supporting pupils at school with medical conditions*. Retrieved from https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3
Education Act. (1966). HMSO Retrieved from https://www.legislation.gov.uk/ukpga/1996/56/contents
Egger, H. L., Costello, E. J., & Angold, A. (2003). School refusal and psychiatric disorders: a community study. *J Am Acad Child Adolesc Psychiatry*, *42*(7), 797-807. https://doi.org/10.1097/01.Chi.0000046865.56865.79
Ettel, D., Glang, A., Todis, B., Davies, S., & Ettel, A. (2016). Traumatic Brain Injury: Persistent Misconceptions and Knowledge Gaps Among Educators. *Exceptionality Education International*, *26*, 1-18. https://doi.org/10.5206/eei.v26i1.7732
Finch, M. E. H., Finch, W. H., Mcintosh, C. E., Thomas, C., & Maughan, E. (2015). Enhancing collaboration between school nurses and school psychologists when providing a continuum of care for children with medical needs. *Psychology in the Schools*, *52*(7), 635-647. https://doi.org/https://doi.org/10.1002/pits.21854
Finning, K., Ukoumunne, O. C., Ford, T., Danielsson-Waters, E., Shaw, L., Romero De Jager, I., Stentiford, L., & Moore, D. A. (2019). The association between child and adolescent depression and poor attendance at school: A systematic review and meta-analysis. *J Affect Disord*, *245*, 928-938. https://doi.org/10.1016/j.jad.2018.11.055
Finning, K., Waite, P., Harvey, K., Moore, D., Davis, B., & Ford, T. (2020). Secondary school practitioners' beliefs about risk factors for school attendance problems: a qualitative study. *Emotional and behavioural difficulties*, *25*(1), 15-28. https://doi.org/10.1080/13632752.2019.1647684
Forrest, C. B., Bevans, K. B., Riley, A. W., Crespo, R., & Louis, T. A. (2011). School outcomes of children with special health care needs. *Pediatrics*, *128*(2), 303-312. https://doi.org/10.1542/peds.2010-3347
Georgiadi, M., & Kourkoutas, E. E. (2010). Supporting pupils with cancer on their return to school: a case study report of a reintegration program. *Procedia - Social and Behavioral Sciences*, *5*, 1278-1282. https://doi.org/https://doi.org/10.1016/j.sbspro.2010.07.275
Glaser, B. G. (1998). *Doing grounded theory : issues and discussions*. Mill Valley, CA : Sociology Press.
Gough, B., & Madill, A. (2012). Subjectivity in Psychological Science: From Problem to Prospect. *Psychol Methods*, *17*(3), 374-384. https://doi.org/10.1037/a0029313
Grandison, K. (2011). School Refusal And Reintegration: From Short Stay School To Mainstream *University of Birmingham Research Archive : e-theses repository* file:///C:/Users/byngc/OneDrive/Documents/University/Thesis/Volume%201/4.%20Literature%20review%20chapter/Search%20Strategy/ETHoS/Grandison_11_EdPsychD.pdf
Grant, M. (2020). *Pupils With SEMH Needs' Experiences Of a Successful Transition To Secondary School. A Grounded Theory Study*. Tavistock and Portman NHS Foundation Trust/University of Essex. http://repository.essex.ac.uk/28892/2/Thesis%20%20Marisha%20Grant%2007032942%20FINAL%20PDF.pdf

Harris, M. S. (2009). School reintegration for children and adolescents with cancer: The role of school psychologists. *Psychol. Schs*, *46*(7), 579-592. https://doi.org/10.1002/pits.20399

Hinton, D., & Kirk, S. (2015). Teachers' perspectives of supporting pupils with long term health conditions in mainstream schools: a narrative review of the literature. *Health Soc Care Community*, *23*(2), 107-120. https://doi.org/10.1111/hsc.12104

Holder, M., & Coleman, B. (2015). Children's Friendships and Positive Well-Being. *Friendship and Happiness: Across The Life-Span and Cultures*, 81-94. https://doi.org/10.1007/978-94-017-9603-3_5

Hughes, M. (2017a). A jolly good sort: The influence of Q Methodology on practice that aims to interpret and represent voice. In J. Hardy & C. Hobbs (Eds.), *Using qualitative research to hear the voice of children and young people*. British Psychological Society.

Hughes, M. (2017b). Joining the Q: What Q Methodology Offers to a Critical Educational Psychology. In A. Williams, T. Billington, D. Goodley, & T. Corcoran (Eds.), *Critical Educational Psychology*. John Wiley & Sons Ltd.

Iverson, P. J. (2018). Adolescents' experiences returning to school after a mental health hospitalization [Educational Psychology 3500]. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, *78*(10-A(E)), No-Specified. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc15&NEWS=N&AN=2017-33535-292 (Dissertation Abstracts International)

Kasamatsu, T., Cleary, M., Bennett, J., Howard, K., & McLeod, T. V. (2016). Examining academic support after concussion for the adolescent student-athlete: Perspectives of the athletic trainer [Physical & Somatoform & Psychogenic Disorders 3290]. *Journal of Athletic Training*, *51*(2), 153-161. https://doi.org/http://dx.doi.org/10.4085/1062-6050-51.4.02

Kesting, S. V., Gotte, M., Seidel, C. C., Rosenbaum, D., & Boos, J. (2016). One in Four Questioned Children Faces Problems Regarding Reintegration Into Physical Education at School After Treatment for Pediatric Cancer: Problems of Reintegration Into Physical Education. *Pediatric blood & cancer*, *63*(4), 737-739. https://doi.org/10.1002/pbc.25852

Kjellström, J., Modin, B., & Almquist, Y. B. (2017). Support From Parents and Teachers in Relation to Psychosomatic Health Complaints Among Adolescents. *J Res Adolesc*, *27*(2), 478-487. https://doi.org/10.1111/jora.12281

Kljakovic, M., & Kelly, A. (2019). Working with school-refusing young people in Tower Hamlets, London [Health & Mental Health Services 3370]. *Clinical Child Psychology and Psychiatry*, *24*(4), 921-933. https://doi.org/http://dx.doi.org/10.1177/1359104519855426

Linden, M. A., Braiden, H. J., & Miller, S. (2013). Educational professionals' understanding of childhood traumatic brain injury. *Brain Inj*, *27*(1), 92-102. https://doi.org/10.3109/02699052.2012.722262

Lindsay, S., Hartman, L. R., Reed, N., Gan, C., Thomson, N., & Solomon, B. (2015). A Systematic Review of Hospital-to-School Reintegration Interventions for Children and Youth with Acquired Brain Injury. *PLOS ONE*, *10*(4), e0124679. https://doi.org/10.1371/journal.pone.0124679

Lorraine, D., Richard, W. A., & Shannon, T.-B. (2013). The Role of School Counselors in Meeting Students' Mental Health Needs: Examining Issues of Professional Identity.

Professional school counseling, *16*(5), 271-282. https://doi.org/10.1177/2156759X0001600502

Lum, A., Wakefield, C., Donnan, B., Burns, M., Fardell, J., Jaffe, A., Kasparian, N., Kennedy, S., Leach, S., Lemberg, D., & Marshall, G. (2019). Facilitating Engagement With School in Students With Chronic Illness Through Positive Education: A Mixed-Methods Comparison Study. *School Psychology*, *34*(6), 677-686. https://doi.org/10.1037/spq0000315

Luthar, S. S., Kumar, N. L., & Zillmer, N. (2020). Teachers' responsibilities for students' mental health:Challenges in high achieving schools. *International journal of school & educational psychology*, *8*(2), 119-130. https://doi.org/10.1080/21683603.2019.1694112

Mansfield, R., Humphrey, N., & Patalay, P. (2021). Educators' perceived mental health literacy and capacity to support students' mental health: associations with school-level characteristics and provision in England. *Health Promot Int*. https://doi.org/10.1093/heapro/daab010

Marraccini, M. E., Lee, S., & Chin, A. J. (2019). School Reintegration Post-Psychiatric Hospitalization: Protocols and Procedures Across the Nation. *School mental health*, *11*(3), 615-628. https://doi.org/10.1007/s12310-019-09310-8

McClanahan, R., & Weismuller, P. C. (2014). School Nurses and Care Coordination for Children With Complex Needs: An Integrative Review. *The Journal of School Nursing*, *31*(1), 34-43. https://doi.org/10.1177/1059840514550484

McKay-Brown, L., McGrath, R., Dalton, L., Graham, L., Smith, A., Ring, J., & Eyre, K. (2019). Reengagement with education: A multidisciplinary home-school-clinic approach developed in Australia for school-refusing youth [Special & Remedial Education 3570]. *Cognitive and Behavioral Practice*, *26*(1), 92-106. https://doi.org/http://dx.doi.org/10.1016/j.cbpra.2018.08.003

McKeown, B., & Thomas, D. (1988). *Q methodology*. Newbury Park, Calif. London : Sage Publications.

Mealings, M., & Douglas, J. (2010). 'School's a big part of your life …': Adolescent Perspectives of Their School Participation Following Traumatic Brain Injury. *Brain Impairment*, *11*(1), 1-16. https://doi.org/10.1375/brim.11.1.1

Meyers, J. (1973). A consultation model for school psychological services. *Journal of school psychology*, *11*(1), 5-15. https://doi.org/10.1016/0022-4405(73)90003-4

Mohr, J. D., & Bullock, L. M. (2005). Traumatic Brain Injury: Perspectives From Educational Professionals. *Preventing School Failure: Alternative Education for Children and Youth*, *49*(4), 53-57. https://doi.org/10.3200/PSFL.49.4.53-57

Moore, C. P., Ohrt, J., & Packer-Williams, C. L. (2020). A Solution-Focused Approach to Student Reintegration into the Traditional School Setting after a Disciplinary Alternative School Placement. *Journal of child and adolescent counseling*, *6*(2), 83-96. https://doi.org/10.1080/23727810.2020.1719350

Moore, G., Angel, L., Brown, R., van Godwin, J., Hallingberg, B., & Rice, F. (2021). Socio-Economic Status, Mental Health Difficulties and Feelings about Transition to Secondary School among 10-11 Year Olds in Wales: Multi-Level Analysis of a Cross Sectional Survey. *Child Indic Res*, *14*(4), 1597-1615. https://doi.org/10.1007/s12187-021-09815-2

NASEN. (2018). Children with medical needs: What schools and settings need to know. In *A guide for all leadership, all staff, governors, link person for medical needs, clinicians, and other agencies*. Staffordshire: NASEN & UCL Centre for Inclusive Education.

Parkin, A. E., Maas, F., & Rodger, S. (1996). Factors contributing to successful return to school for students with acquired brain injury: Parent perspectives. *Australian Occupational Therapy Journal*, *43*(3-4), 133-141. https://doi.org/https://doi.org/10.1111/j.1440-1630.1996.tb01849.x

Pearpoint, J., O'Brien, j., & Forest, M. (1993). *PATH: A workbook for planning positive, possible futures and planning alternative tomorrows with hope for schools, organizations, businesses and families*. Inclusion Press.

Pillay, J., Dunbar-Krige, H., & Mostert, J. (2013). Learners with behavioural, emotional and social difficulties' experiences of reintegration into mainstream education. *Emotional and behavioural difficulties*, *18*(3), 310-326. https://doi.org/10.1080/13632752.2013.769709

Pini, S., Gardner, P., & Hugh-Jones, S. (2016). How teenagers continue school after a diagnosis of cancer: experiences of young people and recommendations for practice. *Future Oncol*, *12*(24), 2785-2800. https://doi.org/10.2217/fon-2016-0074

Preyde, M., Parekh, S., Warne, A., & Heintzman, J. (2017). School Reintegration and Perceived Needs: The Perspectives of Child and Adolescent Patients During Psychiatric Hospitalization. *Child & adolescent social work journal*, *34*(6), 517-526. https://doi.org/10.1007/s10560-017-0490-8

Psihogios, A., & Baber, K. (2017). "Stop My Pain, but Don't Send Me to School!" A Pediatric Case of Irritable Bowel Syndrome and School Absenteeism. *Clin. pract. pediatr. psychol.*, *5*(2), 186-191. https://doi.org/10.1037/cpp0000188

Ravet, J. (2007). Making sense of disengagement in the primary classroom: a study of pupil, teacher and parent perceptions. *Research papers in education*, *22*(3), 333-362. https://doi.org/10.1080/02671520701497589

Rohrig, S. N., & Puliafico, A. C. (2018). Treatment of School Refusal in an Adolescent With Comorbid Anxiety and Chronic Medical Illness. *Evidence-based practice in child and adolescent mental health*, *3*(3), 129-141. https://doi.org/10.1080/23794925.2018.1447855

Sanderson, H. (2000a). *PATH*. Helen Sanderson Associates. Retrieved 20/04/21 from http://helensandersonassociates.co.uk/person-centred-practice/paths/

Sanderson, H. (2000b). *Person centred planning: Key features and approaches*. Joseph Rowentree Foundation. Retrieved 15/03/2020 from www.familiesleadingplanning.co.uk/documents/pcp%20key%20features%20and%20styles.pdf

Savina, E., Simon, J., & Lester, M. (2014). School Reintegration Following Psychiatric Hospitalization: An Ecological Perspective. *Child & youth care forum*, *43*(6), 729-746. https://doi.org/10.1007/s10566-014-9263-0

Schmolck, P. (2014). *PQMethod (2.35)*. http://schmolck.org/qmethod/

Selekman, J., & Calamaro, C. J. (2014). Comprehensive Pediatric Care Includes Communication With the School Nurse. *The Journal for Nurse Practitioners*, *10*(1), 36-41. https://doi.org/https://doi.org/10.1016/j.nurpra.2013.10.005

Seymour, C. (2004). Access to education for children and young people with medical needs: a practitioner's view. *Child: Care, Health & Development*, *30*(3), 249-255. https://doi.org/10.1111/j.1365-2214.2004.00408.x

Soejima, T., Sato, I., Takita, J., Koh, K., Maeda, M., Ida, K., & Kamibeppu, K. (2015). Support for school reentry and relationships between children with cancer, peers, and teachers. *Pediatrics International*, *57*(6), 1101-1107. https://doi.org/10.1111/ped.12730

Stevens, S. A., Provvidenza, C., Zheng, S., Agnihotri, S., Hunt, A., & Scratch, S. E. (2021). Understanding the Needs of Ontario Educators in Supporting Students With Acquired Brain Injury in the Classroom. *J Sch Health*, *91*(4), 285-290. https://doi.org/10.1111/josh.13001

Tashakkori, A., & Teddlie, C. (2003). *Handbook of mixed methods in social & behavioral research*. Thousand Oaks, Calif. London : SAGE Publications.

Thomas, D. V. (2015). Factors affecting successful reintegration. *Educational Studies: Managing and Improving School Attendance and Behaviour: New Approaches and Initiatives*, *41*(1-2), 188-208. https://doi.org/10.1080/03055698.2015.955749

Thomas, G. (2017). *How to do your research project : a guide for students in education and applied social sciences* (3rd edition. ed.). London : SAGE Publications.

Tougas, A.-M., Rassy, J., Frenette-Bergeron, E., & Marcil, K. (2019). "Lost in Transition": A Systematic Mixed Studies Review of Problems and Needs Associated with School Reintegration After Psychiatric Hospitalization. *School mental health*, *11*(4), 629-649. https://doi.org/10.1007/s12310-019-09323-3

Tracy, S. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, *16*, 837-851. https://doi.org/10.1177/1077800410383121

Tracy, S. J., & Hinrichs, M. M. (2017). Big Tent Criteria for Qualitative Quality. In *The International Encyclopedia of Communication Research Methods* (pp. 1-10). https://doi.org/https://doi.org/10.1002/9781118901731.iecrm0016

Tresman, R., Brown, M., Fraser, F., Skinner, R., & Bailey, S. (2016). A School Passport as Part of a Protocol to Assist Educational Reintegration After Medulloblastoma Treatment in Childhood. *Pediatr Blood Cancer*, *63*(9), 1636-1642. https://doi.org/10.1002/pbc.26071

Van Exel, J., & de Graaf, G. (2005). *Q Methodology: A Sneak Preview.* https://qmethod.org/2016/01/08/q-methodology-a-sneak-preview-van-exel-n-job-a-de-graaf-gjalt-2005/

Vanclooster, S., Benoot, C., Bilsen, J., Peremans, L., & Jansen, A. (2018). Stakeholders Perspectives on Communication and Collaboration Following School Reintegration of a Seriously Ill Child: A Literature Review. *Child & youth care forum*, *47*(4), 583-612. https://doi.org/10.1007/s10566-018-9443-4

Vanclooster, S., Bilsen, J., Peremans, L., Van Der Werff Ten Bosch, J., Laureys, G., Paquier, P., & Jansen, A. (2019). Reintegration Into School After Treatment for a Brain Tumor: The Child's Perspective. *Glob Pediatr Health*, *6*, 2333794X19860659-12333794X19860659. https://doi.org/10.1177/2333794X19860659

Vanclooster, S., Bilsen, J., Peremans, L., Van der Werff Ten Bosch, J., Laureys, G., Willems, E., Genin, S., Van Bogaert, P., Paquier, P., & Jansen, A. (2019). Short-term perspectives of parents and teachers on school reintegration of childhood brain tumour survivors. *Dev Neurorehabil*, *22*(5), 321-328. https://doi.org/10.1080/17518423.2018.1498553

Wagner, P. (1995). *School consultation: Frameworks for the Practising Educational Psychologist*. Kensington and Chelsea EPS.

Wagner, P. (2000). Consultation: Developing a comprehensive approach to service delivery. *Educational psychology in practice*, *16*(1), 9-18. https://doi.org/10.1080/026673600115229

Watts, S., & Stenner, P. (2012). *Doing Q methodological research : theory, method and interpretation* SAGE.

West, P., Sweeting, H., & Young, R. (2010). Transition matters: pupils' experiences of the primary-secondary school transition in the West of Scotland and consequences for well-being and attainment. *Research papers in education*, *25*(1), 21-50. https://doi.org/10.1080/02671520802308677

Wilson, H. M. N., Gaskell, S. L., & Murray, C. D. (2014). A qualitative study of teachers' experiences of a school reintegration programme for young children following a burn injury. *Burns*, *40*(7), 1345-1352. https://doi.org/10.1016/j.burns.2014.01.012

Worchel-Prevatt, F. F., Heffer, R. W., Prevatt, B. C., Miner, J., Young-Saleme, T., Horgan, D., Lopez, M. A., Rae, W. A., & Frankel, L. (1998). A School Reentry Program for Chronically Ill Children. *Journal of school psychology*, *36*(3), 261-279. https://doi.org/https://doi.org/10.1016/S0022-4405(98)00012-0

Young, J., Lukersmith, S., Salvador-Carulla, L., & Stancliffe, R. (2017). Case management for children and adolescents with acquired brain injury in community settings: A scoping review [Community & Social Services 3373]. *Brain Impairment*, *18*(2), 226-239. https://doi.org/http://dx.doi.org/10.1017/BrImp.2017.3

7. APPENDICES

Appendix 1- Letters to seek approval from the settings where pupils had successfully reintegrated into

Research study title: Pupil views on successful reintegration to full time education from alternative medical education service provision using a Q-sort methodology.

Dear Headteacher/ SENDCo

My name is Catherine Byng, and I am a trainee educational psychologist in my second year of full-time postgraduate study at the University of Birmingham. I am currently on placement with the X Educational Psychology Service and am writing to request your consideration of allowing my research study gathering the views of pupils who have successful reintegrated into an education setting (mainstream or specialist) following a period being supported by the Medical Education Team (MET), to be undertaken by pupils at your school/ college.

The participants will be a purposive sample of pupils (primary, secondary & post-16) from several settings (mainstream & specialist) within the local authority who have reintegrated to an education setting after a period of support from the medical education alternative provision within the last 3 years. The focus of the research will be exploring the views of children and young people about what factors make a reintegration to a setting from alternative medical education service provision successful. The views will be gathered from pupils who have been supported by the alternative medical education provision and have then reintegrated back into an education setting within the last 3 years. This research will gather the pupils' views about what works and will reflect pupils' views of best practices when reintegrating from an alternative medical education service provision.

What is the research project about?

The aim of the research project is to explore the views of primary, secondary & post-16 pupils who have been supported by the MET and have successfully reintegrated into an education setting, regarding the factors that they perceive to have supported their reintegration. Through this research I aim to encourage professionals to reflect on their practice and to review processes where necessary to further support reintegration from medical education provision.

The research question that I plan to answer will be:

What are the views of CYP who have received support from alternative medical education provision, and have reintegrated back into a school or other education setting regarding the factors that supported their successful reintegration into the school/ education setting?

Your school/ college has been identified as having successfully reintegrated pupil/s from medical education alternative provision within the last 3 years, which is the reason I am seeking your consent for your school to be one of the schools whose pupil/s can take part in my study.

If you do consent, I would be very grateful if you would forward the attached information sheets and consent forms to the following people:

- SENCo/ Headteacher
- Pupil/s (who reintegrated from medical education provision within the last 3 years)
- Parents/ carers of pupils who reintegrated from medical education provision in the last 3 years.

What will taking part involved?

If consent is obtained, I will complete a Q-sort with participants where they will be asked to read through a set of statements on cards and then asked to sort the statements into three piles according to whether they perceive the approach to be 'helpful', 'unhelpful' or 'not helpful, not unhelpful' in supporting their reintegration. The participants will be asked the same question: 'What helped you to settle into your current school/ college after being at with the MET (Medical Education Team) for a while?'.

Participants will be asked to place the cards on the Q-grid from 'most unhelpful' to 'most helpful', beginning with the 'helpful' pile. Once all the cards have been placed on the Q grid this will become their Q-sort.

The participants will then be asked a few questions in the format of a semi-structured interview (about the statements they place at the extreme left hand and right-hand sides of the Q-grid to gain a more in-depth insight into their views.

The Q-sort and interview will be conducted individually with the participant, away from the classroom in a separate confidential room.

COVID-19 precautions will be in place and the researcher will sit at a 2-meter distance to the participant and will wear a face mask and face shield. The researcher will sanitiser their hands before starting the Q-sort and all participants will be given their own individual set of statements and Q-sort grid.

It will take a maximum of 1 hour for each participant to complete both the Q-sort and the interview.

If the participant agrees to take part, can they change their mind?

Yes, if a participant decides they no longer wish to take part in the research, they can withdraw their data up to one week after the date of their Q-sort, by using the contact details below. They will not be expected to 'justify' or provide a reason for any such decision to withdraw; such requests would simply be respected.

What will happen to the data collected during the interview?

Interview data will be treated as confidential. The names of participants will not be reported, nor will any identifying information (e.g., names of other individuals, the school, organisations, or geographical locations etc).

As always in always the case in schools, confidentiality may need to be breeched if a disclosure is made which suggests that a participant or others are at risk of harm and/or which indicates illegal activity.

A Data Management Plan (DMP) will be put in place for this research within the University of Birmingham. Immediately after each participant interview, the electronically audio-recorded data will be transferred from the audio-recording device to a password-protected folder on 'BEAR DataShare', (a secure data storage system used by The University of Birmingham).

The audio files will then be erased from the audio-recorder. Electronic transcripts and notes will be held in a password protected folder on BEAR DataShare. Written notes and consent forms will be scanned to pdf and transferred to BEAR DataShare . Original paper notes (Q-sort and post-Q interview notes) and consent forms will be shredded. In accordance with university research policy, data will be stored on BEAR DataShare for 10 years after completion of the project. A 10-year expiry date will be set for the electronic data stored on BEAR DataShare.

How will the findings be reported?

Following data analysis, a summative research report will be sent to participants, outlining the main findings of the research. A write up of the research will form part of my doctoral thesis.

What if I have questions or require more information?

If you have any questions regarding the project, please contact me at (email); or tel:

My supervisor is Dr Julia Howe, who can be contacted at or tel:
.

Finally, can I thank you for taking the time to read this letter? I hope to hear from you soon.

Yours faithfully,

Catherine Byng

Appendix 2-Information sheets for staff from alternative medical education provision about the research

UNIVERSITY OF BIRMINGHAM

This information has been given to you as I would like you to take part in my research: Comparing pupil views on successful reintegration from alternative medical education service provision using a Q-sort methodology with medical education provision staff views about what supports pupils.

Who am I?

My name is Catherine Byng, and I am a Trainee Educational Psychologist in my 3rd year at the University of Birmingham. I am currently on placement at XXX. I would like to hear from medical education provision staff about what they believe supports pupils to settle at a new setting following support from medical education provision.

What is my research about?

My research is about finding the views of children and young people and medical education provision staff about what things are helpful for pupils when joining a setting from alternative medical education service provision. Your experience is valuable and can inform a better understanding of what can help pupils moving from alternative medical education provision to another education setting. I will compare what pupils say has supported them to what medical education provision staff believe supports pupils to reintegrate successfully to another education setting.

What would taking part involve?

Taking part involves meeting me in person or via an MSTeam meeting and taking part in an interview about things that you believe help pupils to settle into a new setting after receiving support from the medical education team. The interview should take no more than 1 hour.

Can I change my mind?

You can withdraw at any time (even during our meeting) up to 7 calendar days after your interview with me. If you want to withdraw you can let me know when we are together, or you email me on the details below.

What will happen to my interview data?

I will audio-record our interview to help me remember what you said. I won't be playing the audio recording to anyone else during the research project. I will be interviewing several members of staff and will analyse all the interviews and write them up in my university work. Your interview data will be kept confidential, and a record of which code applies to which participant will be stored separately from the data in a password-protected file on the UoB BEAR DataShare to ensure that data are stored securely.

How can I contact you?If you have any comments or questions, please contact me using the details at the bottom of this page.

Catherine Byng (Researcher) Email: Telephone:

Julia Howe (Research supervisor) Email: Telephone:

Appendix 3- Application for Ethical Review

UNIVERSITY OF BIRMINGHAM

Application for Ethics Review Form

Guidance Notes:

What is the purpose of this form?

This form should be completed to seek ethics review for research projects to be undertaken by University of Birmingham staff, PGR students or visiting/emeritus researchers who will be carrying out research which will be attributed to the University.

Who should complete it?

For a staff project – the lead researcher/Principal Investigator on the project.
For a PGR student project – the student's academic supervisor, in discussion with the student.

Students undertaking undergraduate projects and taught postgraduate (PGT) students should refer to their Department/School for advice

When should it be completed?

After you have completed the University's online ethics self-assessment form (SAF), **IF** the SAF indicates that ethics review is required. You should apply in good time to ensure that you receive a favourable ethics opinion prior to the commencement of the project and it is recommended that you allow at least 60 working days for the ethics process to be completed.

How should it be submitted?

An electronic version of the completed form should be submitted to the Research Ethics Officer, at the following email address: aer-ethics@contacts.bham.ac.uk.

What should be included with it?

Copies of any relevant supporting information and participant documentation, research tools (e.g. interview topic guides, questionnaires, etc) and where appropriate a health & safety risk assessment for the project (see section 10 of this form for further information about risk assessments).

What should applicants read before submitting this form?

Before submitting, you should ensure that you have read and understood the following information and guidance and that you have taken it into account when completing your application:

- The information and guidance provided on the University's ethics webpages (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-of-Research.aspx)

- The University's Code of Practice for Research (https://www.birmingham.ac.uk/Documents/university/legal/research.pdf)

- The guidance on Data Protection for researchers provided by the University's Legal Services team at https://intranet.birmingham.ac.uk/legal-services/What-we-do/Data-Protection/resources.aspx.

Section 1: Basic Project Details

Project Title:

Pupil views on successful mainstream reintegration from alternative medical education service provision using a Q-sort methodology.

Is this project a:

University of Birmingham Staff Research project ☐
University of Birmingham Postgraduate Research (PGR) Student project ☒
Other (Please specify below) ☐
Click or tap here to enter text.

Details of the Principal Investigator or Lead Supervisor (for PGR student projects):

Title: Dr
First name: Julia
Last name: Howe

Position held: Academic and Professional Tutor
School/Department School of Education: Disability, Inclusion and Special Needs

Telephone: [redacted]
Email address: [redacted]

Details of any Co-Investigators or Co-Supervisors (for PGR student projects):

Title: Click or tap here to enter text.
First name: Click or tap here to enter text.
Last name: Click or tap here to enter text.

Position held: Click or tap here to enter text.
School/Department Click or tap here to enter text.

Telephone: Click or tap here to enter text.
Email address: Click or tap here to enter text.

Details of the student for PGR student projects:

Title: Miss
First name: Catherine
Last name: Byng

Course of study: Applied Educational and Child Psychology Doctorate
Email address [redacted]

Project start and end dates:

Estimated start date of project: 01/05/2021
Estimated end date of project: 30/06/2022

Funding:

Sources of funding: N/A

Section 2: Summary of Project

Describe the purpose, background rationale for the proposed project, as well as the hypotheses/research questions to be examined and expected outcomes. This description should be in everyday language that is free from jargon - please explain any technical terms or discipline-specific phrases. Please do not provide extensive academic background material or references.

The focus of the research will be exploring the views of children and young people (CYP) about what factors make a reintegration to a mainstream school setting from alternative medical education service provision successful. The views will be gathered from pupils who have been supported by the alternative medical education provision and have then reintegrated back into a mainstream school setting within the last 3 years. This research will gather the pupils' views about what works and will reflect pupils' views of best practices when reintegrating to mainstream from an alternative medical education service provision.

Pupils supported by the medical education team (MET) are referred if a medical condition (physical or mental health condition) has been affecting their attendance at mainstream school (supported by evidence from medical professionals who are working with the pupil). The aim of the MET is to provide short term education while the pupil recovers and to support them to reintegrate into mainstream education. This short-term education takes place in a pupil referral unit (PRU) (alternative provision) specifically for those with medical needs.

I would not be studying participants' previous experience with mainstream education and the acceptance/attitudes of other pupils, *as I want a positive focus on what works- the pupils mainstream experience before going to the MET would have led to non- attendance as this is one of the conditions for entry to the MET.*

Justification for the Research

- **Little existing research.** This research will aim to provide knowledge about what factors contribute to a successful reintegration to mainstream education from alternative medical education provision. Previous research has explored the factors that contribute to successful reintegration from alternative provision where CYP have been excluded from their mainstream provider (Atkinson &

Rowley, 2019). However, factors for successful reintegration with CYP who have medical needs has not been explored. This population of CYP are different to others who attend alternative provision as they have not been formally excluded due to behavioural issues and they are not able to access education in mainstream due to either physical or mental health needs. Therefore, the factors that support successful reintegration to mainstream education may be different to the factors that support previously excluded CYP.

- **Gain views and perceptions of CYP.** Research often explores the views of professionals working with CYP rather than the CYP themselves. CYP with medical needs are often not given the opportunities to share their views or their views are represented by the professionals working with them rather than given by the CYP directly (Seymour, 2004).This research will give CYP who have medical needs the opportunity for their voices to be heard. The factors that professionals believe are important to a successful reintegration may not be important to the CYP or may be important but for different reasons than those that have been considered by professionals.

- **Improve practice.** It is anticipated that the research will have an influence on the practice of school staff and educational psychologists who support and advise school staff with reintegrating pupils back into mainstream education. Having a better understanding of the factors that support CYP with medical needs to successfully reintegrate into mainstream education will enable future provision to be better informed.

Research Question

The research will aim to explore the views of primary and secondary-aged pupils who have been supported by the MET and have successfully reintegrated in mainstream regarding the factors that they perceive to have supported their reintegration. The research question that the research will address will be:

What are the views of CYP who have received support from alternative medical education provision, and have reintegrated back into a mainstream setting regarding the factors that supported their successful reintegration into mainstream education?

Expected Outcomes

It is expected this research will contribute to the extremely limited research currently available about the successful factors of reintegration for those who have had a placement in alternative provision due to medical needs. The research studying pupils with medical needs lacks representation of the views of the pupils themselves and it is vital that the views of pupils with medical conditions are 'heard' as what may be important to professionals and education staff may not be considered important to their successful reintegration by the pupils themselves. This research will give a voice to an underrepresented group within the research (the pupils themselves).
Research findings will encourage professionals to reflect on their practice and review processes where necessary/appropriate to strengthen/further support reintegration into mainstream. By communicating findings to third party services (for example, Educational Psychology Service and managers of local authority medical education alternative provision services); and, through dissemination of this research (to mainstream education providers in the local authority). This will allow professionals to reflect upon their current practice, what is already working well and what could be adapted to improve.

Section 3: Conduct and location of Project

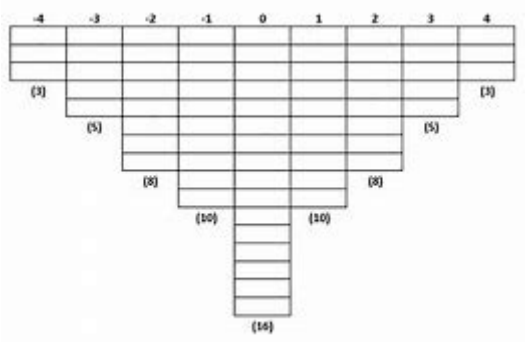
Conduct of project

Please give a description of the research methodology that will be used. If more than one methodology or phase will be involved, please separate these out clearly and refer to them consistently throughout the rest of this form.

I will be using Q methodology (Stephenson, 1953), to gain the views of pupils with medical needs who have successfully reintegrated into mainstream. This methodology actively involves participants within the research process and has been described as ethical, person centred and useful in gaining the voices of marginalised groups (Hughes, 2016). The procedure of the Q-methodology will be as follows:

- The researcher generates a set of statements (the Q-set), which are derived from the 'concourse' (the field of shared knowledge surrounding the topic). Every statement will correspond to an opinion about reintegration into mainstream from medical education alternative provision.
- The statement will be written on individual cards and participants will be asked to sort the statements onto a Q grid (Figure 1).

Figure 1: Q-grid



- Participants will then be asked to sort the cards, within a fixed distribution. The participants will be asked the same question: 'What helped you to settle into your current school after being at with the MET (Medical Education Team) for a while?' This sorting of items should allow participants to share their viewpoint.
- The left-hand side of the grid will be for unhelpful and the right had side helpful with the centre of the grid being not helpful, not unhelpful.
- The sorting of statements by participants can then be analysed using correlation and factor analysis to reveal patterns in participants responses.
- After the Q-sort a post Q-sort interview is completed with participants to allow for qualitative interpretation of their views. This interview will ask why they decided particular factors were helpful, not helpful and neither helpful nor not helpful in their reintegration to their current school.

During the Q-sort:
Participants will be asked to read through the statements (appendix 1) and then asked to sort the statements into three piles according to whether they perceive the approach to be 'helpful', 'unhelpful' or 'not helpful, not unhelpful' in supporting their reintegration. When they have sorted all the statements into the three piles the participants will be given a fixed normal distribution Q-grid (Figure 1) to sort the statements onto.
Participants will be asked to place the cards on the Q-grid from 'most unhelpful' to 'most helpful', beginning with the 'helpful' pile. Once all the cards have been placed on the Q grid this will become their Q-sort.
The participants will then be asked a few questions in the format of a semi-structured interview (post -Q interview) (appendix 2) about the statements they placed on the grid. This should help me to clarify findings when interpreting the participants viewpoints from their Q-sorts.
The Q-sort should take between 20 and 25 minutes to complete and the post-Q interview should take between 20-25 minutes. The whole thing should take approximately 1 hour for each participant to complete.

Piloting of the Q-set
Before completing the Q-sort with participants the Q-set (statements) will be piloted with staff who work in the medical education alternative provision to ensure the final Q-set is representative of the concourse (the field of shared knowledge surrounding the topic). The staff will be asked to read the statements and give any other opinions they think are missing or not represented about successful reintegration to mainstream from medical education provision. The Q-set will then be amended before conducting the final Q-sort with participants.

Geographic location of project

State the geographic locations where the project and all associated fieldwork will be carried out. If the project will involve travel to areas which may be considered unsafe, either in the UK or overseas, please ensure that the risks of this (or any other non-trivial health and safety risks associated with the research) are addressed by a documented health and safety risk assessment, as described in section 10 of this form.

The research will take place in mainstream schools in the focus local authority.

Section 4: Research Participants and Recruitment

Does the project involve human participants?

Note: 'Participation' includes both active participation (such as when participants take part in an interview) and cases where participants take part in the study without their knowledge and consent at the time (for example, in crowd behaviour research).

Yes ☒
No ☐

If you have answered NO please go on to Section 8 of this form. If you have answered YES please complete the rest of this section and then continue on to section 5.

Who will the participants be?

Describe the number of participants and important characteristics (such as age, gender, location, affiliation, level of fitness, intellectual ability etc.). Specify any inclusion/exclusion criteria to be used.

The participants will be a purposive sample of pupils from mainstream schools (primary & secondary age) within the focus local authority who have reintegrated to mainstream after a period of support from the medical education alternative provision within the last 3 years. The number of participants I am hoping to recruit will be between 10-20.

How will the participants be recruited?

Please state clearly how the participants will be identified, approached and recruited. Include any relationship between the investigator(s) and participant(s) (e.g. instructor-student). Please ensure that you attach a copy of any poster(s), advertisement(s) or letter(s) to be used for recruitment.

Gatekeepers (medical education alternative providers within the local authority) will be approached in the first instance and given letters (appendix 3) to seek approval from the headteachers/Special educational needs coordinators (SENCos) of the schools where pupils have successfully reintegrated into. The headteacher/ SENCos will then share information about the research with parents and pupils (who reintegrated from medical education provision) in their schools.

The pupils who express an interest in taking part in the study will be asked to inform the headteacher or SENCo in their school. The headteacher or SENCo will then contact the researcher directly via a council email or telephone number. These details will be shared so that participants can contact the researcher if they have any questions, queries, or concerns before or after the Q-sort. Parents of the participants will be sent a parental information letter (appendix 4) parent consent form to sign (appendix 5) and send back to the school, who will pass this on to the researcher. No personal contact details will be shared (i.e., home address or phone number). Following this contact, prospective participants will be given an information sheet (appendix 6), consent form (appendix 7). A meeting will be arranged at the school through the headteacher/ SENCo at the school for the Q-sort to take place with the participant. The participant consent form (appendix 7) will be signed in person at the meeting at the school.

Section 5: Consent

What process will be used to obtain consent?

Describe the process that the investigator(s) will be using to obtain valid consent. If consent is not to be obtained explain why. If the participants are under the age of 16 it would usually be necessary to obtain parental consent and the process for this should be described in full, including whether parental consent will be opt-in or opt-out.

The British Psychological Society (BPS, 2018), the British Educational Research Association (BERA, 2018) and The University of Birmingham Code of Practice for Research guidelines for freely given,

fully informed consent will be followed. Gatekeepers (medical education alternative providers) will be approached in the first instance and given letters (appendix 3) to seek approval from the headteachers/SENCos of the schools where pupils have successfully reintegrated into. The headteacher/ SENCos will then share information about the research with parents and pupils (who reintegrated from medical education provision) in their schools. The pupils who express an interest in taking part in the study will be asked to inform the headteacher or SENCo in their school. The headteacher or SENCo will then contact the researcher directly via a council email or telephone number. These details will be shared so that participants can contact the researcher if they have any questions, queries, or concerns before or after the Q-sort. Parents of the participants will be sent a parent information letter (appendix 4) parent opt in consent form (appendix 5) to sign and send back to the school, who will pass this on to the researcher. If the parent has literacy difficulties or English is and additional language the headteacher or SENCo will arrange for a meeting between the researcher and parents so the researcher can go through the information letter and consent form with parents to ensure they have understood it and any questions can be answers. No personal contact details will be shared (i.e., home address or phone number). Following this contact, prospective participants will be given an information sheet (appendix 6), consent form. A meeting will be arranged at the school through the headteacher/ SENDCo at the school for the Q-sort to take place with the participant. Prior to the Q-sort, the researcher will talk through the information sheet, which will include information about the study, the study's aims, and what participants will be asked to do. Participants will be given the opportunity to ask any questions and sign consent form (appendix 7) on the day of the Q-sort meeting.

Please be aware that if the project involves over 16s who lack capacity to consent, separate approval will be required from the Health Research Authority (HRA) in line with the Mental Capacity Act.

Please attach a copy of the Participant Information Sheet (if applicable), the Consent Form (if applicable), the content of any telephone script (if applicable) and any other material that will be used in the consent process.

Note: Guidance from Legal Services on wording relating to the Data Protection Act 2018 can be accessed at https://intranet.birmingham.ac.uk/legal-services/What-we-do/Data-Protection/resources.aspx.

Use of deception?

Will the participants be deceived in any way about the purpose of the study?

Yes ☐
No ☒

If yes, please describe the nature and extent of the deception involved. Include how and when the deception will be revealed, and the nature of any explanation/debrief will be provided to the participants after the study has taken place.

N/A

Section 6: Participant compensation, withdrawal and feedback to participants

What, if any, feedback will be provided to participants?

Explain any feedback/ information that will be provided to the participants after participation in the research (e.g. a more complete description of the purpose of the research, or access to the results of the research).

The participants will have the results from the research shared with them by being provided with a summary report. This is so they will be able to have access to the research they contribute to. This will be sent to them through the headteacher/ SENCo at their school.

What arrangements will be in place for participant withdrawal?

Describe how the participants will be informed of their right to withdraw from the project, explain any consequences for the participant of withdrawing from the study and indicate what will be done with the participant's data if they withdraw.

Participants will be able to withdraw from the project and this will be stated in the information sheet and consent forms. Participants will be reminded of this verbally prior each Q-sort commencing. Participants will be given contact details (my local authority phone number and email address) to use should they wish to withdraw from the study. There will be no consequences for the participant if they withdraw from the study and all their data will be immediately destroyed.

Please confirm the specific date/timescale to be used as the deadline for participant withdrawal and ensure that this is consistently stated across all participant documentation. This is considered preferable to allowing participants to 'withdraw at any time' as presumably there will be a point beyond which it will not be possible to remove their data from the study (e.g. because analysis has started, the findings have been published, etc).

Participants will be free to withdraw from the project before, during or (up to one week) after their Q-sort takes place. After this time data analysis and synthesis will be in progress and I will be unable to withdraw their data.

What arrangements will be in place for participant compensation?

Will participants receive compensation for participation?

Yes ☐
No ☒

If yes, please provide further information about the nature and value of any compensation and clarify whether it will be financial or non-financial.

N/A

If participants choose to withdraw, how will you deal with compensation?

N/A

Section 7: Confidentiality/anonymity

Will the identity of the participants be known to the researcher?

Will participants be truly anonymous (i.e. their identity will not be known to the researcher)?

Yes ☐
No ☒

In what format will data be stored?

Will participants' data be stored in identifiable format, or will it be anonymised or pseudo-anonymised (i.e. an assigned ID code or number will be used instead of the participant's name and a key will kept allowing the researcher to identify a participant's data)?

The study involves face-to-face meeting for the Q-sort and post-Q interview, which means that anonymity cannot be offered to participants. To ensure confidentiality, names of participants, the local authority, schools, staff, pupils etc. will not be used and that if identifying information is discussed in the post- Q interview this will not be included in the write up. Pseudonyms will be used to aid readability, and a key will be kept by the researcher to enable the identification of a participant's data. Some information about the participants (e.g. age, year group, time spent away from mainstream, medical need) will be gathered and included to provide contextual and background information.

I will inform participants that the research findings could be shared with the wider school team in a summary report, but that participants' post-Q interview responses and Q-sort responses will be presented collectively and that it will not be possible to attribute an individual response to an individual participant.
Participants will also be informed that the final write up of the research will form the basis of my doctoral research thesis, which will later be available online (I will also explain that the research may be published at a later date). Participants will be made aware that their names will not appear in the final report, nor will any other identifying information. Participants will be told that excerpts from the post-Q interview transcripts will be included in the final write-up of the research project, provided there are no risks that quotations would render participants identifiable.

Within the audio-recorded data and written transcripts the school and individual participants will be labelled with a code (pseudonym) that only the researcher will know. A record of which code applies to which participant will be stored separately from the data in a password-protected file on the UoB BEAR DataShare to ensure that data are stored securely and can be withdrawn on request. As such, the data are confidential but not anonymous.

Will participants' data be treated as confidential?

Will participants' data be treated as confidential (i.e. they will not be identified in any outputs from the study and their identity will not be disclosed to any third party)?

Yes ☒
No ☐

If you have answered no to the question above, meaning that participants' data will not be treated as confidential (i.e. their data and/or identities may be revealed in the research outputs or otherwise to third parties), please provide further information and justification for this:

Confidentiality may need to be breeched if a disclosure were made which suggested that the participant or others were at risk of harm or which indicated illegal activity. In the event of risks relating to safeguarding or child protection arising from an interview, local authority and school safeguarding/whistleblowing procedures would be followed.

To ensure that the reason participants have been recruited is not brought to the attention of other students the researcher will tell the participant that they can tell other students I am interested in pupils' views of school experience and I am interviewing pupils in different schools chosen at random.

Section 8: Storage, access and disposal of data

How and where will the data (both paper and electronic) be stored, what arrangements will be in place to keep it secure and who will have access to it?

Please note that for long-term storage, data should usually be held on a secure University of Birmingham IT system, for example BEAR (see https://intranet.birmingham.ac.uk/it/teams/infrastructure/research/bear/index.aspx).

Immediately after each participant post-Q interview, the electronically audio-recorded data will be transferred from the devices to a password protected folder on BEAR DataShare. The files will then be erased from the recording devices. Electronic transcripts and notes will also be held in a password-protected folder on BEAR DataShare. Electronic copies of the participants Q-sort will be scanned in and stored on BEAR DataShare. Any written notes and consent forms will be scanned in and stored on BEAR DataShare in a password protected folder. Original paper notes (Q-sort and post-Q interview notes) and consent forms will be shredded.

Data retention and disposal

The University usually requires data to be held for a minimum of 10 years to allow for verification. Will you retain your data for at least 10 years?

Yes ☒
No ☐

If data will be held for less than 10 years, please provide further justification:

N/A

What arrangements will be in place for the secure disposal of data?

In accordance with university research policy, data will be stored on BEAR DataShare for 10 years after completion of the project. A 10-year expiry date will be set for the electronic data stored on BEAR DataShare.

Section 9: Other approvals required

Are you aware of any other national or local approvals required to carry out this research?

E.g. clearance from the Disclosure and Barring Service (DBS), Local Authority approval for work involving Social Care, local ethics/governance approvals if the work will be carried out overseas, or approval from NOMS or HMPPS for work involving police or prisons? If so, please provide further details:

I am not aware of any national or local approvals required to carry out this research.

For projects involving NHS staff, is approval from the Health Research Authority (HRA) needed in addition to University ethics approval?

If your project will involve NHS staff, please go to the HRA decision tool at http://www.hra-decisiontools.org.uk/research/ to establish whether the NHS would consider your project to be research, thus requiring HRA approval in addition to University ethics approval. Is HRA approval required?

Yes ☐
No ☒

Please include a print out of the HRA decision tool outcome with your application.

Section 10: Risks and benefits/significance

Benefits/significance of the research

Outline the potential significance and/or benefits of the research

As only a limited number of recent studies have been undertaken in this area, I expect that the current study will make a useful addition to understanding the factors that impact on the reintegration of pupils with medical needs. It will build on previous research that has studied pupils successfully reintegrating into mainstream following an exclusion from mainstream education.

This research will allow pupils with medical needs views to be explored directly rather than through the voice of the professionals who work with them, it will allow a marginalised groups views to be 'heard'.

At a local level, the factors that the pupils consider to be helpful to their reintegration to mainstream will contribute to improving practice by sharing the views about what works for pupils with medical

needs when reintegrating into mainstream with schools, educational psychologists and medical education alternative provision providers who support schools with reintegration.

Risks of the research

Outline any potential risks (including risks to research staff, research participants, other individuals not involved in the research, the environment and/or society and the measures that will be taken to minimise any risks and the procedures to be adopted in the event of mishap.) ***Please ensure that you include any risks relating to overseas travel and working in overseas locations as part of the study, particularly if the work will involve travel to/working in areas considered unsafe and/or subject to travel warnings from the Foreign and Commonwealth Office (see*** https://www.gov.uk/foreign-travel-advice)***. Please also be aware that the University insurer, UMAL, offers access to RiskMonitor Traveller, a service which provides 24/7/365 security advice for all travellers and you are advised to make use of this service (see https://umal.co.uk/travel/pre-travel-advice/).***

The outlining of the risks in this section does not circumvent the need to carry out and document a detailed Health and Safety risk assessment where appropriate – see below.

Potential risks to the researcher, research participants and other individuals not involved in the research are outlined below. Both the British Psychological Society (2018) and British Educational Research Association (2018) ethical guidelines were consulted when considering potential risks associated with this project.

Q-sort- Risk to research staff

Physical risk of harm to the researcher is minimal as the Q-sort and post Q interviews will be conducted in the school setting, with other professionals in the vicinity. The research may have some emotional and psychological risks to the researcher, which could be evoked by the emotive nature of some of the areas that may come up in the post-Q discussion. This should be minimal due to the positive focus of the research on what has been successful. To minimise the risk to the researcher, regular supervision will be used to reflect on and consider the impact of the research.

Q-sort- Risk to research participants

Risks to participants are minimal, although participants may find reflections in the post-Q interview, stressful or upsetting. For example, when considering what was unhelpful to them in their reintegration to mainstream. This should be minimal due to the positive focus of the research on what has been successful. If I sensed that a participant was becoming distressed, I would pause the post Q interview, inviting feedback on whether the participant would like a short break or prefer to discontinue the post Q interview.

Participants will be debriefed following their Q sort and post Q interview, giving them the opportunity to ask any questions and to share any concerns they have. If required, participants will be signposted to professional support from a staff member or mentor in their school, or to relevant external services and agencies. All participants will be provided with contact details of the researcher and university research supervisor, should they wish to ask questions or make any complaint.

Other

The post Q interviews could gather information that could identify the school involved. Information may also be provided by participants that may present these schools in a negative light.

The researcher will ensure any identifiable information is excluded from the final report, so the schools remain anonymous. If information is provided which may present a risk to organisational reputation, advice will be sought through research supervision regarding the inclusion and communication of this data.

University Health & Safety (H&S) risk assessment

For projects of more than minimal H&S risk it is essential that a H&S risk assessment is carried out and signed off in accordance with the process in place within your School/College and you must provide a copy of this with your application. The risk may be non-trivial because of travel to, or working in, a potentially unsafe location, or because of the nature of research that will carried out there. It could also involve (irrespective of location) H&S risks to research participants, or other individuals not involved directly in the research. Further information about the risk assessment process for research can be found at https://intranet.birmingham.ac.uk/hr/wellbeing/worksafe/policy/Research-Risk-Assessment-and-Mitigation-Plans-RAMPs.aspx.

Please note that travel to (or through) 'FCO Red zones' requires approval by the University's Research Travel Approval Panel, and will only be approved in exceptional circumstances where sufficient mitigation of risk can be demonstrated.

Section 11: Any other issues

Does the research raise any ethical issues not dealt with elsewhere in this form?

If yes, please provide further information:

No

Do you wish to provide any other information about this research not already provided, or to seek the opinion of the Ethics Committee on any particular issue?

If yes, please provide further information:

No

Section 12: Peer review

Has your project received scientific peer review?

Yes ☐
No ☒

If yes, please provide further details about the source of the review (e.g. independent peer review as part of the funding process or peer review from supervisors for PGR student projects):

Click or tap here to enter text.

Section 13: Nominate an expert reviewer

For certain types of project, including those of an interventional nature or those involving significant risks, it may be helpful (and you may be asked) to nominate an expert reviewer for your project. If you anticipate that this may apply to your work and you would like to nominate an expert reviewer at this stage, please provide details below.

Title: Click or tap here to enter text.
First name: Click or tap here to enter text.
Last name: Click or tap here to enter text.
Email address: Click or tap here to enter text.
Phone number: Click or tap here to enter text.

Brief explanation of reasons for nominating and/or nominee's suitability:

Click or tap here to enter text.

Section 14: Document checklist

Please check that the following documents, where applicable, are attached to your application:

Recruitment letter to schools Headteacher/ SENCo ☒
Participant information sheet ☒
Consent form ☒
Draft Post Q Interview Schedule ☒
Parental Consent form ☒
Parental Information letter ☒
Example Q-sort statements ☒

Please proof-read study documentation and ensure that it is appropriate for the intended audience before submission.

Section 15: Applicant declaration

Please read the statements below and tick the boxes to indicate your agreement:

I submit this application on the basis that the information it contains is confidential and will be used by the University of Birmingham for the purposes of ethical review and monitoring of the research project described herein, and to satisfy reporting requirements to regulatory bodies. The information will not be used for any other purpose without my prior consent. ☒

The information in this form together with any accompanying information is complete and correct to the best of my knowledge and belief and I take full responsibility for it. ☒

I undertake to abide by University Code of Practice for Research (https://www.birmingham.ac.uk/Documents/university/legal/research.pdf) alongside any other relevant professional bodies' codes of conduct and/or ethical guidelines. ☒

I will report any changes affecting the ethical aspects of the project to the University of Birmingham Research Ethics Officer. ☒

I will report any adverse or unforeseen events which occur to the relevant Ethics Committee via the University of Birmingham Research Ethics Officer. ☒

Please now save your completed form and email a copy to the Research Ethics Officer, at aer-ethics@contacts.bham.ac.uk. As noted above, please do not submit a paper copy.

Appendix 4- Amendments to the Application for Ethical Review

UNIVERSITY OF BIRMINGHAM

APPLICATION FOR ETHICAL REVIEW –

REQUEST FOR AMENDMENTS

Who should use this form:

- This form is to be completed by PIs or supervisors (for PGR student research) who are requesting ethical approval for amendments to research projects that have previously received ethical approval from the University of Birmingham.

  Please be aware that all new research projects undertaken by postgraduate research (PGR) students first registered as from 1st September 2008 will be subject to the University's Ethical Review Process. PGR students first registered before 1st September 2008 should refer to their Department/School/College for further advice.

- What constitutes an amendment?

  Amendments requiring approval may include, but are not limited to, additions to the research protocol, study population, recruitment of participants, access to personal records, research instruments, or participant information and consent documentation. Amendments must be approved before they are implemented.

NOTES:

- Answers to questions must be entered in the space provided
- An electronic version of the completed form should be submitted to the Research Ethics Officer, at the following email address: aer-ethics@contacts.bham.ac.uk. Please **do not** submit paper copies.
- If, in any section, you find that you have insufficient space, or you wish to supply additional material not specifically requested by the form, please submit it in a separate file, clearly marked and attached to the submission email.
- If you have any queries about the form, please address them to the Research Ethics Team.

UNIVERSITY OF BIRMINGHAM APPLICATION FOR ETHICAL REVIEW - REQUEST FOR AMENDMENTS	*OFFICE USE ONLY:* Application No: Date Received:

1. **TITLE OF PROJECT**

Pupil views on successful mainstream reintegration from alternative medical education service provision using a Q-sort methodology.

2. **APPROVAL DETAILS**
   What is the Ethical Review Number (ERN) for the project?

21-0009

3. **THIS PROJECT IS:**
   University of Birmingham Staff Research project ☐
   University of Birmingham Postgraduate Research (PGR) student project ☒
   Other ☐ (Please specify):

4. **INVESTIGATORS**

   a) **PLEASE GIVE DETAILS OF THE PRINCIPAL INVESTIGATORS OR SUPERVISORS (FOR PGR STUDENT PROJECTS)**

Name: Title / first name / family name	Dr Julia Howe
Highest qualification & position held:	Academic and Professional Tutor
School/Department	School of Education: Disability, Inclusion and Special Needs
Telephone:	[redacted]
Email address:	[redacted]

Name: Title / first name / family name	
Highest qualification & position held:	
School/Department	
Telephone:	

Email address:	

b) PLEASE GIVE DETAILS OF ANY CO-INVESTIGATORS OR CO-SUPERVISORS (FOR PGR STUDENT PROJECTS)

Name: Title / first name / family name	
Highest qualification & position held:	
School/Department	
Telephone:	
Email address:	

c) In the case of PGR student projects, please give details of the student

Name of student:	Catherine Byng	Student No:	[redacted]
Course of study:	Applied Educational and Child Psychology Doctorate		
Principal supervisor:	Dr Julia Howe		

Name of student:		Student No:	
Course of study:			
Principal supervisor:			

5. **ESTIMATED START OF PROJECT** Date: 01/05/2021

ESTIMATED END OF PROJECT Date: 30/06/2022

6. **ORIGINAL APPLICATION FOR ETHICAL REVIEW AND ANY SUBSEQUENT APPROVED AMENDMENTS:**

Please complete the table below for the original application and any subsequent amendments submitted

Title and reference number of application or amendment	**Key points of application and/or changes made by amendment (include: aims of study, participant details, how participants were recruited and methodology)**	**Ethical considerations arising from these key points (e.g. gaining consent, risks to participants and/or researcher, points raised by Ethical Review Committee during review)**	**How were the ethical considerations addressed?** **(e.g. consent form, participant information, adhering to relevant procedures/clearance required)**
Original application- *AER2020-CBERN_21-0009*	The focus of the research will be exploring the views of children and young people (CYP) about what factors make a reintegration to a mainstream school setting from alternative medical education service provision successful. The views will be gathered from pupils who have been supported by the alternative medical education provision and have then reintegrated back into a mainstream school setting within the last 3 years. This research will gather the pupils' views about what works and will reflect pupils' views of best practices when reintegrating to mainstream from an alternative medical education service provision. Research Question- What are the views of CYP who have received support from alternative medical education provision, and have reintegrated back into an education setting regarding the factors that supported their successful reintegration into the education setting? Q-methodology (sorting exercise and post q interview)	To ensure that the reason participants have been recruited is not brought to the attention of other students the researcher will tell the participant that they can tell other students I am interested in pupils' views of school experience, and I am interviewing pupils in different schools chosen at random. .	Consent from parents and pupils. Right to withdraw

	The participants will be a purposive sample of pupils from settings within the focus local authority who have reintegrated to mainstream after a period of support from the medical education alternative provision within the last 3 years. Number of participants hoping to recruit between 10-20		
Subsequent amendment 1 *AERamendmentsCBERN_21-0009*	Same methodology with pupils, however fewer participants available. Now looking to also do interviews with medical education team staff about what can support a successful reintegration for pupils after support from medical education provision. Interviews maximum 1 hour (semi-structured) (see appendix 1 for interview schedule) Additional research questions: What are the views of staff from alternative medical education provision, regarding the factors that supported pupils' successful reintegration into an education setting following support from the medical education provision? How do professional views about what supports a successful reintegration to an education setting following support from the medical education provision compared to the views of the pupils themselves?	Consent for MET staff to complete interviews. Secure data storage recording of interviews.	Information sheet for medical education provision staff (appendix 2) Consent Form for medical education staff (appendix 3), To ensure confidentiality, names of participants, the local authority, schools, staff, pupils etc. will not be used and that if identifying information is discussed in the interview this will not be included in the write up. Pseudonyms will be used to aid readability, and a key will be kept by the researcher to enable the identification of a participant's data. Within the audio-recorded data and written transcripts the school and individual participants will be labelled with a code (pseudonym) that only the researcher will know. A record of which code applies to which participant will be stored separately from the data in a password-protected file on the UoB BEAR DataShare to ensure that data are stored securely and can be withdrawn on request. As such, the data are confidential but not anonymous.

7. **DETAILS OF PROPOSED <u>NEW AMENDMENT</u>**
Provide details of the proposed new amendment, and clearly and explicitly state how the proposed new amendment will differ from the details of the study as already approved (see Q6 above).

Same methodology with pupils, however. Now looking to also do interviews with medical education team staff about what can support a successful reintegration for pupils after support from medical education provision. Interviews maximum 1 hour (semi-structured) (see appendix 1 for interview schedule).

Additional research questions: What are the views of staff from alternative medical education provision, regarding the factors that supported pupils' successful reintegration into an education setting following support from the medical education provision? How do professional views about what supports a successful reintegration to an education setting following support from the medical education provision compared to the views of the pupils themselves?
Qualitative interviews with medical education staff to gain rich data about factors that might support successful reintegration after support from medical education provision. Would be looking to recruit (3-4) members of staff from medical education provision to take part in interviews.

8. **JUSTIFICATION FOR PROPOSED <u>NEW AMENDMENT</u>**

Fewer pupil participants available than originally considered- not enough data- less reintegrated due to Covid-19 also participants recruited were lost. Medical education staff work most closely with these pupils throughout transition from medical education provision to new setting so will be knowledgeable in what supports successful transition for pupil but can compare their view to the small number of participants who complete the Q-methodology.

9. **ETHICAL CONSIDERATIONS**

What ethical considerations, if any, are raised by the proposed new amendment?

Additional population of participants (medical education provision staff) would need informed consent. Appendix 2- information sheet for medical education staff participants. Appendix 3- Consent form for medical education staff.

10. **DECLARATION BY APPLICANTS**

I make this application on the basis that the information it contains is confidential and will be used by the

University of Birmingham for the purposes of ethical review and monitoring of the research project described

herein, and to satisfy reporting requirements to regulatory bodies. The information will not be used for any

other purpose without my prior consent.

I declare that:

- The information in this form together with any accompanying information is complete and correct to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to abide by University Code of Conduct for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) alongside any other relevant professional bodies' codes of conduct and/or ethical guidelines.
- I will report any changes affecting the ethical aspects of the project to the University of Birmingham Research Ethics Officer.
- I will report any adverse or unforeseen events which occur to the relevant Ethics Committee project to the University of Birmingham Research Ethics Officer.

Signature of Principal investigator/project supervisor:	
Date:	

Appendix 5- Information sheet for pupils

This information has been given to you as I would like you to take part in my research: Pupil views on successful reintegration from alternative medical education service provision using a Q-sort methodology.

UNIVERSITY OF BIRMINGHAM

Who am I?

My name is Catherine Byng, and I am a Trainee Educational Psychologist in my 2nd year at the University of Birmingham. I am currently on placement at X. I would like to hear from you and other young people about what has helped you to settle into your current school after being at with the MET (Medical Education Team) for a while.

What is my research about?

My research is about finding the views of children and young people about what things are helpful when joining a school setting from alternative medical education service provision. I think it is important that young people are involved in research. Your experience is valuable and can inform a better understanding of what can help pupils moving from alternative medical education provision to a full-time school setting.

What would taking part involve?

Taking part involves meeting me and organising statements about things that helped you to settle into your current school after being at with the MET (Medical Education Team) for a while onto a grid deciding which things were helpful and unhelpful. We would then have a short interview where I would ask you questions about the statements you sorted. This will be completed individually with you, away from the classroom in a separate confidential room. We would arrange a date and time where I could meet you at your school. I will be following Covid-19 precautions and I will sit at a 2-meter distance from you and will be wearing a face mask. You will be given your own set of statements to sort. The whole thing should no more than 1 hour.

If you were to tell me something which made me think that you, or someone else, were at risk of harm or that something illegal is happening or has happened, I would have to share this information with another adult in line with your school's policy.

Do I have to take part?

No, whether you take part in the study is your choice. If you are under 16 years of age, this will also depend on you parent/carer giving permission. It is important for you to know that you will not have to talk about anything you do not wish to.

What will happen to my interview data?

I will audio-record our interview to help me remember what you said. I won't be playing the audio recording to anyone else during the research project. I will be interviewing several other children and young people and will analyse all the interviews and write them up in my university work. I will not use your name in my write up.

What will happen next?

If you'd like to take part in this research, your parents/ carers will need to sign the parental consent form and return it to [insert name of SENCo/ Headteacher] at your school. I will then be in touch to organise a meeting for the research to take place at your school. Your consent form will be signed at the meeting before we begin where you will also be given the chance to ask any questions.

Can I change my mind?

It is important for you to know that you have the right to withdraw. This means you can change your mind about taking part and won't need to give a reason. You can withdraw at any time (even during our meeting) up to 7 calendar days after your interview with me. If you want to withdraw you can let me know when we are together, or you can tell [insert name here] at your school.

How can I contact you?

If you have any comments or questions, please contact me using the details at the bottom of this page.

Catherine Byng (Researcher) Email: Telephone:

Julia Howe (Research supervisor)

Appendix 6- Pupil consent form

UNIVERSITY OF BIRMINGHAM

Please read the following statements and tick each one to indicate your agreement:

		Tick to indicate agreement ✓
1	I have read/ been read the participant information sheet and have had the opportunity to ask any questions about what will happen if I choose to take part in the study.	
2	I agree to take part in the study. For students under the age of 16, I know that my parent/carer has also given their permission.	
3	I understand that I have the right to withdraw. I can change my mind about taking part before or during the planned research interview, without having to provide a reason.	
4	I understand that, as part of my right to withdraw from this study without having to provide a reason. I can ask for the recording of my interview to be deleted up until 7 calendar days after my interview with the researcher (Catherine Byng, trainee educational psychologist).	
5	I understand that my data (interview transcript & Q-sort) will be used in Catherine Byng's thesis and may also be edited for inclusion in a published journal article and / or conference presentation(s).	
6	I consent to be contacted by Catherine Byng after the meeting, so she can ask me whether I'd like to learn about the findings of her research.	

Signed: _____

Name: _____

Date: _____

Appendix 7- Parent letter about the research

Dear Parent/Carer,

Invitation for to participate in research

My name is Catherine Byng. I am a trainee educational psychologist from the University of Birmingham and I am on placement with the Educational Psychology Service. As part of my course, I am researching the views of pupils who have successful reintegrated into an education setting following a period of time being supported by the Medical Education Team (MET).

In this research project I want to ask pupils about what helped them to settle into their current school/ college after being with the MET (Medical Education Team) for a while. I would like to invite [insert young person's name] to take part in my research and have included some information which I hope will enable you to make an informed decision about whether to give your consent for [insert young person's name] to be involved.

What does taking part involve?

If [insert young person's name] takes part, I would arrange a time and date to complete a Q-sort (organising sets of statements about things that may have been helpful to helping them to settle at their current school/ college) with them at school/ college. They will then be asked a few questions (in the form of a short interview) about the statements they have sorted. The Q-sort and interview will be conducted individually with [insert young person's name], away from the classroom in a separate confidential room. It is important for you and [insert young person's name] to know that he/she [delete as appropriate] will not have to talk about anything they do not wish to. This would be pre-arranged and last for a maximum of one hour.

COVID-19 precautions will be in place and the researcher will sit at a 2-meter distance from [insert young person's name] and will wear a face mask and face shield. The researcher will sanitiser their hands before starting the Q-sort and [insert young person's name] will be given their own individual set of statements and Q-sort grid.

The interview will be audio-recorded to help me remember what was said. I will write up the recording and change [insert young person's name] name to keep the research data confidential. This is to avoid [insert young person's name]'s data being linked directly to him/her [delete as appropriate]. Your child's interview data will be analysed by me (the researcher) and written up in my thesis. I will handle [insert young person's name]'s data in accordance with the Data Protection Act (2018), General Data Protection Regulations (GDPR) and the University of Birmingham Code of Practice for Research and Ethics.

Does my child have to take part?

No. Participation in this research is entirely voluntary. If [insert young person's name] does not take part, no questions will be asked and there will be no consequences for [insert young person's name]. You also have the right to withdraw. This means that if you agree and then change your mind, you can withdraw your consent up until 7 calendar days after my interview with [insert young person's name]. You can email me at X or contact (insert name of SENCO [special educational needs coordinator] or Headteacher on – insert email address and telephone number) at school. You will not have to provide

a reason.

If I agree for my child to take part, what will happen next?

1. If you agree for [insert young person's name] to take part, please complete and sign the parental consent form.
2. Please return the parental consent form in an envelope to the [insert name of SENCO or Headteacher] (Special Educational Needs Co-ordinator/Headteacher) at school.
3. Once I have your consent, I will contact [insert name of SENCO or Headteacher] (Special Educational Needs Co-ordinator/Headteacher) at school to arrange the date and time of the Q-sort.
4. I will also need [insert young person's name]'s consent. He/she [delete as appropriate] will need to read the participant information sheet and on the day of the Q-sort prior to starting, the researcher will talk through the information sheet and get [insert young person's name]'s to sign the participant consent form.

How can I contact you?

Researcher: Catherine Byng, Trainee Educational Psychologist	
Telephone:	Email:
University Supervisor: Dr Julia Howe, University Supervisor	
Telephone:	

Please do contact me if you have any questions, concerns or suggestions regarding the study.

Yours sincerely,

Catherine Byng

Appendix 8-Parent consent form

UNIVERSITY OF BIRMINGHAM

Please read the following statements and tick each one to indicate your agreement:

		Tick to indicate agreement ✓
1	I have read the parent/carer information letter and have had the opportunity to ask any questions about what it means if my child takes part in the study.	
2	I give permission for my child to take part in the study if they also give their agreement.	
3	I understand that my child and I both have the right to withdraw. Either of us can change our minds about taking part, without having to provide a reason. It is possible to withdraw up until 7 calendar days after the interview with my child.	
4	I understand that my child's data (Q-sort & interview transcript) will be used in Catherine Byng's thesis and may also be used in a published write-up or conference presentation(s).	
5	I consent for my child to be contacted by Catherine Byng after the Q-sort has taken place, to allow Catherine to offer my child the opportunity to learn about the findings derived from the research.	

Signed: _____

Name: _____

Child's name: _____

Date: _____

Appendix 9- Staff consent form

UNIVERSITY OF BIRMINGHAM

Please read the following statements and tick each one to indicate your agreement:

		Tick to indicate agreement ✓
1	I have read the participant information sheet and have had the opportunity to ask any questions about what will happen if I choose to take part in the study.	
2	I agree to take part in the study.	
3	I understand that I have the right to withdraw. I can change my mind about taking part before or during the planned research interview, without having to provide a reason.	
4	I understand that, as part of my right to withdraw from this study without having to provide a reason. I can ask for the recording of my interview to be deleted up until 7 calendar days after my interview with the researcher (Catherine Byng, trainee educational psychologist).	
5	I understand that my data (interview transcript) will be used in Catherine Byng's thesis and may also be edited for inclusion in a published journal article and / or conference presentation(s).	
6	I consent to be contacted by Catherine Byng after the meeting, so she can ask me whether I'd like to learn about the findings of her research.	

Signed: _____

Name: _____

Date: _____

Appendix 10- Interview schedule

Housekeeping: (after consent form signed)

- Thank them for agreeing to take part
- Explain will ask question about what supports pupils to reintegrate to a new education setting successfully after support from medical education provision

Interview commences (turn on audio-recorder):

Topic	Possible questions	Possible prompts and follow up questions	Probes
1. Helpful	What things do you think help pupils the most when reintegrating into a new education setting?	*Can you explain how that supports them?* *Follow up-* *Things at home/ in the new setting that support them* *Flexibility/ adaptions in new setting* *How can teachers in new setting support?* *Are there things other pupils can do to support in the new setting?* *What kind of things do staff from medical education provision do support successful reintegration?*	*Tell me more.* *Can you describe what that looks like?*
2. Unhelpful	What kind of things are unhelpful to pupils and have a negative effect on reintegration?	*Can you describe how this would be unhelpful to them?* *Follow up-* *Things at home/ in the new setting that support them*	*Tell me more*

3. Not helpful, not unhelpful	Are there things that don't have an impact either way so things new settings might think help but they are not helpful or unhelpful to the pupil reintegrating?	*Is there any way these things could be made to be helpful to helping pupils settle into their new setting?*	*Go on*
4. Other factors helpful	Was there anything else that you think has helped pupils to settle into new settings after support from medical education team?	*e.g., friends, teachers, peers, any changes over time, self-esteem, confidence pupil…* *What would this look like?*	*Can you tell me more?*

Conclude interview (turn off the audio-recorder):

- Thank the participant for taking part.
- Remind the participant of their right to withdraw within the next 7 calendar days, and of the steps to take should they wish to do so.

Appendix 11- Initial Q-set

1. Other pupils were kind and welcoming.
2. I had friends in school.
3. A 'buddy system' was in place when I moved to this school.
4. I knew pupils who attended the school before I started.
5. No pupils knew me at the school when I started.
6. I had a particular member of staff that I could go to in school.
7. I got on well with staff in school.
8. School staff listened to me and tried to understand me.
9. Staff in school believed that I could do well.
10. Staff in school noticed my strengths and achievements.
11. I had support and encouragement from my family.
12. I talked to my family about school.
13. I knew that my parents/ carers wanted me to do well in school.
14. My parents/ carers talked positively about the school.
15. My parents/carers met with school staff often.
16. I wanted to do well in school.
17. I got good grades/marks in my schoolwork.
18. I set myself goals/targets.
19. I felt ready to join a school.
20. I made a lot of effort to do well at school.
21. I started school on a part-time basis and gradually increased my time here.
22. I knew what the steps were going to be in moving to this school.
23. I could make choices about which lessons I went to.
24. The MET prepared me before I moved to this school.
25. I was able to visit my school before starting.
26. I knew what was happening every day.
27. I was asked what I thought about moving here.
28. Staff in school were aware of the things that I need more help with.
29. I had a meeting with my parents and school staff before I joined the school.
30. I knew what I should and should not do in school.
31. I was allowed 'time out' when I needed it.
32. I felt included in this school.
33. I felt safe in this school.
34. I received extra support with learning and academic tasks.
35. I took part in activities outside of school hours e.g., after-school clubs or sports teams.

Appendix 12- Final Q-set

1. Other pupils were kind and welcoming.
2. I had a particular member of staff that I could go to in school.
3. I knew that my parents/ carers wanted me to do well in school.
4. I received praise for my schoolwork.
5. I started school on a part-time basis and gradually increased my time here.
6. I knew what was happening every day and what I should and should not do in school.
7. 7. I had somewhere I wanted to go to at breaks and lunchtimes.
8. I had at least one friend in school.
9. School staff listened to me and tried to understand me.
10. My parents/ carers talked positively about the school.
11. I set myself goals/targets.
12. I could make choices about which lessons I went to.
13. I was asked what I thought about moving here.
14. I received extra support when I needed it at school.
15. A 'buddy system' was in place when I moved to this school.
16. Staff in school believed that I could do well.
17. My parents/carers met with school staff often.
18. I felt ready to join a school.
19. The MET and/or other services (e.g., CAMHS, Family Support, Physiotherapy) prepared me before I moved to this school.
20. Staff in school were aware of the things that I need more help with.
21. I took part in activities outside of school hours e.g., after-school clubs or sports teams.

Appendix 13- Post Q sort interview schedule

Housekeeping:

- Thank the participant for completing the Q- sort.
- Explain that will now ask questions about how they sorted statements to find out more about their reintegration experiences.

Interview commences (turn on audio-recorder):

Topic	Possible questions	Possible prompts and follow up questions	Probes
5. Medical needs	What led to you previously attending the medical alternative education provision?		*Anything else?*
6. Most helpful	Why do you think these, *(refer to statements from Q-Sort)* things were the most helpful for settling into your current school?	*Can you describe how this was helpful to you?*	*Tell me more.*
3. Most unhelpful	Why do you think these, (refer to statements from Q-Sort) things were the most unhelpful for settling into your current school?	*Can you describe how this was unhelpful to you?*	*Tell me more*
4. Not helpful, not unhelpful	Why do you think these, (refer to statements from Q-Sort) things were neither helpful nor unhelpful for settling into your current school?	*Is there any way these things could have been helpful to you settling into your current school?*	*Go on*

5. Other factors helpful	Was there anything else that helped you to settle into your current school?	*e.g., friends, teachers, peers, any changes over time…*	*Can you tell me more?*
	Is there anything that you did not have that you think would have helped you to settle into your current school?	*What would this look like?*	*Anything else?*

Conclude interview (turn off the audio-recorder):

- Thank the participant for taking part.
- Remind the participant of their right to withdraw within the next 7 calendar days, and of the steps to take should they wish to do so.

Appendix 14– A table identifying the rank and Z-scores of each factor for each Q-set item

Q Set Statement	**Factor 1 Z-score**	**Factor 1 Rank**
1 Other pupils were kind and welcoming.	-0.38	15
2 I had a particular member of staff that I could go to in school.	2.02	1
3 I knew that my parents/ carers wanted me to do well in school.	0.00	10
4 I received praise for my schoolwork.	1.05	4
5 I started school on a part-time basis and gradually increased my time here.	1.31	3
6 I knew what was happening every day and what I should and should not do in school.	-1.81	21
7 I had somewhere I wanted to go to at breaks and lunchtimes.	-0.26	13
8 I had at least one friend in school.	0.72	7
9 School staff listened to me and tried to understand me.	1.31	3
10 My parents/ carers talked positively about the school.	0.00	10
11 I set myself goals/targets.	-0.50	16
12 I could make choices about which lessons I went to.	0.05	8
13 I was asked what I thought about moving here.	-0.72	17
14 I received extra support when I needed it at school.	0.76	6
15 A ‘buddy system’ was in place when I moved to this school.	-0.17	12
16 Staff in school believed that I could do well.	0.93	5
17 My parents/carers met with school staff often.	-0.38	15
18 I felt ready to join a school.	-0.93	18
19 The MET and/or other services (e.g., CAMHS, Family Support, Physiotherapy) prepared me before I moved to this school.	-0.17	12
20 Staff in school were aware of the things that I need more help with.	-1.64	20
21 I took part in activities outside of school hours e.g., after-school clubs or sports teams.	-1.19	19

Appendix 15 -Factor Array for Viewpoint 1

Q-set statement	**Rank**
2 I had a particular member of staff that I could go to in school.	4
9 School staff listened to me and tried to understand me.	3
5 I started school on a part-time basis and gradually increased my time here.	3
4 I received praise for my schoolwork.	2
16 Staff in school believed that I could do well.	2
14 I received extra support when I needed it at school.	1
8 I had at least one friend in school.	1
12 I could make choices about which lessons I went to.	1
3 I knew that my parents/ carers wanted me to do well in school.	0
10 My parents/ carers talked positively about the school.	0
15 A 'buddy system' was in place when I moved to this school.	0
19 The MET and/or other services (e.g., CAMHS, Family Support, Physiotherapy) prepared me before I moved to this school.	0
7 I had somewhere I wanted to go to at breaks and lunchtimes.	0
1 Other pupils were kind and welcoming.	-1
17 My parents/carers met with school staff often.	-1
11 I set myself goals/targets.	-1
13 I was asked what I thought about moving here.	-2
18 I felt ready to join a school.	-2
21 I took part in activities outside of school hours e.g., after-school clubs or sports teams.	-3
20 Staff in school were aware of the things that I need more help with.	-3
6 I knew what was happening every day and what I should and should not do in school.	-4

Appendix 16-Crib Sheet for Viewpoint 1

Item ranked at +4
2 I had a particular member of staff that I could go to in school.
Items ranked at +3
9 School staff listened to me and tried to understand me.
5 I started school on a part-time basis and gradually increased my time here.
Items ranked at -3
21 I took part in activities outside of school hours e.g., after-school clubs or sports teams.
20 Staff in school were aware of the things that I need more help with.
Item ranked at -4
6 I knew what was happening every day and what I should and should not do in school.

Appendix 17-Transcript of example interview with member of alternative medical education provision staff

Speaker 1- Interviewer

Speaker 2-Interviewee

Speaker 1

There we go.

It's recording now.

Perfect.

So this interview will just be able to ask you questions about what supports people reintegration from the medical education provision.

It's kind of semi structured so there will be some questions that I might kind of follow up on a few things.

If there's anything interesting that you say.

But yeah, just it's really just your opinions.

From what you know from your work, what you've seen that works that works kind of well.

And so I guess to start what things do you think help pupils the most when they're actually reintegrating into a new setting?

Speaker 2

Right, OK, so are we talking specifically a new setting or reintegrating back into their original setting?

Speaker 1

A new setting to start with.

Speaker 2

A new setting.

OK, well, I think that. I mean, you know most children have some measure of anxiety, which is the prohibiting factor.

So even though you know we do have children that have physical medical conditions, the vast number of them have mental health difficulties, normally anxiety and so making connections with the placement is really really important, so it will be that they would.

The placement works together with us to get a full understanding of the student and their their difficulties.

And you know what are their absolute no? Do this with them. Don't do that with them.

What does work and what are their points of interest and sharing of obviously information with the new placement in terms of and then understanding sort of the diagnosis of what's happened during the time that they've been out of school, and so liaison is really importantly.

But also that the school then involves themselves wherever possible in transitioning, so coming into the unit and meeting with the child, and so there are some familiar faces and points of connection from from wherever the setting might be and then come in and sort of start to do that handover gradually.

And then perhaps when the child visits that they would offer, you know, a preliminary visit for child and parents and then trial sessions. That there will be a negotiation in terms of the timetable and what the child feels that they can comfortably access with kind of like a stage plan so that they know where there you know where they're going.

In particular, children that are, you know, have ASD, they they need a plan, and they made very kind of clear parameters. Even before they visit the setting things like photographs showing the child.

Photographs of the of the new setting and can prove to be really useful as well, so they can kind of visualize it and which and you know that that's really helpful.

Again, should be with children with the diagnosis of ASD, so I think you know initially that kind of liaison that kind of stage integration, those connections being made and with the kind of full understanding.

Of the child situation, their position as it is at the how it has been, how it is currently and what their needs are likely to be going forward.

And so I mean that that's really, really important and we've we've had, you know, examples of good success with that.

Obviously with with the position as it is with COVID and things over the last couple of years, they haven't had the transition and the support that we would have liked across 2 settings, but generally that is that is the ideal.

Speaker 1

Yeah, and you mentioned a bit about, I suppose adaptions to kind of timetable and the lessons.

Are the kind of other adoptions that could be made in this school, so when they actually start, are there any other adaptions within when the pupils actually starts at the new settings that you've seen that's helped any individual pupils?

Speaker 2

Yeah, I mean I, I suppose it would be things like in in terms of, you know, like you said with with with timetables, but it will be things like perhaps initially getting them to go in just for social times play times, or you know, for the story times if they're little or choose your your favorite subject.

But there may be some exclusions in the timetable, so for some children, PE, for example, is one of those big no nos, so they may not be required to do PE for example, and things like you know that.

I mean, we we we had a student that had particular issues with certain sounds.

And with certain triggers in terms of words as well so you know briefing teachers on try not to where possible or you know and and if they do have a a meltdown these the ways in which they they might need to, you know be be supported either that they needed a breakout rooms so that they could kind of self soothe.

Either they might need somebody that would, and you know, be their point of contact that will be the person that calms them down and things like you know stress, stress, toys and whether a child might need something like and you know doing some artwork or some doodling is what calms them down.

You know so I think there are all sorts of kind of little bits that that can be done that makes it kind of more comfortable.

For the child, where possible, things like and avoiding direct questioning of the child and right, you know, rather invite them to to the class to give an opinion rather than to sort of pick on a child.

Things that they wouldn't want to do, like for example, and don't pick that person to read out loud, you know initially, and so I think that there are sort of modifications and and things that can be made.

There may be things also within the school, so things like an access to uh, like a mental health, first aider or the the the counseling support and you know access to a base, timeout cards. If they're feeling particularly stressed.

Just sometimes, modifications to uniform as well if that is possible and you know sometimes you know to do with particular sensory issues, why I really, really struggle with a tie or shirt or whatever it might be, so it's quite a range of things that can be quite specifically individual to the child that is really important break times as well can be particular stressors.

So having somewhere to go at break time, maybe a support or a structured activity that they can go somewhere and play a board game with a TA and some other children.

But being as well, you know, finding somebody that they can buddy with in in in the the you know in their new groups could be helpful as well.

Yeah, there's there is quite a lot and obviously some places are better at those things than than than others really, and also depends on resourcing and you know, in an ideal world You know some initial one to one support is really important, and it's something that's very often you know, if I write an EHCP and report and suggest recommendations for placement, you know having that one point of contact and some individual support in the beginning is really helpful, but not always very easy to kind of resource or staff, really, but yeah, so I think that's probably the kinds of things.

Speaker 1

And I just wondered then is it different then for those pupils who are reintegrating back to the original setting that they came from?

So before they they come to yourself if they're going back to that setting, is there anything else that should be considered or different things that need to happen?

Speaker 2

Yeah, I mean obviously all those previous things apply if they're returning to their new their original setting, but I think that one of the most important things is to consider.

I mean, obviously any child that's referred to the MET has basically been unsuccessful in this goal, their school placement has not been able to support them.

For for whatever reason that might be.

And sometimes that's to to do the suitability of the placement or is to do relationships and history and with the child and and so we do have sometimes that children will go return to school, but maybe have a different tutor group.

Might be setted differently to be away from certain groups of children that have caused them difficulties and upset prior to them you know, coming to the MET.

It maybe sometimes the children don't wish to be with certain teachers and they will.

You know I had an example of a child who felt that their particular class teacher had not been sympathetic to their situation prior to them coming to the MET and so did not want to go back with that teacher and needed to avoid that teacher where possible.

And so sometimes there are some additional things.

So you really have to kind of pay attention to.

What I mean, and sometimes the schools have done all they can, you know?

So I'm not saying it's the schools fault on on on occasions and generally, isn't the schools have done all they can and being as accommodating as they can and as flexible as they're able to be.

But you know, sometimes there are certain things that they really can't cope with certain areas in the school.

That have very difficult associations.

And so you know those kinds of things.

Then come into playing with.

Well, what will be, though the prohiters, is to then return to school what they're most worried about and and in the main children, or if not children, their parents are very good at being able to communicate that.

So those factors can be and can be dealt with as far as possible.

Speaker 1

And I just wondered, I suppose this happens, I guess before they're actually reintegrating or transitioning, but I guess how things that the MET staff do to prepare them that can help those pupils with a certain things that are done in the setting prior to them reintegrating or with MET staff.

Speaker 2

And yeah, I mean I, I don't know that you know that we do anything astonishingly different to what you know. The recommendations would be within within a school.

I think the good thing is obviously because we have small numbers and we really kind of get to know what works with the children and what doesn't.

And so we get better kind of embedding those procedures and those processes and with the children and those routines that then will be continued into into school.

And so it could be anything to do with you know if for example, a child had difficulties with social interactions in school and that was one of the the the keys of reasons why they were placed with us, that they really struggled with relationships and friendships and and you know they misunderstood the the meaning of people and felt victimized or whatever else, so we would do kind of a lot of work in terms of kind of building up their social skills in in break times, you know, sort of playing games with them.

Things like turn taking for example, and how they might manage if they kind of, you know, have a little bit of a a meltdown and.

You know what so you know, so I think that that that we would be quite good at sort of embedding those things.

Stress toys, soothing things, (sorry I'm just plugging in). Sometimes you know we we would know that the child prefers bluetack to sensory toy and sometimes you know.

It It is a a matter of yeah, pretty pretty much kind of supporting with with the areas that we know that they struggle with, in particular talking to people, framing conversations, modeling conversations, and supporting them in how they might express their their concerns, and how an effective way of doing that.

So whether it is that they're able to articulate that whether they write it down, whether they have a little, you know their their red and green cards to indicate that when they feeling upset or worried or need some time out that they use the card.

The little faces you know, whereabouts am I now where I am? Where am I later? You know all those kinds of things that that we can do.

Excuse me, sign there yet.

Yeah are quite helpful so we we do. The thing is, I suppose by the time by the time they leave us the multi-agency has agreed that they are in a better place.

They're in a good place to move on, so all of the things that all of the work that we've done with them on all that preparation that that we do, and sometimes it literally is just the gift of the setting because the setting is small, it's quiet, it's the same people, it's a small number of staff, it's the same people all the time.

And so sometimes it is just a matter of reducing that anxiety, getting them back on an even keel, re-engaging them in education in a a different kind of setting. Uhm, that actually is is the the biggest the biggest thing.

Just taking the time out to settle.

Sometimes there's more work to do and than with others, particularly if we're transitioning key stage three children.

So a lot of those I could say the social gains their turn taking and all those kinds of things are really, really important because a lot of the children find that very, very difficult.

Speaker 1

Yeah, that makes sense, and I suppose then.

So when they get to a point where you've kind of prepared them and everyone in the multi agency who's involved has agreed that they're they're ready. Is is the pupil kind of told about that? Do they have a? Do they get some kind of decision and kind of say in in when when they actually reintegrate? How how does that happen I suppose?

Speaker 2

Yes they do, and obviously and when we do our PEP reviews six weekly there is a pupil voice, and that's recorded in the PEP review along with the parents, the school, and the health or whatever else.

So we kind of do get an idea of whereabouts they are and what they what they want.

Sometimes the children are really keen to go back to school, not necessarily because they they missed school, because often they missed their friends so sorry don't think can hear me.

OK, you're frozen on the screen.

Speaker 1

Yeah, sorry, I can hear you.

Speaker 2

Are you there?

Speaker 1

Yeah, can you hear me?

Speaker 2

Oh, you froze on the screen are you are you?

Can you hear me OK?

Speaker 1

I can hear you.

Speaker 1

Yeah, I can hear and see you fine can you hear me?

Yes, I can hear.

Speaker 2

You now you two frozen screen but no, no, that's that's fine.

Speaker 2

And yes, so in terms of the pupil voice, so sometimes they will express a desire to go back to school.

And that does happen.

Like I say, generally because they probably missed their friends and they missed the fun subjects because we are a core provision and that's actually quite a useful way to sell.

Going back to school to a child because actually we don't have PE.

Speaker 2

We don't have our. We don't have those kind of you know those exciting subjects children enjoy. Particularly creative subjects or IT facilities, so sometimes they want to go back to school.

And will express that and sometimes they will be nervous about going back to school and will have really taken to our setting and be reluctant to return.

Obviously, the pupil always has a voice in what it is that they want to do but to some extent we are a temporary provision though, so there are never any.

So even when people joins us at the beginning when they come in for their first meeting, they absolutely everybody understands and it's very, very clear on the table that this is where you come to feel better to re engage and then you go back to school so that that is always something that they are aware of and each of the PEP reviews are around should the placement continue, should it not so that they would be familiar with those with those kinds of conversations and as they say, sometimes they are reluctant to return and in which case their their transition will be handled more carefully and over a more prolonged period of time.

And you know, generally we would be looking to transition over the period of half a term.

And so that they would have sometimes with some time with us and some time in their in their new setting.

Some children that doesn't work. They don't want to be in two places. It kind of messes with them.

They're driving, they're over here or they're there.

So some children say.

OK, well I know then I visited my view setting and then I know that I'm going to be going there and so I've I've had a few taster days and I should be starting there and two weeks on Monday and then, that's it.

Yeah, and for others it's a a longer process.

And we do. In in days gone by as well when we were better used and it was pre Covid we would have gone with the children into their school and or their new setting where possible and and get into their lessons met their teachers.

And kind of being there to support that that transition as as a point of continuity, yes, but yeah.

I mean they always have a say, but that doesn't mean that they don't get to go back to school when it is time for them to go back to school.

Speaker 1

Yeah, so as I guess COVID actually I guess impacted how successful the reintegration has been when MET staff haven't necessarily been able to go into school with those pupils that would would need it.

Speaker 2

Yes, I mean yeah, when I suppose in terms of specific examples, if you imagine you know reintegration into school and you know we we, we don't have one a half term or one a term you know it it's quite it doesn't happen that often. I I know recently that you know we can't. We have had our TA's are going back out again and trying to support that reintegration into school.

And so we are doing that again.

So it was kind of suspended for a period of time when people didn't want, you know, people in two settings, which is kind of understandable, but yeah, and that's sometimes can be helpful.

And and sometimes the children don't want it because the other thing is as well, because they don't want to look different.

They don't want to be the new kid who brings their teacher or their TA with them. Sometimes if they're a little more, or you know, sensitive to their, the way that they are perceived.

They may not wish to be identified as being any of the any different, because it's their new which is different enough really, isn't it?

Speaker 1

Yeah asbsolutely

Speaker 2

I've lost you, oh there you are, I loosed sound for a second.

Speaker 1

Sorry, I think I guess are there things then that you've noticed that sometimes are actually quite unhelpful when reintergrating so things that can sometimes happen but are actually quite detrimental to the reintegration process.

Speaker 2

I think that sometimes we we've had issues previously where a plan has been arranged or agreed and the MET hasn't been consulted and to give our kind of our input and our insights that might have helped to formulate a more successful plan.

Given that we have had that time with the child.

Sometimes a plan is agreed and then doesn't happen because there are insufficient resources or for whatever reason.

Oh well, you know they promised that there would be somebody to meet him every morning and then there wasn't and and that kind of thing.

So sometimes those things can you know, prove to be detrimental into their then transition back somewhere and other things that might be.

Speaker 1

So it sounds a bit like the I suppose for yourselves a communication between school, yourselves, I guess family, and when the plans actually agreed that everyone is involved.

Speaker 2

Yeah that is the preference, it doesn't always happen, but that is, you know, and and as you say, that that tends to be kind of more successful. Because actually sometimes as well as they're reintegrating that the child that they remembered. School previously may not be.

I mean generally the presentation in the MET is different.

Obviously there are certain elements of you know if a child is sensitive to a particular sound that remains there aren't you know, these things don't suddenly disappear when they come to the MET.

But sometimes the child that we kind of then send back or move on is not necessarily the child that they would have seen previously and so you know, things like certain sensitivities or preferences or you know, supports for self soothing or whatever it might be, but you know those things are they may change, or they may remain the same.

But yeah, I think the the meeting with the the the school or the OR the setting is really really important and kind of the sharing of that and also as well.

You know, in terms of the health input is really important so that we you know the MET are very much steered by health.

They tell us what they feel that the child can comfortably do. They tell us to what extent we can, you know, sort of push or encourage the child you know how time might be increased and and that kind of thing

So if the the school also tried to move things along too quickly, that would be that can be very detrimental, you know so.

For example, you know we have a child who has chronic fatigue, who still, after eight weeks of MET placement, is still well supposed to be attending one hour, 3 days a week and is still not achieving that, and so we go back to health and say you know should we, you know, can we say well, you know you really ought to be doing this, that and the other and they say no, no give it another six weeks you know with all sorts of other things that need to be taken into that need to be remedied and sorted and addressed in terms of patterns and sleep, hygiene and various other things so you know.

So the the I guess the good thing about the MET is that we are very very informed by health and work closely with health.

Once they're back in school so for example, you know if that child was then in a position to start doing her three hours a week in her school setting if they then tried to move that on too quickly

because they didn't have that health, important that liaison, then that that would could potentially sort of lead to it it not working.

Speaker 1

Yeah, yeah, absolutely.

And and I suppose just because you've got pupils, of course in the MET, someone with kind of the mental health difficulties and then some who do have kind of I guess more physical health issues.

Is is the reintegration different for those with I guess physical health conditions and does it depend I guess on the condition itself that they have?

Speaker 2

Yeah, I mean in the main it's generally more straightforward if it's a physical health condition, because either it's something that resolves itself with treatment, medication, operation, whatever it might be, and that there's a period of rehabilitation and or and then they can return.

They are, if it was kind of that type of thing that generally you know that they are as they were when they came out of school, they just return and continue in in the main part.

Depends on what kind of illness it is.

You know.

If it was something like a child returning after you know chemo and again there would need to be certain sort of measures in school in terms of the reduced timetable kind of building up stamina and that kind of thing, but also special considerations if there are if their immunity is is is compromised in any way and making sure that and you know any concerns of anything that is communicated to parents that may potentially cause an issue for the child should they contract the you know the measles or whatever it is that's going round, you know there.

So I think you know in terms of if it was, uh, you know, the post operative and you know, uh, physical condition that this has been treated and resolved.

Those things are much, much more straightforward.

It is the mental health difficulties that are very, very difficult to kind of balancing and get right and and really support in terms of the reintegration.

But yeah, so I think yes there is a difference.

Yeah, and in the main part.

Yeah, it's certainly easier really if it's physical, yeah.

Speaker 1

And I guess is there anything that you see that maybe schools put in place?

That it doesn't really It's it's not unhelpful, but it's not necessarily helpful for pupils either.

Is there anything that I guess schools do that think will be helpful, but often it doesn't really you don't think it impacts the reintegration?

Speaker 2

I mean, that's a good question.

I'm sure that we haven't would have had it had examples of it previously.

I might have to think about that because I think in general schools if they do something that's unhelpful and they they generally hadn't realized that it was a, it was a kind of an unhelpful thing to do, and I'm just trying to think of if we've got any specific examples

Yeah, so for example, if a school put in a TA to support the child and the child didn't want to be identified as being different.

You know.

Or if they were withdrawn from something that they wanted to take part in 'cause the school said this.

Although well, they didn't like PE before they went to the MET, so we won't give them PE, you know.

So I suppose there are certain things that could maybe happen that would be detrimental, and you know to to the child, but obviously the the school wouldn't kind of mean to do that.

But in terms of specifics.

Speaker 1

Sounds almost like if they've kind of made assumptions without consulting others 1st to check that that's still the case, I guess for the child.

Speaker 2

Yeah, yeah.

And also an acknowledgement of that maybe the child is has moved on or is slightly different or slightly different needs now so you know, for example, you know a child might be offered.

I don't know some you know, the little sensory toys or something and they don't do that now 'cause they're far too grown up for that for that kind of thing you know.

I suppose, conversely, near the side of things, we do have a a child in year 10 who still brings a stuffed toy with her as well as her comfort so you know, though, is those kinds of things, or you know.

She might not take her stuff to if she was back in school because she might not want others to see her, whereas met is kind of a a safer space in a way, isn't it?

Yeah, so I think for all of their.

All sorts of kind of little subtleties that.

Well, those seem quite quite small.

Could be really quite significant and you know so you know and and things like that that are difficult for schools like the uniform for example.

And and, you know, in terms of restrictions on appearance, there are certain things that they they can't let go and which makes it difficult.

We had a, uh, a boy that was trying to reintegrate into his school was desperate to go back to school and was was originally referred to us for kind of mental health difficulties, but actually he'd been discharged 2 years by the time he moved on from the MET.

Really didn't have any health input or involvement at all and was ready to go back to school and wanted to go back to school and had disengaged with the MET, but of course then because we're part time and when he went back to school and he wanted to be allowed to have cigarette breaks.

Speaker 1

Yeah.

Speaker 2

And the school said no, yeah.

You know, so we can't accommodate that.

But you know so. So there are certain things things that you know, the the schools can't do in certain things that they they can.

And you know just say certain aspects of of uniform.

Although we do have a sort of uniform here, we we try to make it a smart but kind of comfortable arrangement so we don't insist on things like shirts and ties and blazers.

But we like them to be smart but then if they've got trainers and you know dark trainers or every we don't tend to quibble on that.

I mean, we had one girl that had a real thing for kind of wearing wigs.

You know she like wigs and they were some of them they were quite brightly coloured again those things couldn't really be accommodated within within school, so you'd be surprised at kind of what those little issues are that actually are for some kids kind of deal breakers because they're they they just cannot be accommodated within the setting that they are moving onto or returning to. So those are tricky negotiations.

Speaker 1

Yeah sounds sounds difficult. Yes because the school have that uniform and they know that it would help for the child to be able to be accommodated. But then it's I guess from the schools point of view they're thinking of their uniform policy that they have aren't there, which is really difficult.

Speaker 2

Yes, yeah, and so. And for this you know, this boy obviously with you know he's addicted to cigarettes. It affects his, his mood and his conduct. And of course, when he was at the MET and working part time, you know doing part time hours or whatever he could, you know. Get through it, but when he was going back to school.

You know, so although it seems a ridiculous request and we actually is a ridiculous request on behalf of the parent if they say can you have fag breaks well?

No, but it you know it's to d you know, we know the cigarettes kind of affect their their mood, you know.

Speaker 1

Yeah, and if he's getting to that point where he's been in school for a long time is yeah, he's got his attention's gonna be affecting his concentration, yeah?

Speaker 2

That's it, so he's far more likely, and he did have tendency to kick off in school.

He's far more likely to kick off if he doesn't get a cigarette so.

And actually, as it turned out, he then he is one that didn't wasn't just not able to reintegrate back to school and then did go onto a different kind of alternative provision that was really for, and, you know, kind of aspects of behavior rather than, you know health needs.

Speaker 1

Yeah, so it sounds like sometimes although the health needs are what they come to the MET for in the first place. Sometimes then getting back in it, it's other things as well as the health needs that can affect it, whether it be sensory needs or other things that are going on as well for the child.

Speaker 2

Yes, yes, absolutely.

Speaker 1

And and was, I guess there anything else that you think is really important, that I guess we haven't spoken about for pupils just settling back whether it's to a new setting or to their previous setting anything to do with friends, teachers. I guess the pupil themselves their self esteem anything like that.

Speaker 2

Well, I mean yes. And I suppose we have kind of touched on on those really. Haven't we previously in terms of you know if they've been, you know, going back to a friendship group that helps if they've got somebody in their class that they know that helps.

If it was a teacher, they had in previous years, as their form tutor or their class teacher, that they particularly sort of engaged well with or sometimes it is.

You know, schools do go to it and lengths at the times to suit temperaments you know, say, oh, he you know he'll go really well with so and so because he loves his PE an he's a big football fan and they'll be able to talk about that.

And this so you know, there is a lot of thought that kind of goes into that, but it's also really important, particularly for returning pupil that they feel wanted and welcome and and I have had had experience of children who were obviously extraordinarily challenging within their school

settings that have been to us for a period of time, and it was time for them to kind of reintegrate back, and they wanted to go to school. They were actually they hadan EHCP and were but they did not get allocated a specialist provision and that was really the the the requirement or the hope you know from from all parties so he you know he was quite young so he did end up trying to transition back to school but there was a feeling that of resistance and reluctance.

That certainly would have been communicated within the professionals and meetings and with us sometimes the parents you know we're attending were aware, or you know, or in certain ways aware that the child wasn't really, you know, welcome because they proved difficult previously and staff members were wary.

And so that is that is tricky. And you know, as it happens in that instance, again, the school. You know, the school reintegration and that was a very, very prolonged and supported transition from the MET to school. We did a terms worth of work with the school and our TA actually, who's working part time for us went and supported thought in his school and she ended up working at the school and being his one to one TA. So I mean that was a very unusual circumstance, but you know we did and we all did.

You know I was going in for days. We all shared it between us and we were sitting in for you know whole half days and things in lessons with that child. It was a very very long supported transition. On behalf of the MET. But even then he did end up with a specialist ASD provision, which is better for him, and it was a better outcome, but in a way it was it was a bit of a shame that the way the system is setup sometimes that it has to not work somewhere before they can get the place that will work.

Speaker 1

Yeah so long and he's always spent so long trying to reintegrate back to there and so many resources when actually If that other placement was available straight away, that probably would have been easier transition forward.

Speaker 2

It would have been much better for all concerned, I think much, much easier, much easier on him, but you know, and since then you know he's he's he's settled and and doing very well. So again, you know he's kind of matching the provision to the child and she would.

It wouldn't surprise you to know in terms of kind of resourcing and things that transition in a child with special needs into a specialist setting is a far more successful thing than trying to transition a child back into mainstream when previously mainstream has been unable to kind of meet need.

And even sometimes within the EHCP, sometimes schools are just not able to provide the things that are named on any EHCP, even with some additional funding.

So sometimes it will say things like, you know they need. I don't know daily mindfulness or something.

You know they they they can't do that but in a specialist setting obviously they there are they they can meet the needs of the EHCP much more effectively and easily, I think.

Speaker 1

And I've noticed you mentioned a few times in a few examples pupils with ASC and kind of autism as well. Is this something you see kind of co-occurring with kind of the children that you're getting 'cause obviously they they come to you for kind of mental health and difficulties and mental health illnesses, but it is something you see co-occurring alongside them?

Speaker 2

Very much so. The yeah, the majority of our children have or get a diagnosis of ASD during their time with us, and I don't think that's an exaggeration to say, and certainly the balance has shifted during the time that I've been at the MET, we have more children with an ASD and.

And as I say, they they sometimes get their diagnosis while they're here with us, and it's very difficult for children that have anxiety and ASD because they kind of fall between that and because CAMHS will not take them on unless they think that it's a mental health issue rather than anxiety that's linked to their autism, and so there's a whole swathe of children that are not really getting that kind of mental health support because they they don't meet the CAMHS criteria because of the ASD and they will judge or consider that it's to do without their autism, and and then they're not coping in school.

So yeah, we get an awful lot of children with anxiety and autism. And in fact it says the demographic in the unit. All of the children have a diagnosis of what of anxiety alongside whatever else it is that they are here for. Or you know, anxiety is sometimes the reason they're here and you know depressive illness and and you know the variety of and conditions associated with that.

But you know, we do have a lot a lot of kids with ASD we do have most, if not all of our children have anxiety.

Most for the majority of the children, that is the main reason that they were this anxiety and depression over and above, you know, physical conditions.

Physical, actual, physical referrals are reasonably be few and far between.

Speaker 1

Yeah, yeah, so it sounds like those that were almost like the same, almost kind of missed by health because of other things that are going on, but they still have kind of health issues that they need support with as well as at different health, yeah.

Speaker 2

Yeah, especially the presentation for the MET because sometimes the letter that supports their placement at the MET is also a discharge letter, so there is no intention that any further therapeutic input will be provided, so they come to the MET in terms of supporting them. You know in a smaller setting and helping them to access their education, but actually their ability then to really access mainstream education is very, very limited, because of course they're not getting that therapeutic input.

So in a way we may kind of sort of patch them up and get them in a better place.

Get them in their routines, get them attending, get them building trusts and relationships, get them learning.

And in good routines, getting out of bed. You know having a purpose.

But then you know they're not actually, though the underlying issue isn't always being being supported, and that's that is difficult.

Yeah, and puts us in a bit of a bind really as as a service.

Speaker 1

Yeah, it sounds really tricky and just the last thing and you you have kind of touched on this throughout.I just wondered if there are certain things that parents and families can do when working with yourselves so it can help to support their children when they're thinking about that reintegration.

Speaker 2

Yes, and I think consistency of messaging and supporting the plan.

So whatever the plan is that the parents stick to the plan and it's very difficult for a lot of our parents, because obviously they're very worried about their children understandably so, and and have experienced such difficulty's in the past that they struggle to kind of then keep on plan because they want to be flexible and they want to make accommodations on he was really upset this morning so I didn't think he was able to.

So sticking with the plan and being supportive of the plan and being very explicit to the child about what the plan is and how they are supporting it, being absolutely on board, but also in terms of the narrative and the messaging from the parents that it has to be consistently positive.

And and a lot of our parents don't realize they're doing it, and I will sometimes say and point out to them. Do you know what? When they come out of the MET, it's really really important that you say O what did you do that you enjoyed, or you know, rather than sometimes they would come out and the parents say you look tired, have you had have you had a hard day or you look a little bit upset?

Are you OK or or yes that was going to be tough for you I knew that you'd really struggle with it today, so well done for. and and the kind of the the way in which they kind of would address the child is not helpful it's not forward looking and it's not picking up on the positives and there's too much dwelling on some of the negatives.

And that comes from the parents fear and the parents concerns and for for the child which we understand.

But trying to get them persuade them to just keep it on, you know with with the positives and speak very positively and be looking forward and planning and not constantly ruminating on well course. Yes, you would be worried about that 'cause you really struggled with our school, didn't you?

Or if you didn't like her or she was mean to you, or you know he didn't listen to you or he didn't and and and that's the thing, I think that parents tend to kind of ruminate unhelpfully, sometimes you know.

So when a child says, well, I don't want to go there 'cause I don't like Mr. So and so as they were, where you haven't got Mr X. So and so you've got, you know, got someone. So haven't you and you really liked her and of course, you've got your friend in that group and you know all you don't need

to worry about that, and you know, so instead of it it would be oh well, yes no it was really hard with Mr so and so wasn't it he did you know so you know parents need to be trained up a little bit in terms of us and say they they can't you know, being very kind of positive and consistent in terms of their messaging. Very supportive, very encouraging. Dwell on the positives.

You know, not not to not to shut down the child, not allow them to express their concerns about things, but not be the initiator of the negativity.

Speaker 1

Yeah, yeah, absolutely.

And I suppose that that is hard for parents when they've gone through probably the process for so long. It's it's tricky, but yeah I guess with that support it's about actually you working with the parents to to kind of show them that and how to do that as well sometimes.

Speaker 2

Yes, yeah. Very much so.

Very much so and always kind of it.

You know, having that assuming that the child can do and we'll worry about it if they can't not, or you know, and sometimes they will put limits on, well, you know or negotiations that are unhelpful.

Well, if you could just go in for one lesson and then I'll come and pick you up instead of well we'll take it lesson by lesson and the MET will let me know if things that are tricky.

You know, so there's just kind of ways of doing things that that are more helpful in terms of and then obviously with getting them onto the the new setting.

And also if the parent has had a history of difficulties or difficult relationships, or the relationship has broken down with the setting that they're returning to, there has to be you know a lot of kind of building up of those relationships and making them all kind of positive again and just that whole thing of being absolutely consistent and positive and all on the same page.

And that's MET, that’s parents, that's school, whatever it might be is really, really important.

And I think that's a really kind of nice place to finish.

Speaker 1

Everyone on the same page, so thank you so much for taking the part.

Speaker 2

It's alright you’re welcome.

Appendix 18- An example of the coding process

Transcript P111	**Code**	**Theme**	**Subtheme**
But also that the school then involves themselves wherever possible in transitioning, so coming into the unit and meeting with the child, and so there are	Connection	Relationships	Staff
some familiar faces and points of connection from from wherever the setting might be and then come in and sort of start to do that handover gradually.	Small steps	Planning	Gradual transitions
And then perhaps when the child visits that they would offer, you know, a preliminary visit for child and parents and then trial sessions. That there will be a negotiation in terms of the	Visit setting	Environment/ setting	Routines
timetable and what the child feels that they can comfortably access with kind of like a stage plan so that they know where there you know where they're going.	Timetable	Planning	
In particular, children that are, you know, have ASD, they they need a plan, and they made very kind of clear parameters. Even before they visit the setting things like photographs showing the child.	Needs	Individual Support	Other needs