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**A Mixed-Methods Exploration into the Educational  
Psychologist's role in supporting children post Acquired  
Brain Injury**

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\*Please note- midway through the process I changed my name and so please know that Charlotte Kilroy and Charlotte Renton are the same person.

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## **Abstract**

One of the most common neuropsychological conditions that educational psychologists (EPs) come across in their practice is Acquired Brain Injury (ABI) (Misheva, 2020; Mackay, 2005). Despite education being highlighted within the literature as a key area in the recovery and rehabilitation of child brain injury (Slomine & Locascio, 2009), students with an ABI continue to be under-served and under-identified within the school system (Glang et al, 2008). Recent guidance (N-ABLES, 2021), aimed at better meeting the needs of children with an ABI, includes acknowledgement of the EP within the education team as someone who can provide support. To explore how EPs support children with an ABI, and to better meet the needs of these children, Misheva (2020) suggested that future research should be conducted in this area. This research aimed to do just this through two research aims:

1. What are EP experiences and practices of working with CYP with an ABI?
2. What is considered as good practice in EP work supporting children with an ABI?

This research adopted a mixed-methods design and was carried out in two phases. Phase 1 consisted of a national survey exploring the views and experiences of qualified EPs in the UK, investigating their work with children with an ABI and the perceived barriers to providing support. Phase 2 consisted of two focus groups with EPs to identify examples of good practice when supporting children with an ABI in further depth. Key outcomes, in addition to applications for practice and suggestions for future research are discussed.

## Glossary of terms

<b>Neuropsychology</b>	The scientific study of brain-behaviour relationship (Baron, 2010)
<b>Kennard principle</b>	The view that the immature brain should be more able to recover from injury than the more developed brain (Bennet et al., 2013)
<b>Initial Training</b>	The initial training course required for Educational Psychologists to practice.
<b>Acquired Brain Injury</b>	Acquired Brain Injury is the term used to refer to non-degenerative damage to the brain after birth (Headway, 2018) and can be divided into traumatic and non-traumatic categories.
<b>Traumatic Brain Injury</b>	Traumatic brain injuries occur as a result of external force or injury causing damage to the brain e.g., accidents, assault or falls (Headway, 2018)
<b>Non-Traumatic Brain Injury</b>	Non-Traumatic brain injuries occur as a result of events within the body such as brain tumours, strokes, infections, hypoxia (oxygen deficiency) or haemorrhages.
<b>Nominal Group Technique</b>	A process for 'identifying strategic problems and developing appropriate and innovative programs to solve them' (Delbecq & Van de Ven, 1971, pg. 467)



## Glossary of Abbreviations

<b>ABI</b>	Acquired Brain Injury
<b>CBIT</b>	Child Brain Injury Trust
<b>CPD</b>	Continuous Professional Development
<b>CYP</b>	Children and young people
<b>DEdCPsy</b>	Doctorate in Child and Educational Psychology
<b>EHCNA</b>	Education, Health and Care Needs Assessment
<b>EHCP</b>	Education, Health and Care Plan
<b>EP</b>	Educational Psychologist
<b>EPS</b>	Educational Psychology Service
<b>N-TBI</b>	Non-Traumatic Brain Injury
<b>NGT</b>	Nominal Group Technique
<b>PEP</b>	Principal Educational Psychologist
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>SALT</b>	Speech and Language Therapy
<b>SEN</b>	Special Educational Needs
<b>SEND</b>	Special Educational Needs and Disabilities
<b>SEP</b>	Senior Educational Psychologist
<b>TA</b>	Thematic Analysis
<b>TBI</b>	Traumatic Brain Injury
<b>TEP</b>	Trainee Educational Psychologist

## Research Interest

The idea for this research came from my experiences of working with children with ABI and my long-standing interest in neuropsychology and supporting children with neurological conditions. I saw first-hand the difficulties children with an ABI faced and also recognised their successes and progress. Since gaining a place on the DEdCPsy course, I have become increasingly curious about how EPs can provide support to this population and whether EPs are often asked to provide support. Although EPs have been cited in research as being perfectly placed to support children with an ABI and have been named in recent guidance regarding supporting children with an ABI (N-ABLES, 2021), when having discussions with EP colleagues, many believe they have never provided support to children and young people (CYP) with an ABI. I was interested in understanding current practices of EPs in relation to ABI and the ways in which EPs could provide support in the future.

Misheva (2020) supported the research of MacKay (2005) and identified that the most common neuropsychological conditions that EPs come across in their practice are Brain Injury and Epilepsy (Reilly & Fenton, 2013). Misheva (2020) suggested that future research should explore the work EPs do to support CYP, families and schools with these conditions and explore the knowledge base of EPs on such conditions. Both ABI and Epilepsy within EP practice need researching, however I have chosen to focus on ABI due to my previous experience and interest, therefore this research will focus on ABI and the role of the EP in supporting rehabilitation and adjustment to life after ABI.

## **Chapter 1. Background and literature review**

### **1.1. Overview**

In this chapter, an overview of the existing literature relevant to ABI and EP practice will be presented. Initially, ABI will be discussed, considering rehabilitation and the impact of the injury on the child, their family, the school and wider society. This will then be followed by a critical overview of a range of perspectives on the role of the EP in providing support to CYP with an ABI and potential barriers to providing this support.

### **1.2 Acquired Brain Injury**

According to Headway (2018), acquired brain injury (ABI) refers to non-degenerative damage to the brain that occurs after birth and can be classified as either traumatic or non-traumatic. Traumatic brain injuries (TBIs) are the most common cause of mortality and disability in children worldwide (Faul, Xu, Wald & Coronado, 2010) and originate from an external force or injury that damages the brain (e.g., accidents, assaults, falls). Although sports and veterans receive the majority of media attention for brain injuries, school-aged children have the highest chance of suffering a TBI (Arroyos-Jurado & Savage, 2008). Non-traumatic brain injuries (n-TBI) are caused by physiological occurrences including brain tumours, strokes, infections, hypoxia (low oxygen) or haemorrhages.

Due to medical advances, survival with significant ABI is an increasingly common outcome that would previously have been fatal (Hayes, Shaw, Pearce & Forsyth, 2017) and therefore CYP are left with significant challenges to their physical and cognitive health (Vella, 2013). Unfortunately, research shows that CYP with an ABI is a population that continues to grow every year (Law, Anaby, DeMatteo & Hanna, 2011). Data shows that the most prevalent aetiology in ABI is traumatic (Greenwald, Burnett & Miller, 2003), however, children with non-traumatic injuries still account for a significant proportion of the population (Walker & Wicks, 2012). Due to the higher prevalence of TBI, more information on recovery and impact is available on TBI than on other types of ABI (e.g., n-TBI) (Di Scala, Osberg, Gans, Chin & Grant, 1991).

TBI can have a significant detrimental impact on a CYP's physical, emotional and cognitive well-being lasting from a few days to the rest of their lives (Forsyth & Kirkham, 2012). The extent and lasting impact of the injury is often dependent on the severity. Typically, a mild brain injury is classified when the patient has been unconscious for up to 15 minutes. A moderate brain injury is classified

when the period of unconsciousness lasts for between 15 minutes and 2 hours, whereas a severe brain injury is classified if the period of unconsciousness lasts over 6 hours (Ball & Howe, 2013).

There are many causes of TBI of which the commonality varies depending on age. The most common cause of a TBI in children under 14 years is falls, however, other common causes include abusive injuries, motor vehicle accidents or other transportation-related injuries (e.g., bicycles) (Araki, Yokota & Morita, 2016). Unfortunately, abusive head trauma is particularly common in infants under two years of age and during the recent COVID-19 pandemic lockdowns, these rates of child abuse and domestic violence in the UK increased (Sidpra, Abomeli, Hameed, Baker & Mankad, 2021). In regard to n-TBI, tumours are the most common in children (Vella, 2013) but other causes include, but are not limited to, spontaneous haemorrhage, anoxia and encephalitis (Cullen, Park & Bayley, 2008).

Due to inconsistent systems for recording ABI, it is extremely difficult to determine the prevalence rate in children and adolescents with any degree of accuracy (Hawley et al., 2002). Particularly for TBI, most of our understanding is based on statistics of children who attend the Accident and Emergency department at the hospital, or those admitted to hospital. Our current understanding underestimates the frequency of child ABI, particularly TBI, as children with mild TBI or concussions may seek care at other clinical facilities or may not seek care at all, making it challenging to correctly determine the true prevalence (Haarbauer-Krupa et al., 2018; Cassidy et al., 2004; Kirkwood et al., 2008). However, according to The Children's Trust (2022), approximately 40,000 CYP experience a brain injury every year. This suggests that both mainstream and specialist settings are likely to be required to support a CYP with an ABI and it is vital that there is appropriate knowledge and support in place to facilitate and aid recovery and adjustment to life after brain injury (Davies & Ray, 2014).

CYP can present with a range of difficulties following a brain injury, most commonly executive functioning difficulties (Anderson & Catroppa, 2005), cognitive and physical fatigue (Wilkinson et al., 2018), memory (Conklin, Salorio & Slomine, 2008), attention (Catroppa et al., 2015), speech and language (Alighieri et al., 2021), absenteeism (Zemek et al., 2016), sensory sensitivities and learning capabilities (Ylvisaker et al., 2005), all of which can impact educational success. Neurological symptoms can include headaches, sleep disturbances, seizures, sensory sensitivities, dizziness and blurred vision (Jantz, Comerchero, Canto & Pierson, 2015). Behavioural changes post brain injury can include increased aggression, inappropriate sexual behaviour, substance abuse, impulsive behaviours and non-compliance (Woods et al., 2014). Socially, the CYP may experience increased social awkwardness, difficulty with social norms and rules, inappropriate comments towards others,

social isolation and impairments in recognising emotions in self and others (Muscara, Catroppa, Eren & Anderson, 2009). CYP can also experience emotional disturbances including increased irritability, difficulty with anger management, apathy, depression, anxiety or post-traumatic stress disorder (PTSD) (Davies et al., 2016).

The severity of injury closely correlates with the severity and range of symptoms experienced post injury (Anderson, Spencer-Smith & Wood, 2011). Most cases fall within the mild category, the effects of which are usually short-lived, and most CYP would show significant improvement within 3 months of injury (Toledo et al., 2014). However, around 33% of those who sustained a mild TBI will experience persistent symptoms 28-days post-injury (Zemek et al., 2016); most commonly difficulties with attention, fatigue, depression, anxiety and sleep (Yang et al., 2014). Due to the nature of child brain injury, development continues alongside rehabilitation and therefore effects of the injury may only become apparent as the child grows. For those with moderate or severe injuries, the effects of the ABI may not be immediately evident, only becoming apparent as development continues (Glang, Tyler, Pearson, Todis, & Morivant, 2004) and skills that should develop at a certain age, fail to do so. This is one way in which child brain injury differs to that of adult brain injury as rather than dealing with a fully developed brain, child brain injury is considered in the context of the developing brain and developmental trajectories (Reed & Warner-Rogers, 2009).

Researchers have looked at the effect of age of injury and the impact of injury on the developing brain. Some research supports the 'Kennard Principle', the view that the child's immature brain should be more able to recover from injury than the more developed adult brain due to increased brain plasticity (Bennet et al., 2013). However, others believe that younger is not always better with recent research suggesting that children do not in fact make quicker or better progress than adults within rehabilitation following TBI. It has been argued that due to the dynamic and complex nature of the developing brain, "early injury may compromise the development of neural networks underlying later stages of cognitive development" (McClusker, 2005, as cited in Ball & Howe, 2013). In fact, research has shown that children who experience a brain injury before the age of 8 experience a larger range of difficulties compared to older children and adults (Ball & Howe, 2013, Verger et al., 2000) and that the injury has more of a deleterious effect on the cognitive skills of younger children (McClusker, 2005). However, as mentioned above, the severity of the injury must also be considered as experiencing a severe brain injury at any stage of childhood and adolescence can have profound implications for the child's cognitive, educational, behavioural and socio-emotional outcomes.

### 1.3 Impact of an ABI on the family

Child brain injury can have a significant effect on the family unit, often altering the family homeostasis overnight. Families of CYP with a brain injury report changes in family relationships, loss of income due to caring for the CYP, high rates of psychological distress, social isolation and enduring burden (Gan et al., 2006; Anderson et al., 2011). Taking care of a child with a brain injury can be extremely difficult, not only in supporting their medical needs but managing changes in behaviour, mood, cognition and general function (Tyerman, Eccles & Gray, 2017). The emotional impact on the family of an ABI can be immeasurable, with research showing that stress, anguish, grief, helplessness and aggravation due to role alteration and loss of control are all common amongst parents of children with an ABI (Wade et al., 1996; Hawley, Ward, Magnay & Long, 2003; Shudy et al., 2006). Extended family members and friends may help the family initially, but this support often declines over time (Matthews et al., 2012).

Brothers and sisters can feel isolated, guilty that they are healthy or guilty of taking attention away from their injured sibling, terribly anxious about the new circumstances, often craving some attention, or else feeling responsible in some way (CBIT & Nasen, 2018). Families also enter a grieving process following their CYP's brain injury as they adjust to its effects, grieve the child they have lost, the future they hoped for them, and come to terms with what may be a very different child (Grovesman & Brown, 1985). The family often struggle with adjusting to new expectations and hopes for the child, holding onto the hope of recovering to pre-injury levels of function which often is not the case, particularly in moderate and severe TBI (Jantz, Comerchero, Canto & Pierson, 2015).

Research has shown that improved identification and provision of services is a potentially modifiable factor that may decrease family burden after ABI (Aitken et al., 2009). In addition to this, parents have highlighted within previous research that they wanted professionals to acknowledge the uncertainty of their child's recovery but at the same time, respect their need to maintain hope and positive thinking in regard to possible outcomes for their child (Guerriere & McKeever, 1997; Robson, Ziviani & Spina, 2005; Roscigno & Swanson, 2011; Norberg & Steneby, 2009).

### 1.4 Rehabilitation and education

CYP can begin to comprehend how the ABI has affected their abilities as soon as they leave the hospital or treatment facilities and resume their regular routines (Turner, Fleming, Ownsworth &

Cornwell, 2011). The first year after brain injury is considered critical in the rehabilitation process (Forsyth, Salorio & Christensen, 2010). Rehabilitation and recovery success following a brain injury is the focus of everyone supporting the child as the rehabilitation received can have a significant impact on the long-term functioning and outcomes for the CYP (Slomine & Locascio, 2009). Research has shown that TBI can be a risk factor for criminal offences (Williams et al., 2018) and poor long term mental health (Williams et al, 2010), including an increased risk of suicide (Knight, Norman & Simpson, 2020) to name a few. The prevalence of ABI among those who are in prison is higher than that of the general population, yet it is rarely considered by the legal system during police or court interviews or sentencing (Menon & Bryant, 2019).

However, due to the fact that research in offender groups typically focuses on TBI and information about n-TBI is usually not available, the estimated prevalence is likely to be underestimated (De Geus et al., 2021). Further complicating the assessment of prevalence amongst the prison population are memory difficulties and the individual's lack of insight or understanding of the injury, particularly in research utilising retrospective self-report evaluations for TBI (De Geus et al., 2021). Finally, it is also difficult to understand the prevalence of different severities of a TBI retrospectively or with self-report methods as severity is indicated by the Glasgow Coma Scale score which is frequently only recorded for hospitalised TBIs and the individual may not be aware of how severe their TBI was (Durand et al., 2017).

According to Leo, Macey & Barzi (2017), childhood brain injury can also significantly affect attendance, integration, engagement, and achievement (Sariaslan et al, 2016). Williams et al. (2015) found that CYP with a history of ABI are over-represented in alternative provision. Moreover, it has been shown that fewer individuals with ABI continue their education or find jobs, and many claim to feel socially isolated. Early detection and treatment of ABI's effects may have significant personal, societal, and financial advantages. Therefore, having comprehensive rehabilitation in place is vital not only for the child but also considering the long-term impact on society.

Research has demonstrated the influence of environmental factors such as family functioning/dysfunction, socioeconomic factors, parenting style and levels of distress contributing to longer-term outcomes for the CYP (Micklewright et al., 2012). Education has also been highlighted within the literature as a key area in the recovery and rehabilitation of a brain injury (Slomine & Locascio, 2009). CYP spend a large proportion of their lives in school, making it one of the most influential factors of rehabilitation following a brain injury (CBIT & Nasen, 2018). According to the 2018 All-Party Parliamentary Group (APPG) on ABI Time for Change report, all educational

professionals should have a "minimum level of awareness and understanding about acquired brain injury and the educational requirements of children and young people with this condition," (Barnes, Bennet & Etherington, 2018, pg. 7) as schools become the default rehabilitation facility for children after ABI (Bate et al, 2021). Despite this, how to support a child with a brain injury is not covered during teacher training or during training for SEN and learning support roles (McKinlay et al., 2016). It is also not included within the Special Educational Needs Code of Practice (N-ABLES, 2020). Therefore, many teachers and SENCOs lack basic knowledge about ABI, and schools regularly experience a lack of preparedness and knowledge (Linden, Braiden & Miller, 2013; Ettl et al., 2016).

Upon returning to school, it is likely that a child with an ABI will be classified as having special educational needs (SEN), making the SENCO's role in coordinating the support for these needs essential (Howe & Ball, 2017). As a result, it has been argued that it is especially crucial for SENCOs working with CYP to be aware of the effects of a brain injury. Howe & Ball's (2017) findings highlighted the participant's tendency to show a high level of ambiguity regarding their ability to correctly answer questions about their understanding of ABI. They also found that most SENCOs within their research had limited access to training and were forced to rely on their own research and experience as opposed to receiving instruction from a professional with competence in this field (Bennett, Thomas & Woolf, 2022). This implies that SENCOs are learning as they go when they do come into contact with a student who has an ABI, which is not ideal for either the SENCO or the student given the complexity of fulfilling the requirements of many students with an ABI.

Similarly, Mealings, Douglas & Olver's (2012) research found that one of the most frequent challenges that families and children report is the lack of brain injury knowledge within the educational sector. This often results in extra stress for parents who can find themselves repeatedly explaining their child's difficulties to professionals who may have a poor understanding of their needs and how to support them. It can also put a lot of stress on the school who lack the knowledge necessary to understand and support the child (Linden, Braiden & Miller, 2013).

According to Walker and Wicks (2012) it is likely that students with an ABI will be encountered in many educational settings, both mainstream and specialised, indicated by the statistics regarding prevalence. As a result, educators and support staff have a duty to become more knowledgeable and aware of the needs of CYP with ABI (Hux, Walker, & Sanger, 1996). Unfortunately, the education system continues to underserve and under-identify students with ABI despite the negative implications of the condition (Glang, Todis, Thomas, Hood, Bedell, & Cockrell, 2008). Therefore,



when ABI is not recognised or is misunderstood, research shows that children are more likely to be excluded, disengaged, and underachieve (N-ABLES, 2020).

There is often a large team of medical professionals involved in supporting a CYP following an ABI. In most cases, the hospital staff will offer acute care, eventually handing over care to community and educational colleagues following discharge from hospital. Certain professionals, including (but not limited to) Physiotherapist, Occupational Therapist, Speech and Language Therapist, Clinical Psychologist and the Neuropsychology Team, may continue to offer longer-term support and can serve as a useful point of contact for schools (N-ABLES, 2021). There are also charities such as the Child Brain Injury Trust (CBIT), The Children's Trust for children with brain injury, and the Eden Dora Trust for children with encephalitis, who provide support to young people and their families following a brain injury and help them to adjust to life after injury. The hospital-based and specialised charities can also provide training and advice to community and educational professionals that may lack experience dealing with CYPs who have an ABI.

However, support from clinical-based services often ends once the child has been discharged from hospital. For example, Neuropsychologist involvement often centres around conducting neuropsychological assessment and evaluation whilst in the hospital setting, rather than after discharge from hospital (Haarbauer-Krupa et al., 2017). However, discharge from services does not mean that the CYP has recovered from the effects of the ABI, just that the services have done all they can to support the child at the time. Also, some CYP may not access any therapeutic support following a TBI (Hawley, 2003).

Until recently, there was great focus placed on returning to physical activities, also referred to as 'return to play', with 'return to learn' often overlooked (Olympia, Ritter, Brady and Bramley, 2016), despite education being essential to rehabilitation. Recent guidance from the National ABI in Education and Learning Syndicate (N-ABLES) has been introduced for educational professionals working with CYP with ABI to prepare for, and achieve, a successful return to education and to help progress their recovery. It was created as a result of the suggestions made in the APPG 2018 Time for Change report, which revealed that educational professionals often lack knowledge of ABI. The guidance states that the student, their parents/caregivers, health, and school professionals must plan, collaborate, and carefully coordinate the return (N-ABLES, 2021). The EP is named amongst the educational professionals whose guidance should be sought if deemed appropriate.

### 1.5 The suggested role of the EP

Educational Psychology has been defined as “a branch of psychology dealing with the application of psychological principles and theories to a broad spectrum of teaching, training, and learning issues in educational settings. Educational psychology also addresses psychological problems that can arise in educational systems” (APA Dictionary of Psychology, retrieved 2021).

A child with an ABI can create challenges for schools and require unique support, assessments and behavioural support plans (Bullock, Gable, & Mohr, 2005; Shaughnessy et al., 2006). Also, due to the heterogeneity of ABI (McCoy et al, 1997), frequent and continuous monitoring is required to assess recovery and developing need. It has been noted that EPs are perfectly placed to monitor these changes in need and provide continued support to children, their families and their school following an ABI (Ball & Howe, 2013). This is due to EPs having extensive training in the identification, assessment and intervention of learning and behavioural difficulties, in addition to systemic knowledge, and are therefore uniquely placed to support students with an ABI throughout their education (Davies et al., 2013).

Bozic & Morris (2005) argued that if the complexities surrounding the long-term impact of ABI are acknowledged, it must also be acknowledged that there is a need for multi-level and multi-professional provisions to address the complex needs of the child, their family and their school. Bozic & Morris (2005) highlighted how the EP is well placed to contribute to this support as they can influence events at most levels. They demonstrated this by using the Ecological-Transactional Model (Cicchetti & Toth, 1997; Empson et al., 2004) that represents risks and protective factors in the development and education of CYP with an ABI. They put forward that at the ontological level, EPs can work directly with the CYP and help them to develop effective strategies and positive ways of coping with life after brain injury.

They also argue that EPs are likely to have contact with people within the classroom and home environment and can therefore influence the microsystemic level by providing advice and support in line with the graduated approach and through signposting to other agencies (Department for Education and Department of Health, 2015). At this level, EPs can also translate medical and neuropsychological reports into practical information that can be applied within a school setting (Gelbar & Bray, 2019).

At the exosystemic level, EPs can support schools and other agencies involved with the child to develop plans that consider the child’s complex needs and the interacting factors affecting such

needs. This can be done through consultation, involvement in planning or direct intervention, and through in-service training. This can also be done by the completion of an EHCNA to inform an EHCP, a key aspect of the EP role that brings all of the information about the child's needs, strengths, outcomes and provision into one holistic document. An EHCP is a legal document that outlines what support the CYP needs and gives schools the funding to be able to meet these additional needs above SEN support level (Sales & Vincent, 2018), therefore enabling schools to better meet the needs of these young people. There are also non-statutory alternatives which can be used to specify need and support required e.g. a support plan.

As part of providing support at the exosystemic level and developing plans of support, EPs often seek out and represent the opinions of CYP (Farrell et al., 2006). This gives CYP the ability to participate in the conversation about how to improve outcomes in their lives and ensure that their voices are heard and valued (Harding & Atkinson, 2009; Roller, 1998). Improved motivation, independence, a sense of personal control, and the development of meta-learning skills like reflection, planning, and monitoring, according to research, are just a few of the advantages that including SEN students in evaluation, planning, and review processes have (Smillie & Newton, 2020). Children can offer extra insight on these themes as well as potential interventions if they are aware of their preferred learning styles, individual strengths and limitations (Todd, 2003). The possibility of successful results is increased and a higher sense of responsibility for change is developed in the child by seeking out and listening to their voice (Roller, 1998).

Within the development of these support plans, Bozic & Morris (2005) also argued that EPs are often the most qualified educational professional and the only psychologist involved in the long-term planning of provisions for the CYP post injury, as mentioned above, some clinical or neuropsychology involvement often ends upon discharge from hospital. Long-term support for children with an ABI is needed because as the injured brain regions develop and mature, child ABI survivors' needs are likely to change (McKinlay et al., 2016). Research suggests that support plans must therefore be updated frequently, with particular focus on major educational and social transitional points, such as preschool, primary school, secondary school, and the workplace, to prevent interventions from becoming redundant or useless (McKinlay et al., 2016).

Finally, Bozic & Morris (2005) argue that at the macrosystemic level, there is scope for research and project work that look at the wider educational system that children with an ABI are educated within.

### 1.6 Barriers to EPs providing support.

However, research indicates that there are several obstacles to EPs meeting the needs of pupils with an ABI, including communication about the injury, and a perception that brain injury is not important by school staff (Canto, Chesire, Buckley, Andrews, & Roehrig, 2014). This lack of educator awareness contributes to ongoing under-identification of children with a brain injury for support services in schools, e.g., from the EP service (Davies, 2016; Glang et al., 2015).

In addition to this, research shows that EP knowledge of ABI may also be a barrier to meeting the needs of this population. It has been suggested that EPs would need to understand pre-injury function, post-injury function, and the different factors that can be linked to both the recovery and outcomes of a brain injury in order to provide optimal support to the child and their system (Arroyos-Jurado, Paulsen, Ehly, & Max, 2006). However, research shows that EP initial training provides either very little or no preparation for this area of practice, leaving the majority of EPs with limited knowledge of ABI (Misheva, 2020; Bozic & Morris, 2005). Some courses include a seminar on child neuropsychology; however, this frequently focuses on the biological underpinnings of behaviour and recent advances in neuroscience rather than the knowledge and abilities needed to work with the population of CYP who have suffered an ABI (Hooper, 2006).

During recent research, Misheva (2020) found that around 90% of qualified EPs encounter neuropsychology type cases within their work, with one of the most common conditions within this area being ABI. Of this 90%, less than a quarter felt confident about their theoretical knowledge of the area and supporting a child with such conditions. Similarly, Glang, McCart, Moore & Davies (2017) found that although most EPs felt confident to perform some of the core responsibilities in their role (e.g., working as part of a multi-disciplinary team, suggesting provision and observations), a low percentage of EPs felt confident in performing other duties for children with a brain injury (e.g. assessment work). Hooper (2006) also found that 83% of participating EPs felt that they did not have the knowledge to support a CYP with a brain injury. Therefore, although a role has been identified for the EP, and some EPs feel they can offer support, the research suggests that many EPs do not feel equipped to do so.

However, given the incidence of ABI, the statistics suggest that an EP will be required to support a child with a brain injury within their career more often than most believe. Therefore, Bozic & Morris (2005) argued that there is a need to further develop the skills and capacity of EPs to enable them to

support schools to deliver an informed and enhanced range of quality provision for CYP with an ABI. Ball & Howe (2013) argued that that all EP initial training courses should have a module on brain injury and neurological development to support with this. However, some would argue that there are a lot of disorders and conditions that are not covered in initial training or offered as CPD e.g., Down Syndrome. Also, it may be the case that EPs feel that highlighting this topic as an area for CPD is not as important or relevant to their practice than other topics such as mental health (Shojaei & Masoumi, 2020), or that the EP feels confident in providing support to a child with an ABI without undergoing further training.

In addition to knowledge being identified as a barrier to support, many EP services have a limited offer to schools due to the current SEN climate and increase in EHCP requests across the UK (Thomas & Loxley, 2022) and the variation in service delivery models (Lyonette, Atfield, Baldauf & Owen, 2019). As a result, the number of children that an EP can help outside of an EHC needs assessment is constrained . Therefore, it could be that children with an ABI within some local authorities are receiving an increased amount of support than those in other local authorities, resulting in a 'postcode lottery' for support (Thomas, Atkinson, & Allen, 2019).

### 1.7 An exploration into the EP's role in supporting children post ABI.

Previous research, along with recent guidance (N-ABLES, 2021), names EPs as part of the education team and identifies EPs as having a role in supporting children with an ABI. However, it is unclear what is currently happening within EP services across the UK and whether these suggestions are already implemented within EP practice.

My research is divided into two parts, the first of which is a thorough examination of EP practices about ABI through a comprehensive survey. In light of the research done by Misheva (2020), I'm curious to hear how frequently EPs have been asked to assist a CYP after an ABI, as well as how capable and confident they felt in providing this support. Participants will be asked what they think should be their role in providing support for a CYP with an ABI, as well as the obstacles to fulfilling this support. It will also be interesting to know if they have ever received CPD on the subject or have attended any related seminars during their initial training.

The second part of my research will explore examples of good practice where EPs felt that their involvement in supporting a child with an ABI had a positive impact. This would give participants the

chance to elaborate on their survey responses and explore EP involvement in supporting a child with an ABI in greater detail to identify EP support strategies that will be useful in supporting CYP with an ABI in the future.

## **Chapter 2. Research questions and methodological approach**

### **2.1 Research Questions**

The literature review has identified recommendations for how EPs can support children with an ABI and the barriers to support. Two main research questions, with sub-questions, were identified in order to explore whether any of the recommendations from previous research are already happening within EP practice, how confident EPs feel in supporting children with an ABI, the perceived knowledge levels on ABI and how this knowledge was gained. Research question one and the relating sub-questions will be explored in phase one through a nationwide survey. Research question two will be explored in phase two through focus groups.

1. What are EP experiences and practices of working with children post ABI?
  - a. What is the prevalence of children with ABI within EP work?
  - b. What is the perceived role of the EP in supporting children post ABI?
  - c. What are the barriers to meeting the needs of children post ABI?
  - d. What is the perceived knowledge and confidence level of EPs around ABI?
  - e. What is the prevalence of EPs who have accessed CPD on ABI?
2. What is considered good practice in EP work supporting CYP post ABI?

### **2.2. Methodological approach**

This section intends to give a comprehensive overview of the approach and guiding principles for the research, whilst the methodology for each phase of the study will be described in Chapters 3 and 4.

#### **2.2.1 Research approach and paradigm**

It is my positional belief that ABI happens within our world and cannot be argued to be part of our social construction. Rather it exists and is part of the 'real world', underpinning the need for a realist approach. However, our understanding of ABI can change over time depending on one's positionality and experience. Based on these views, I adopted the critical realism paradigm to guide the research. Critical realism, with its origins associated with Roy Bhaskar (Joseph, 2014), is a theoretical approach that uses retroductive reasoning (using logic to look for the best explanation for something happening) to reach conclusions about a phenomenon (Fryer, 2020). Critical realism uses the concepts of experiences (the perceptions of things by people), events (the things that

happen in the world, some of which are perceived by people) and causal mechanisms (the things that produce events) as the basis of this logic.

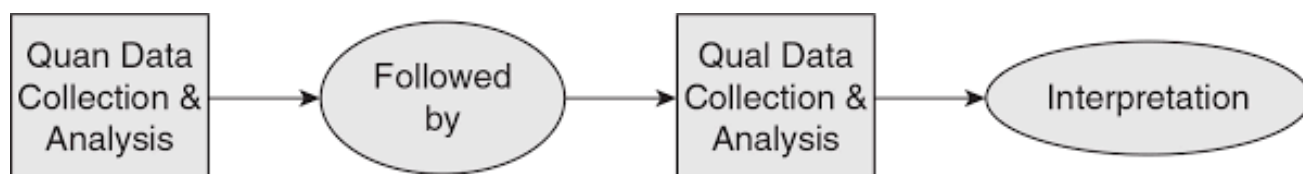
In order to develop my understanding of critical realism and to confirm that it was an approach congruent with my beliefs and mixed-methods research, I read Fryer's (2020) guide to understanding critical realism. Mixed-methods research in critical realism aims to characterise and improve the explanation, interpretation, and understanding of social psychological systems and objects. From a critical realist perspective, using both quantitative and qualitative designs is useful in a mixed methods study because they support, improve, or challenge plausible explanations of phenomena (Ryba, Wiltshire, north & Ronkainen, 2022). Both quantitative (extensive to address population patterns/regularities) and qualitative methods (intensive to address how processes work in specific cases) are crucial in a critical realist mixed methods study (Bhaskar et al., 2005).

Therefore, using a mixed methods approach allowed me to take a critical realist positionality and explore the phenomenon of ABI in a way congruent with my beliefs. Within the context of this research, critical realism outlines that we cannot say that EP involvement causes an improvement for CYP with an ABI, but that it could have more or less impact in different contexts with different students.

### 2.2.2 Mixed methods design

The use of a mixed methods approach, which has been described as combining "qualitative and quantitative approaches in the methodology of a study" (Tashakkori, Teddlie & Teddlie, 1998, p. ix), allowed the research to produce a more comprehensive picture of the phenomenon than would have been possible with just one method. In order to build on the preliminary quantitative results, I employed the explanatory sequential design (see image 1), which begins with the gathering and analysis of quantitative data, followed by the collection and analysis of qualitative data (Creswell & Clark, 2017).

*Image 1. The Explanatory Sequential Design within Mixed Methods research (Creswell & Clark, 2017).*





This design was chosen as it was felt the most appropriate and suitable approach to gather data in a comprehensive manner that would allow the research to answer the research questions.

Research questions 1, a, b, c, d and e were concerned with obtaining an overview of the views and experiences of local authority EPs across the UK in supporting CYP with an ABI, and exploring the suggestions made by previous research about the role of EPs with this population. Therefore, it was decided that a large-scale survey would be most appropriate to gather data to answer these questions. The survey included both closed and open-ended questions so that participants could elaborate on their answers where appropriate. This allowed for the collection of richer data and address some of the difficulties with just using closed-ended questions e.g., they lack detailed information and do not provide opportunity for participants to expand on their answer.

Research question 2 was focussed on exploring examples of good practice where the EP felt their involvement when supporting a child with an ABI, led to a positive outcome. This could be through (but not limited to) involvement as part of the MDT, involvement in the return to school meeting, or having a service protocol for identifying and supporting children with an ABI. A qualitative approach was viewed as most appropriate through the use of focus groups. This would allow participants to expand upon their answers given within the survey and reflect upon what was it about their involvement that led to the EP feeling that it was an example of good practice in providing support to CYP with an ABI. I chose to conduct focus groups rather than interviews as I wanted to reduce researcher bias by not asking specific questions that could be leading, instead allowing the participants to shape the discussion points. I also wanted to allow participants the chance to elaborate on each other's answers, prompting further discussion through opportunities for participants to provide similar or opposing ideas which would not have been possible with one-to-one interviews. Within the focus groups, I focussed on asking clarifying questions to check that my understanding of their discussions was correct.

The research was carried out in two phases, phase one of which was the survey and phase two the focus groups. The findings from both phases were integrated in order to provide an overview of the beliefs about the role and the current practices of EPs in supporting CYP with an ABI. The findings from the focus group were also considered in order to identify aspects of EP practice that are helpful in supporting CYP with an ABI.

The research was granted ethical approval by the University of Sheffield School of Education Research Ethics Committee (ethical approval letter can be found in Appendix 1).

## **Chapter 3. Phase 1: National Survey Methodology**

### **3.1 Chapter overview**

Phase 1 of the research aimed to delve deeper into whether the suggestions from previous research identified in Chapter 1 are already in practice, what the barriers are to providing support and to look at the confidence levels of EPs in providing support to CYP with an ABI. This chapter will provide a detailed overview of the methodology and procedure of the first phase of the research.

### **3.2 Methodology**

#### **3.2.1 Survey development and design**

The survey questions were developed with reference to research questions 1, a, b, c, d, and e using suggestions from previous research about the potential role of the EP and the considerations regarding what might be needed for EPs to provide this support. The survey questions focussed on the prevalence, current practices and attitudes of EPs around supporting CYP with an ABI within their practice. The survey also explored their knowledge and confidence levels in providing such support.

The questionnaire consisted of 23, closed/rating scale and open questions that took approximately 10-15 minutes to complete. The questions were developed based on past research and the survey can be found in appendix 2. The survey also collected demographic data including information on region, role (whether specialist or main grade) and how long the participants have been qualified. Although the results were anonymous, participants had the opportunity to provide their email addresses at the end of the survey if they agreed to be contacted to participate in the phase 2 focus groups. The survey was created using Google Forms and included the information sheet and consent form presented in a digital format. The participants were automatically emailed a copy of the information sheet, consent form and their responses upon completion of the survey.

As part of the development of the survey, a pilot study was conducted to ensure survey reliability. As part of the pilot study, 3 EPs (two main grade EPs, one senior EP) from a local authority Educational Psychology Service (EPS) were asked to complete the survey and provide feedback on the clarity of the questions, whether there were enough opportunities to expand on their answer, and how long it

took them to complete the survey. Based on the feedback (see appendix 10), the following amendments were made:

- Inclusion of a question that gave participants the opportunity to explain where they had gathered knowledge on the topic.
- The question around the prevalence of ABI within EP work was changed to the prevalence amongst children accessing education.

Once the amendments had been made and reviewed, a final version of the survey was created using Google Forms. When participants clicked the link to the survey, they initially saw a detailed information sheet and a subsequent electronic consent form that would not allow them to continue to the survey unless they consented. The questions were then presented to the participants. In order to increase the validity of the survey data, the survey was disseminated via email to all of the EP services within the UK who had a contact email on their public website. This was decided upon to increase the likelihood of getting participants from across the UK and to get a more coherent understanding of this topic from EPs working in different local authorities. The email contained information about the research as well as a link to the survey (Appendix 3).

*Thesis Diary note 19/07/2022:*

*In order to develop a list of EPS emails across the UK, I gained a list of the local authorities in the UK from the internet and began to search for each of their local council websites. Some of them were districts and didn't have an EPS but were covered by a larger local authority EPS. I wrote telephone numbers for those where I couldn't see an email on their website. I phoned these services to ask for an email address that I could send the survey link to, some of which provided an email and some did not. I chose not to include areas that operate through private services as within the current research I was interested in local authority services and practices.*

*It is acknowledged that not every EPS within the UK had a contact email on their website, and so the results cannot be fully generalised to the whole of the UK. However, with a large selection of EPS emails collected, the data should still give an insight into the general practices within the UK.*

### 3.2.2 Sample, distribution and regional representation

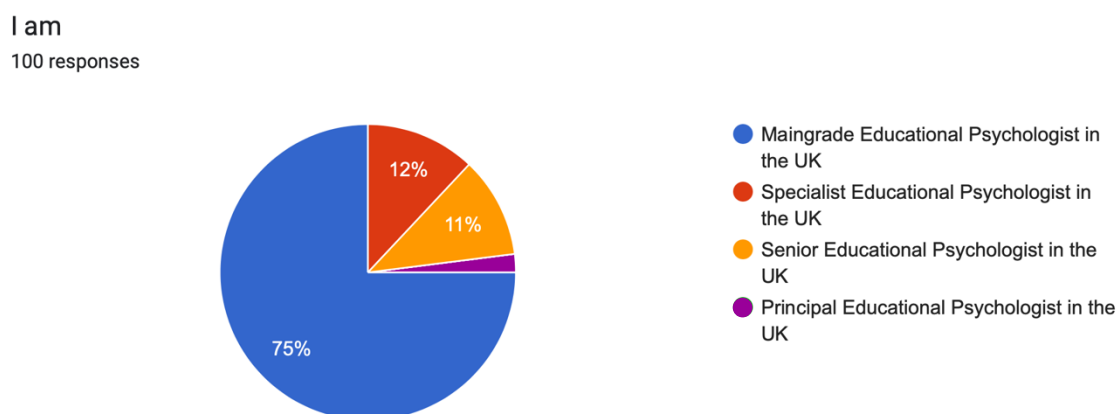
In order to gain an understanding of the current practices of EPs across the UK, the link to the survey was sent out to 156 local authority EPSs who were asked to forward it to their team. The survey was open to qualified EPs, including SEPs, PEPs, and Locum EPs.

The following steps were taken to try and improve participation in the survey:

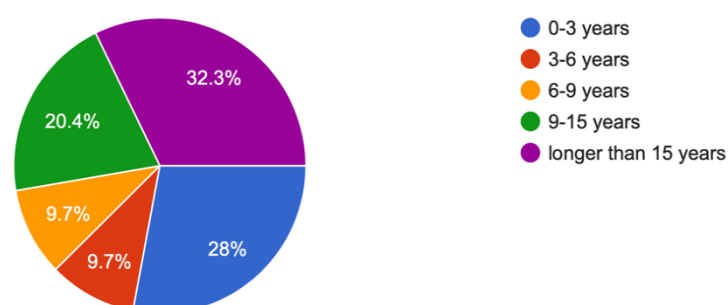
- 2 x reminder emails to services regarding the deadline for completing the survey.
- Within the email to the services, I explicitly asked EPs who felt that they had no experience in this area to complete the survey to try and ensure a more representative data set.
- I left the survey open from July to September to give EPs 2 months opportunity to participate. This would ensure that even those who take some of their annual leave during these months would still have the opportunity to participate.
- I chose not to offer an incentive as I was conscious of introducing more bias to the data.

A total of 100 EPs completed the survey. To guarantee that the sample only included EPs based in the UK, all participants were asked to declare what region they were based in, whether they were main grade, senior, principal, or specialised EP, and how long they had been a qualified EP in the UK. A detailed breakdown of the sample characteristics, including current role, level of experience and geographical location can be found in Figures 1-3.

*Figure 1. Role*

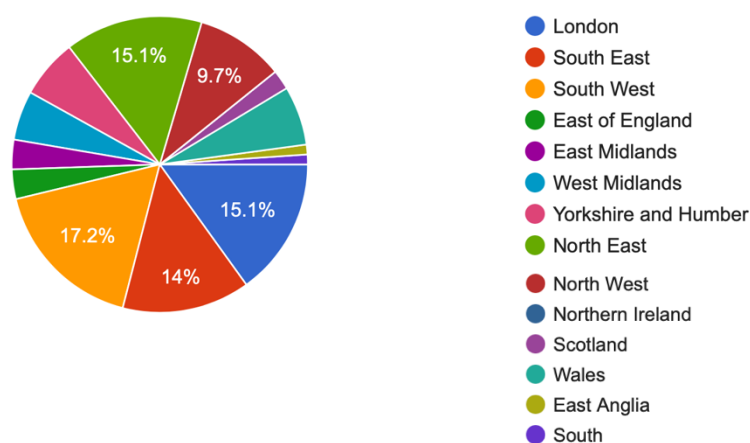


*Figure 2. Experience Level*



Demographic data on role and years of experience (figure 3.1 and 3.2) was gathered in order to understand how long participants had been practicing as a qualified EP and therefore how much time they had had the opportunity to support a CYP with an ABI. Only qualified EPs were invited to complete the survey as all would have at least three years of experience to reflect on (newly qualified EPs will have had 3 years of experience as a TEP) and be able to give more comprehensive responses to the survey questions. The majority of respondents had been practicing for longer than 9 years (53%), 19% of participants had been practicing for 3-9 years and 28% of participants had been practicing for 0-3 years.

Figure 3. Participant location by region



As the sample was self-selected, it is important to consider the limitations of using this sample selection strategy. Self-selected samples in surveys affect the external validity of research and compromises the interpretation of findings due to coverage and selection bias (Bethlehem, 2010), possibly obtaining a sample of participants who have an interest in the area rather than hearing from those who do not. Therefore, if information from the non-respondents had been available, the survey's overall findings might have changed, leading to nonresponse bias (Draugalis & Plaza, 2009). In order to try and counteract this bias, in the email sent to EPS, I explicitly encouraged participants who did not feel they had worked with CYP with ABI to complete the survey as well.

In order to determine the data's generalisability, it was important to consider the response rate. The School Workforce Census (Department for Education, 2023) reported that there were 2325 EPs working for a local authority in 2022. Based on this statistic, Krejcie & Morgan (1970) detailed that a sample of between 322—341 would be needed to allow for confidence in generalising to the wider population. Therefore, despite best efforts, the response rate to the survey was too low to be able

to generalise to the wider population and therefore the data can only give us insights into what might be happening. In addition to this, in some regions, only one participant completed the survey which further reduces the generalisability of the data. Also, there were no responses from participants that worked in Northern Ireland and so the results do not include EP practices from this region.

### 3.2.3 Ethical considerations and data protection

Within the survey, some questions may be classed as sensitive as the research asked participants to reflect on their own experiences of supporting CYP post ABI. This may have stirred uncomfortable feelings for the participants if they felt they have not been able to provide as much support as they would have liked or if they had a difficult experience in providing such support. The potential for causing upset for the participants was justified as the hope was to learn from past experiences to identify what would help EPs feel more confident in providing such support and improve the well-being of not only the EPs but the CYP with an ABI they are supporting.

Also, within the survey, the line of questioning could have caused upset if the participants were parents or relatives to a child with an ABI who may have not received adequate support. Again, the justification for this potential risk was that hopefully participants would feel good about the fact there was research happening that aims to look at how EPs can provide support to children with an ABI, which would hopefully lead to better outcomes.

To alleviate these potential risks, at the end of the survey and focus groups, participants were thanked for their participation and given the link to a charity that supports children with brain injuries and their families (The Child Brain Injury Trust : CBIT) where they could find further information and support. This would hopefully help those who have been personally affected by ABI and those wishing to find out more information.

Also, within the information sheet, participants were given the contact details of the lead researcher, the project supervisor and the course director, should they wish to ask a question or contact someone who would be able to address any concerns, within a reasonable time period, if, following participation they experienced stress, harm or had any other concerns about the research.

### 3.2.4 Survey Data Analysis

Prior to comparing and integrating the findings of a mixed methods study, the data from each phase are individually examined. Additionally, I intended to use the survey data analysis to guide the focus group questions. For the analysis of both types of data, I followed the suggested process provided by Creswell and Clark (2017), which is as follows:

*Image 2. Creswell and Clark (2017) guide to data analysis:*



Research question 1: What are EP experiences and practices of working with children post ABI?

Research question 1 was explored through analysing the responses from the survey data. Descriptive and inferential statistics were generated from the data for each question. All qualitative data gathered from the open questions included in the questionnaire were analysed using Braun and Clarke's (2006) Thematic Analysis (TA), congruent with the data in phase 2 (see chapter 4). Details of how the TA was undertaken for the responses from the open-ended questions in the survey can be found in appendix 8.



## **Chapter 4. Phase 2: Focus Groups**

### **4.1 Chapter overview**

EPs who had consented to be approached about participating in a focus group during the survey were invited to participate in phase two of the study. I conducted focus groups utilising the nominal group technique to investigate examples of good practice for helping CYP with an ABI. As EPs from across the UK participated, the focus groups were conducted online. I was able to ask open-ended questions during the focus groups that might not have been possible with fixed-choice questions (Bryman, Becker, & Sempik, 2008).

### **4.2 Focus group design**

The focus group was developed with reference to research question 2, focussing on examples of good practice where the EP felt that their unique contribution made a difference when supporting a child with an ABI. To structure the focus group, Nominal Group Technique (NGT) was used. NGT was developed by Delbecq and Van de Ven (1971) as a process for 'identifying strategic problems and developing appropriate and innovative programs to solve them' (Delbecq & Van de Ven, 1971, pg. 467). The NGT helps people come up with ideas for issues, solutions, or both for a given question. These ideas are then discussed and prioritised by participants (Gallagher et al. 1993). According to Carney et al. (1996), the NGT promotes equal participation and permits all viewpoints to be respectfully considered. This reduces dominant personalities and the emphasis on one particular point of view.

#### **4.2.1 Participants**

27 EPs who completed the survey consented to be contacted regarding phase 2 of the research: the focus group. Of those 27, 9 participants responded that although they were happy to be contacted, they didn't feel that they had examples of good practice to share of working with this population. Therefore, these participants were not contacted about the focus group and 18 participants were emailed a link to sign up to a focus group. Of these 18, 6 participants signed up to a focus group, however only 4 participants attended at the pre-arranged time (2 participants in each focus group). Although this is not as many participants as hoped (I hoped to have between 6-8 participants in each focus group), the participants were still able to generate interesting ideas for discussion.

The following steps were taken to try and improve participation within the focus group:

- 2 x Reminder emails to the 18 participants regarding the deadline for signing up to a focus group.
- 2 x reminder emails to the 6 participants who had signed up to a focus group to confirm and remind them of the time and date of their focus group and to provide more information about what to expect.

#### 4.2.2 Procedure

Google Meet video conferencing software was used to host the focus group. The focus group was recorded (voice only) and transcribed upon completion to allow for analysis.

Dunham's (1998) users guide to using NGT was used to structure and guide the process (see appendix 6 for the script used). Within the introduction, participants were reminded not to identify children in any way when speaking about a specific case to ensure confidentiality. They were also told that if this were to happen by mistake, any identifying information would be immediately removed from the data. Similarly, real names of participants and places were pseudonymised and details that may identify particular individuals were removed or masked.

The first step to NGT is for participants to write key ideas silently and independently to allow adequate time for thinking, equal opportunities for participants to have their ideas heard and to avoid interruptions from dominant personalities (Dunham, 1998). These ideas are typically fed aloud to the group one by one, however as the focus group was virtual, I made use of Jamboard where participants could post their ideas anonymously to a board that can be seen by all involved. Participants were given 5 minutes for this step, in which participants were asked to use Jamboard to make virtual post-it notes with their initial ideas in response to the following question:

*“Thinking about your work with children with an ABI, how has your role made a difference to the situation/support? (What did it involve? How did it help? What was the outcome?)”.*

During step 2, participants were asked to comment on the ideas posted. The purpose of this step is to discuss each idea separately to allow equal consideration to every contribution and to provide opportunity for clarification and elimination of any misunderstandings to increase the validity of the

data (Dunham, 1998). Participants could expand on their own ideas in addition to adding comments to the ideas of others. Participants were reminded that there was no pressure for them to expand on their own idea or identify it as their idea. As participants discussed the ideas, I began to move the ideas into themed groups, checking with the participants that they agreed with the theme name.

Once all of the ideas had been discussed and grouped into a theme, participants were moved onto step 3. This step is used to determine the relative importance of each idea. Participants were given 3 votes to place over the idea or theme that they believed were the most important and impactful examples of EP practice in making a difference to CYP with an ABI. The votes were virtual and anonymous. To close the focus group, participants were thanked for giving up their time to participate in the research. They were also given the opportunity to ask any questions they had, in which one participant asked about the next steps for the research. The focus group lasted between 1 - 1.5 hours.

As part of the preparation and development for the focus groups, a pilot study was conducted. Five TEPs (trainee EPs) were asked to participate in a focus group and provide feedback on the clarity of the question, the clarity of the instructions, and whether they had enough opportunities to share their views. As a result of the feedback (see appendix 10), I made the following changes to the main research:

- The main question was sent to the participants before the focus group so they could begin to generate initial thoughts but were told that they shouldn't feel the need to prepare anything (see appendix 4).
- I gave guidance to participants regarding joining the focus group using a tablet (see appendix 4).
- A test Jamboard link was sent to participants before the focus group so they could familiarise themselves with the software (see appendix 4). However, participants were reminded that an explanation on how to use Jamboard would be given at the beginning of the focus group.
- Clarification questions were asked throughout the focus groups to check for understanding to increase the validity of the data and to give participants the opportunity to expand on their answer.

*Thesis Diary note 03/10/2022:*

*I felt that the pilot focus group went well, and the structure worked how I thought it would. It was great to hear feedback from pilot participants and was reassuring to know that the questions and procedure were clear. I am hoping it works just as well in the main focus groups. I was worried about speaking too much but felt the need to ask clarifying questions which group fed back were okay and not leading just useful.*

*Thesis Diary note 16/11/2022:*

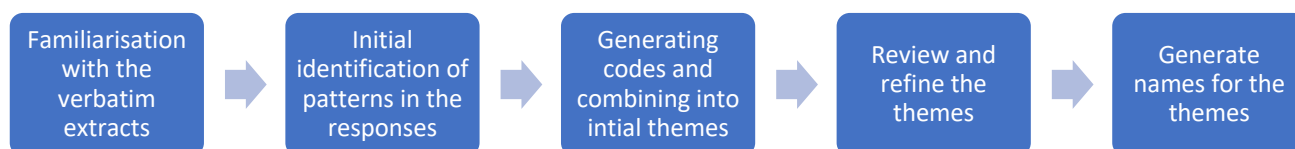
*Both focus groups are now done and went really well. It was a great opportunity for participants to expand on their answers and unpick what it is about the EP role that adds to the support given to children with an ABI. Some interesting themes have already begun to emerge that appear to be in line with the results from the survey data.*

#### 4.2.3 Data analysis

Research question 2: What are examples of good practice in EP work supporting children post ABI?

I used Clarke and Braun's (2021) TA model to examine the qualitative information I gathered from the focus groups (see image 3) in relation to research question 2. Previous research has suggested ways in which the EP is perfectly suited to supporting a child with an ABI e.g., using EP skills to provide support at all levels of the ecological system (Bozic & Morris, 2005; Cicchetti & Toth, 1997). The aim was to see if these suggestions were already happening within local authority EPSs, what the barriers are to providing support and what are the beliefs amongst EPs regarding the delivery of support to this population. I was also keen to explore new themes that arose within the data relating to the research questions. Details of how the TA was undertaken can be found in appendix 9.

*Image 3. Braun and Clarke's Thematic Analysis Model (2021).*



Following analysis of both sets of data, the results were combined and analysed in light of the research's questions. More information on how this model was used is provided in the results section. Robson's (2016) Real World Research framework was also used to inform the design of the research and to appraise the integrity of the design and the quality of the data analysis. This will be returned to in chapter 6.

## **Chapter 5: Results**

### **5.1. Phase 1: National Survey Findings**

The national survey allowed the collection of rich data concerning the experiences and practices of EPs when working with CYP post ABI. In the following section, the findings from the survey will be presented with reference to the research questions and sub-questions. All quotes used are written as they were written by the participants.

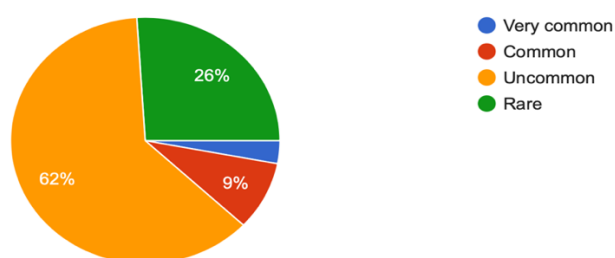
#### **5.1.1 Research question 1a: What is the prevalence of children with ABI within EP work?**

Research question 1a was explored through 4 questions within the national survey. These questions involved collecting data from participants about how common they believe ABI is within CYP in education, whether they have supported a CYP with an ABI within their practice and if so, how many, how old were they and how recent were the cases. The findings from each question are outlined below and then considered alongside each other in the *Research Question 1a: Findings Summary* section.

The survey responses indicated that the majority of participants (62%) believed that ABI within CYP in education is uncommon or rare (26%) (Figure 4). However, according to CBIT, studies conducted in the UK have demonstrated the prevalence of a TBI alone is higher in the general population of CYP compared to other more widely acknowledged and understood neurodevelopmental disorders e.g., Autism and ADHD (Hughes, 2012). This could suggest that although the prevalence rates appear to be high within the general population, the prevalence rates amongst EP casework are low. Questions 2, 3 and 4 were used to see if this is the case.

*Figure 4: Commonality of ABI within the CYP population*

How common do you feel Acquired Brain Injury is within children and young people within education?  
100 responses

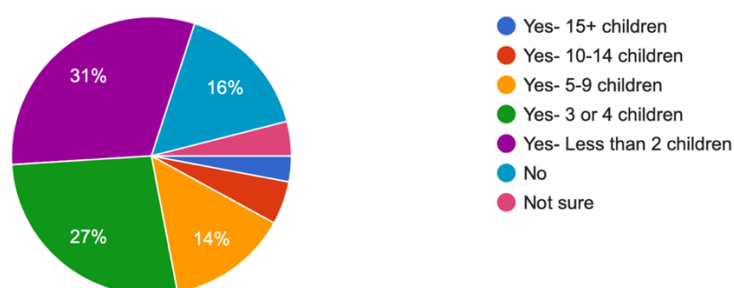


The results showed that the majority of participants have supported a CYP with an ABI within their practice (Figure 5). Survey responses indicated that 31% of participants had supported less than 2 CYP with an ABI and 27% reported that they had supported 3 or 4 CYP within their practice. In contrast, 16% of participants reported that they had never supported this cohort of children, and 4% indicated they were unsure. Therefore, these results suggest that the majority of EPs have been called upon to support CYP with an ABI within their practice.

*Figure 5: Commonality within EP practice*

Have you ever supported a child with an Acquired Brain Injury within your practice?

100 responses



Of those participants that had provided support, 63 of the cases they were involved in were with children of primary school age, 53 of a secondary school age, 28 within early years and 13 post-16 cases. In regard to how recent the involvement in these cases were, just over half of participants shared that it was within the last year, 15% indicated their support was within the past 2 years, 21% shared their involvement was within the past 2-5 years and 12% indicated it was over 5 years ago.

#### Research Question 1a: Findings Summary:

Research question 1a was concerned with the prevalence of CYP with ABI within EP practice. The national survey findings indicated that the majority of EPs have been called upon to support a child with an ABI within their practice, however some EPs have never provided such support. The results also shed some light on participants understanding of how common ABI is within the paediatric population and those attending an educational setting. The majority of respondents indicated that they believed ABI within children is rare or uncommon, which contradicts the previous research indicating high prevalence (Hughes, 2012) and that ABI, which includes both traumatic and non-traumatic brain injury, is the leading cause of death and disability in children worldwide (Faul, Xu, Wald & Coronado, 2010). The results indicate that for some reason, the rates of injury may not be

translating into the rates of occurrence within EP practice, which may be contributing to the participants understanding of the commonality. It is also possible that EPs have supported children where the ABI has not been disclosed or the school or the family have not recognised its relevance or importance for mentioning, contributing to the EPs understanding that they haven't supported a CYP with an ABI.

### **5.1.2 Research Question 1b: What is the perceived role of the EP in supporting children post ABI?**

Of the 100 participants who completed the survey, 81 participants indicated in what capacity they had provided support to CYP with an ABI in their practice to date. According to the survey, the most common method of involvement within EP practice in supporting CYP with an ABI was through providing an EHC psychological advice (58%). Participants also shared that they have conducted consultations (54%), attended the 'return to school' meeting (10%), had ongoing involvement as part of the MDT (17%) and supported schools to interpret medical reports (25%). Other methods of support highlighted were delivering training to schools, attending annual reviews, conducting cognitive and dynamic assessments, direct intervention, signposting to other support, and assessment of barriers to learning. Also, 7% of participants shared that there is a specialist EP in this area within their service and 2% shared that there is a service protocol they follow for CYP with an ABI.

When asked, what they believe the role of the EP should be in supporting children with an ABI, participants listed a number of responses. The overarching theme that arose from the results was utilising existing skills that EPs have and applying them to offer systemic and holistic support:

*"An EP could help identify the holistic strengths & needs of the child and support the school & family."- Participant 91*

*"Key for me was working with school staff, the child and family to improve educational outcomes and monitor the social and emotional wellbeing of the child once she had returned to school."- Participant 25*

A number of sub-themes arose within the answers that reflect on support given and future support in the opinion of the participants:

### Theme 1: Statutory work

Some participants referred to the benefits of conducting the statutory elements of the EP role, primarily EHC needs assessments and attending review meetings, in supporting children with an ABI:

*“Statutory is of course a very important part of our work - for example through my cases the child could no longer attend or access as mainstream environment and so through a well written EP advice we can support the child to access a specialist provision.”—Participant 42*

*“I also think perhaps the most important part of the role is to gather all threads (speech therapist, OT, physio, hospital teacher, clinical psych, optometry etc) and weave these together into a holistic understanding and narrative of what this child may need to thrive”- Participant 42*

### Theme 2: Consultation

Another sub-theme that arose was the benefits of using consultation as a method to help reconstruct the narratives around the CYP, provide containment around the emotions held by school staff and families, alongside helping them to develop their understanding of need and create a plan of how to meet such needs:

*“Consultation with schools to develop their understanding of ABI and its effects, and jointly plan ways forward.”- Participant 34*

*“Consultation to help the family and school to reach a shared understanding of the ABI and the impact upon the child in different contexts was previously described as helpful by both family and school.”- Participant 60*

*“I often find a key part of the role is supporting adults to support the young person. For this group of young people, a part of this involves listening to and containing the emotions of the adults around them.”- Participant 53*



### Theme 3: Working as part of an MDT.

One of the sub-themes that was mentioned frequently throughout the responses was that the EP should be invited to work as part of the MDT around the child to apply EP skills alongside working with other professionals, and to provide an alternative understanding or an educational view to what can be a primarily medical view of the child:

*“The unique perspective we can provide to a child / young person's situation adds value to the process as part of a MDT around them, providing an educational view to what might otherwise be a medicalise view; a pupil is more than their brain injury.”- Participant 48*

*“Involvement as part of multidisciplinary working would be a clear role for EPs as I was able to offer some reflections upon why the assessment scores may have varied which other professionals had not considered. I feel that we have a valuable role in supporting children with ABIs right from the initial injury, through hospitalisation (including ensuring access to appropriate educational resources and teaching when they are ready), to transition back into an educational setting and onwards.”- Participant 60*

*“Part of an MDT - focusing systemically on how the school can interact with the specialists involved/family/child in the most empathetic, positive and helpful way”- Participant 14*

*“If the team is wide ranging, then EP role can be focused on advice to school, assessment of needs as they present in school, consultation, attendance at review meetings, etc. If the wider team is lacking then the EP may need to support more systemically, therapeutically, wherever he or she can!”- Participant 23*

### Theme 4: Translating medical reports.

For other respondents, being able to translate medical reports into real life implications for learning in the educational setting:

*“In an ideal world we would be referred to once a medical diagnosis has been received to support schools with interpretation of reports and how an ABI might present in the classroom.”— Participant 93*

*“Helping to implement advice from health/specialists into a school context, remove barriers to the mainstream or specialist school context in order that these children have inclusive support and reach their potential.”—Participant 94*

*“I often find the medical advice does not translate well into schools. I have seen them repeatedly advocate for an EHCP despite the need in school being met at SEN support which then puts SENDCo in a tricky position.”- Participant 16*

#### Theme 5: Child voice

Some respondents believed that the ability of the EP to gather child voice, to advocate for the child and to help them to explore their personal constructs, was a key part of the role:

*“Being an advocate for child/young person (or family) as appropriate - this could be at a variety of levels (statutory, individual and therapeutic)”- Participant 81*

*“Not in every case, but individual work to explore a young person's self-perception following an injury could also be a very helpful role for the EP. I have done this in two pieces of casework, and the YP found it very helpful, and surprisingly had not been offered elsewhere. Of real importance was finding an agreed way with the YP to share this with a wider team including their family and teaching staff.”- Participant 81*

*“I think we can help the young person to talk about and process their experiences and their personal constructs about themselves now.”- Participant 16*

#### Theme 6: ‘Return to school’ meeting.

The final sub-theme that arose within the data was that it would be beneficial for the EP to attend the ‘return to school’ meeting following discharge from hospital so that they can provide a link between health and education and support the school staff to understand the implications for learning:

*“I think it would be helpful for EPs to be involved once a child has been identified as having ABI, particularly if they are in an educational setting or about to start/return to one. We can provide a helpful link between health and education, for both families and teaching staff.”- Participant 64*

*“I think EPs are well placed (if they have sufficient knowledge) to ease the return to school for a child or YP with ABI and to help school staff to understand the implications for teaching and learning from a practical (less medical more educational) point of view”- Participant 100*

*“I think it would be helpful to EPs to be involved over time in working with school colleagues to support the child's reintegration back into school.”- Participant 61*

#### Research question 1b summary of findings:

Research question 1b was concerned with the role of the EP in supporting CYP post ABI. In order to answer this question, participants were asked in what capacity they had been involved with CYP with an ABI in the past and what they think the EP role should involve for this population. Many of the responses focussed on the application of EP skills to provide an alternative perspective to what can sometimes just be support from the medical model which tends to reduce the complex problems of disabled people to issues of medical prevention, cure or rehabilitation (Shakespeare, 2006). It was evident from the answers given and the themes identified that participants believed EPs have something unique to offer which would be beneficial to supporting the CYP and the system around them.

#### **5.1.3 Research question 1c: What are the barriers to meeting the needs of children post ABI?**

When asked what they believe the barriers are to meeting the needs of CYP with an ABI, participants listed a range of answers in which TA (see appendix 8) revealed the most common themes.

##### Theme 1: Hidden disability

In the first theme that arose, participants alluded to their belief that an ABI is a hidden disability and therefore CYP may be under-identified, under-referred for support and sometimes have their needs misinterpreted:

*“That it’s a hidden disability and that behavioural needs can be misinterpreted also lifelong impact.”- Participant 1*

*“Perhaps a YP going “under the radar” and not being referred for EP support”- Participant 8*

*“Knowing if they have one in the first instance, several cases I have had have come to me due to concerns about behaviour, when I have then tracked back, I have found they have an ABI. Staff and professionals have a limited understanding of this. There is a strong ASC lens when people interpret the behaviour of these c/yp, and they can often go down the wrong route.”- Participant 96*

## Theme 2: Awareness of the EP support

The second theme that arose was regarding the school staff awareness of what the EP could offer to support a CYP with an ABI. Participants also spoke about how school staff may not refer for EP support as the ABI is seen as medical in nature, or how schools may ask for EP support reactively rather than proactively:

*“They may not be referred to an EP until they begin to struggle in school - early referral and intervention may be important for better outcomes”- Participant 79*

*“Not being referred for EP support if the school does not understand the role an EP can have in supporting YP with an ABI.”- Participant 8*

*“Would schools raise CYP with an acquired brain injury with their link EP or go to a health professional or clinical psychologist for advice?”- Participant 22*

*“School's not raising these children to us as they feel it is 'medical' in nature.”- Participant 47*

*“Some belief that only clinical psychologists can do this work”- Participant 69*

*“I have found that schools may not prioritise children with an ABI for traded EP time, because there is a view that the children and their families are already receiving specialist support from other services.”—Participant 81*

### Theme 3: ABI knowledge amongst school staff

Another theme that arose was the level of knowledge amongst school staff about ABI and how to provide support:

*"I'm not sure that some school staff were aware of the potential extent of the impact of a brain injury or that there are possible strategies that could be tried to address difficulties."*-

*Participant 68*

*"Lack of awareness from schools as to the range and prevalence of ABI and the impacts."*-

*Participant 42*

*"Unless the ABI is very serious and traumatic, the child is often not recognised as having additional needs."*- *Participant 23*

*"Settings not understanding the long-term impact"—Participant 26*

### Theme 4: Occurrence within EP practice

Some participants also wrote about the frequency in which cases of this nature arise in their practice, putting forward the argument that due to its infrequency, the knowledge base of EPs is often out of date, or the EP feels inexperienced and has low confidence levels:

*"I think the frequency you come across children with ABI in a generic role is relatively rare so some of it is lack of practice or up to date knowledge" - Participant 2*

*"Lack of confidence due to lack of experience"- Participant 27*

*"I think because it is a very medical and neurological condition, people perhaps lack confidence in the area"- Participant 62*

### Theme 5: EP capacity and time

One of the most frequently mentioned barriers to support was the limited time and capacity of the EP. Due to the current SEN climate and rise in EHCP requests across the UK, many EP services have a limited offer to schools as the statutory workload is very high (Thomas & Loxley, 2022). This therefore then limits the number of CYP an EP can support outside of an EHC needs assessment. Some services also work through a traded or part-traded model which means schools have to buy in time from the EP service. If schools' budgets are particularly stretched, buying in EP time to support a CYP with an ABI is not always possible:

*“Time is an obstacle for sustained work with any child at the moment due to statutory pressures squeezing all other work”- Participant 27*

*“Providing appropriate support within a traded model where schools may not always wish to purchase in the additional services we can provide (e.g., attending an MDT following producing a statutory report).”- Participant 48*

*“The main barrier for me has been funding, specifically whether schools commission work from us or not. I've known of other CYP with ABIs through termly planning meetings but have not been involved as schools have limited funding and have prioritised other children, often with externalising SEMH needs at risk of PEX.”- Participant 60*

*“Our offer to school is consultation or statutory work. This means it is unlikely we can offer support over time.” – Participant 61*

*“Lack of EP time would most likely be the biggest barrier to be able to fully understand the child's needs and provide some ongoing support for the school and family.” – Participant 87*

#### Theme 6: lack of EP involvement within the MDT

Another theme that was identified as a barrier is the lack of EP involvement within the MDT. Poor communication with health professionals and the MDT not understanding the role of the EP and what support they could offer were also barriers that were identified:

*“Lack of multi-agency cooperation and perspective (education and health services)”— Participant 20*

*“Minimal contact with the MDT once the child had been discharged from hospital.”- Participant 25*

*“Timely and detailed information from health professionals; in my experience when information from health professionals is limited, it’s harder to plan work and come up with a working hypothesis on what is happening”- Participant 38*

*“Difficulties in co-ordinating work with MDT - especially community/hospital as understandably they are all just as stretched as we are”- Participant 42*

*“Poor links between health and education to ensure early support is put in place to maximize outcomes for YP (this population is over-represented in criminal justice system)”- Participant 73*

*“I also feel that lack of understanding of the EP role can impact on whether we are invited/included in supporting a child/YP with an ABI. The breadth of skills and support we can offer are not always understood by wider agencies and also by some schools; resulting in some seeing the EP role as quite narrow (in terms of EHC assessments, or cognitive assessments).”- Participant 81*

*“The team were not clear on the role of the EP and what we could provide.”- Participant 89*

### Theme 7: Grief, loss and trauma

Some participants also gave responses that sat within general barriers that these CYP and their families face such as grief, loss, and trauma. It was also acknowledged that absence from school and difficulties returning to school are barriers to meeting the needs of these young people:

*“Grief/acceptance issues”- Participant 11*

*“Feelings of loss”- Participant 73*

*“There could be high levels of trauma attached to the cases depending on how the injury was acquired- considerations need to be given to losses experienced by the families and CYP in terms of alternative futures possibly?”- Participant 96*

## Theme 8: Knowledge and confidence amongst EPs

Another theme that was identified as a barrier was lack of knowledge and confidence levels amongst EPs:

*“There is not a full understanding, even in the EP profession, about how ABI impact varies depending on the age of the child”. – Participant 24*

*“knowledge and understanding of 1) what ABIs are 2) what are the signs 3) how to work with children and young people with ABIs 4) what the impact of ABIs are 5) ABIs and trauma context 6) SEND needs and provision for children with an ABI 7) educational and life outcomes for children and young people with ABIs 8) links to ABI and youth justice outcomes 9) ... EPs not seeing themselves as neuropsychologists and eschewing work in a medical context”- Participant 23*

*“Lack of ‘in the moment’ knowledge as requires me to go away and research/find out more, use of medical terms within letters etc that are difficult for me to understand and take time to translate”.- Participant 27*

Some EPs felt there was a need for CPD to help them feel more confident in providing support to this population, or that it should be included within initial training:

*“There is a need like most things to ensure we keep up to date with research so ensuring appropriate CPD is available is beneficial”. – Participant 49*

*“Lack of access to CPD” – Participant 58*

*“Lack of training and awareness amongst EPs”- Participant 81*

*“Insufficient focus in the training programmes for EPs, lack of trainers available to deliver input”. – Participant 64*

One participant shared they believe there should be a specialist EP within the team that could support colleagues through signposting and knowledge transfer when they are called on to support a CYP with an ABI:



*“It would be helpful to have an EP in the team who specialises in ABI, as a first point of support if involved in an ABI case”. -Participant 51*

#### Research question 1c summary of findings:

Research question 1c was concerned with identifying the barriers to meeting the needs of CYP post ABI. In order to answer this question, participants were asked what they believed these barriers were. Several themes were identified within the data, including an ABI being a hidden disability, low EP knowledge and lack of confidence around ABI, and the possibility that a lack of knowledge amongst school staff regarding the impact of an ABI but also their awareness of what an EP could offer in supporting these children, therefore resulting in low rates of referral to the EP service.

Another factor identified was the capacity of the EP to pick up such referrals even if the school were to request support due to statutory work taking up most of the EP's time. Participants also identified that as some services work within a traded or part-traded model, some schools have to pay for EP involvement and therefore school monetary strains could impact on their ability to buy in support for a child with an ABI from the EP service. Some participants commented on the low prevalence rates of ABI amongst EP work as a barrier to meeting the needs of these children as if a referral did come in, they may not have the knowledge or confidence levels to feel able to provide this support.

Another theme that was identified was around the lack of involvement the EP has within the MDT and potentially existing professionals within the MDT not understanding the role of the EP and what they could add to enhance the support for the child with an ABI. A small number of participants also considered the general barriers to children with an ABI getting their needs met such as grief, loss, trauma and absences from school.

#### **5.1.4 Research question 1d: What is the perceived knowledge and confidence level of EPs around ABI?**

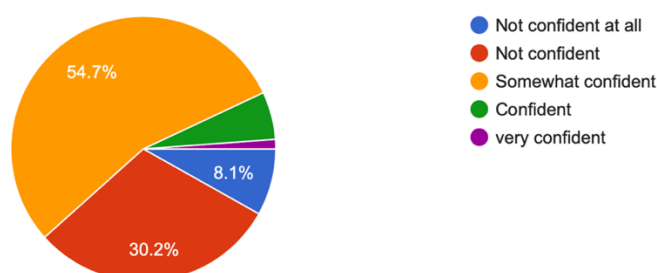
The national survey results indicated that 30.2% of participants shared they were 'not confident' and 8.1% shared they were not confident at all in their knowledge and understanding of neuropsychological theory (figure 6) which could therefore impact upon the level of support these EPs feel confident and prepared in giving to this population. Similarly, only 7% of participants believed they had a good understanding of the common difficulties after ABI and 18% who shared that they were unsure about what these common difficulties are. 27% of participants also felt 'not

confident', alongside 12% who felt 'not confident at all', in signposting schools and families to where they could receive extra support.

On the other hand, 75% of all participants believed that they had some knowledge about the most common difficulties children face after an ABI (figure 6). Similarly, 54.7% of participants felt 'somewhat confident' in their knowledge and understanding of neuropsychological theory to support their work with CYP with an ABI. Also, 50% of participants felt somewhat confident, alongside 10% who felt confident and 1% who felt very confident, in signposting schools and families to where they could receive extra support. This suggests that the majority of participants believe they have the basic level of understanding of the common difficulties and neuropsychological theory that would then inform their practice with this population.

*Figure 6: Confidence levels in knowledge and understanding of neuropsychological theory.*

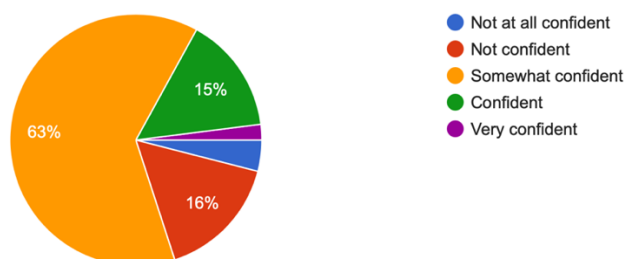
How confident were you in your knowledge and understanding of neuropsychological theory to support your work on these cases  
86 responses



In regard to confidence in providing support, 16% of participants voiced that they would not be confident in supporting a child with an ABI and 4% of participants shared they would feel not at all confident (figure 7). This suggests that there are some EPs who if they were called upon to support a child with an ABI in the future, would not feel confident in their knowledge on the topic which may affect their confidence in providing the support. However, the majority of participants (63%) indicated that they would feel 'somewhat confident' in supporting a child who had an ABI (figure 7) which is a promising result.

Figure 7: Confidence levels amongst participants

How confident would you feel in supporting a child who had an Acquired Brain Injury?  
100 responses



A TA of the qualitative data indicated five themes regarding why participants gave the answer they did:

#### Theme 1: Personal Experience

Some participants highlighted their own personal experiences as an important contributing factor to their confidence levels in providing support for a CYP with an ABI within their EP practice:

*"I have an ABI and not that all ABI are the same, but I feel I have personal experience and knowledge which is useful."- Participant 1*

*"I have acquired brain injury myself - having developed meningitis as an adult - and I am aware that the long-term outcomes for me have been very different from what the medical staff, at the time, were expecting"- Participant 13*

#### Theme 2: Self-directed learning

Other responses highlighted that self-directed learning and seeking advice from colleagues (e.g., peer supervision) had an effect on their confidence levels, with some saying that they had done this and others saying they felt they could do so in order to help them feel more confident if a case arose:

*“I have the capacity to explore the area and seek support from colleagues to find out more should a case arise in my practice”- Participant 8*

*“I would understand where further information and advice could be accessed to support the child/family/school and for my own professional development.”- Participant 12*

*“I feel that I have good skills in self-directed exploration to further my knowledge through reading relevant articles and information”—Participant 46*

*“I would work closely with health and other professionals and our service has the required expertise for consultation in (for e.g.) access technology, SALT. Also, I would do my own research as needed.”- Participant 27*

### Theme 3: applications from general EP practice

Another theme that was identified was that some participants felt confident in supporting children with an ABI in their practice as they felt they could use existing key skills within EP practice as part of the support they provide. Therefore, the EPs felt confident in their abilities to use these skills in the absence of any specialist ABI knowledge:

*“Although I do not have detailed neuropsychological knowledge in this area, I feel that I am skilled in understanding the current presenting individual needs of CYP and supporting schools to plan support for CYP in collaboration with other professionals.”- Participant 9*

*“Educational Psychology practice involves supporting children and young people through evidencing and analysing the holistic picture of their strengths and areas for development; an ABI would be an element of this alongside the wider context historically, home wise and educationally which places Educational Psychologists in a unique position to support”- Participant 48*

*“I work with two special schools and a whole host of SEN children I am often having to read up about a special need, I don't need to know everything there is to know about everything....I can ask lots of questions and think about the young person holistically in the context they are in.”- Participant 70*

*“I think that EPs have a lot to offer within consultation that we do not always need to have specific knowledge about a condition/ diagnosis. We can support others who know the children/ family/ school best to problem solve collaboratively. For that reason, I would feel ok supporting a child with ABI in a consultative way, but I would not feel confident to deliver training/ answer specific questions. If I was writing an EHC advice, I would need time to do some research.”- Participant 77*

*“I feel that many of the psychological principles that I use in my work can be applied to work with all children/young people, for example acting as an advocate, seeking and promoting young people's views. generating a problem-solving framework to support change etc.(...) I feel that often what has been missing is really 'hearing' and promoting the voice of the young person and I feel confident in being able to do this for young people including those with an acquired brain injury.”- Participant 8*

#### Theme 4: Accessed CPD

Another theme that was identified was whether the participants had accessed teaching on working with this population within their initial training or through accessing CPD on the topic. Some participants shared that they felt less confident in supporting these CYP due to lack of training and CPD in this area, whilst others felt confident in their abilities due to accessing further input and training:

*“I do not feel that I have received training on this. I would lean on medical advice to support my work.”- Participant 32*

*“I have accessed very little CPD on this area”- Participant 15*

*“I have received no input as part of my doctoral training on supporting CYP with ABI.”- Participant 97*

*“I feel that I can draw on sessions from my initial training as well as CPD pre- and post-training.”- Participant 6*

*“I attended a CPD event in a neighbouring LA delivered by EP specialists in Acquired Brain injury; I was there able to refer to this information.”- Participant 14*

*"I have attended training from CBIT which was excellent. I will be disseminating the key parts of this training to three EP services as part of a team CPD day in autumn 2022."*- Participant 42

*"I attended a training session on the topic. This gave me some understanding of the kinds of difficulties commonly experienced by those with an acquired brain injury. I now feel more confident having this basic overview and having some understanding of the possible sources of relevant information should I need to carry out further research in relation to a specific case in the future."*- Participant 68

*"I do feel that more neuropsychological training is required for EPs though but as part of initial training and CPD across services (rather than as an optional interest for certain EPs as all EPs are likely to come across children with ABI)"*- Participant 100

#### Theme 5: Professional experience

Another theme that was identified was whether the participants had low confidence levels in supporting children with an ABI due to having no or limited experience in this area:

*"I have had no experience in this area of EP practice and have very little knowledge"*- Participant 71

*"Due to very little experience of working with children with ABI in our service"*- Participant 7

*"My experience with ABI is limited and I therefore cannot provide advice regarding what a child's progress would look like, if the behaviour or needs we are seeing relate to the ABI or provide an evidence-based interventions"*- Participant 62

One participant also shared that they felt unprepared last time they supported a child and would feel just as unprepared in the future:

*"I felt extremely underprepared when I did it before, and that has not really changed."*- Participant 85

However, some participants shared that their confidence levels in this area were due to having professional experience working within a specialist MDT or service in a private capacity, alongside their role within the local authority:

*“I am part of a multi-disciplinary team (not local authority based) who specialise in providing support for children with ABI. To prepare for this role I undertook a lot of reading in this area. I now have my experiences with different cases to draw on and have also learned lots from other professionals on MDTs.”- Participant 23*

*“I previously worked in \*\*\*\*\* Children's Trust for children with brain injury. We also had a lecture while training from an EP who was currently working there. I am comfortable with how to work with parents, the children, and the staff.”—Participant 35*

*“I have worked with children with acquired brain injury at a specialist neuro-rehab setting for the past six years.”- Participant 55*

*“I work privately with a company involved in ABI rehabilitation”—Participant 73*

Some participants shared that their confidence levels in this area were due to having professional experience working within an MDT and that working alongside other professionals help them feel more confident:

*“I have usually found when a child has an acquired brain injury there is a team involved from Health who provide specific support and neuropsychological assessment, so I feel confident as part of that multidisciplinary team of professionals. However, were I to be the only professional involved, I would feel somewhat less confident as I feel expertise of neuropsychology is needed alongside Educational Psychologist involvement.”- Participant 53*

Other participants shared that their confidence levels in this area were due to having professional experience in supporting a child through an EHCNA, casework and developing a system that better identified children with an ABI who needed support:

*“I have also had some experience in this area through EHCNA and casework, so I have that to draw on.”- Participant 16*

*"I have researched the topic and worked alongside Hospital and Outreach to develop a system of working in this area. The system was successful but is no longer in place."- Participant 69*

#### Research question 1d summary of findings:

Research question 1d was concerned with the perceived knowledge and confidence level of EPs around ABI. In order to answer this question, participants were asked what their confidence and knowledge levels were. The majority of participants shared they were 'somewhat confident' in supporting children with an ABI, however there were participants who voiced that they were not confident, or not confident at all. When asked to give reasons for their responses, several themes were identified within the data. These themes included personal experience, self-directed exploration, advice from colleagues, applications of existing EP skills, whether they had accessed CPD, and their level of professional experience. It is also important to note the variation in reasons for both confidence and lack of confidence, in that it was evident some participants thought that generic EP skills are enough, and others felt that they were not, and further training would be needed to enable them to provide this support confidently.

#### **5.1.5 Research question 1e: What is the prevalence of EPs who have accessed CPD on ABI?**

The national survey asked participants where they had gathered any knowledge they had on ABI. 21% of participants shared that they gained knowledge from previous experience, and 34% shared that they had accessed CPD on the topic. Some of the participants shared that they gained knowledge from initial training, however 49% of participants shared that no coverage on ABI was given during initial training and 42.7% stating there was very little coverage.

The most common answer given for acquiring knowledge on ABI was through self-directed exploration with 75% of respondents giving this answer. Some participants also shared that they had gained some knowledge through discussions and collaborations with clinical professionals, support groups, brain injury specialists (e.g., neuropsychologists), and seeking advice from EP colleagues. Two participants also shared that they learned about brain injury from their parent, one of which was a neuro-physiotherapist and one of whom had an ABI.

Participants were asked whether they believed further training on ABI would be beneficial to their practice. 25% of participants answered that further training might be beneficial and 2% believed it



would not be beneficial. A TA of the qualitative data indicated the reasons some participants didn't believe that further input on this area would be necessary:

*"It's something I come across so infrequently that I'm not sure devoting time to additional training would be that much of a good use of public sector resources but if it was a short (1/2 day or 1 day) training I would be interested."- Participant 5*

*"It seems that this does not come up very commonly in practice, although I would like to know more, I feel there are other areas of practice that I would prioritise seeking further training on before ABI"- Participant 8*

*"Given the specialist services in my local authority which support children with ABI it is not very often that I come across these cases in my work. As such I think that the training I have had in this area is sufficient"- Participant 17*

*"Because ABI has been so rarely encountered, it would not be good use of or a priority for CPD at this time. Sorry. The same goes for the myriad of very specific conditions that exist. I've found that it works for me to have CPD experiences on a need to know as and when basis with rarely encountered conditions/needs."- Participant 95*

*"In 6 years of practice, I have only worked with one pupil with ABI. Whilst my lack of knowledge is likely to have impacted the outcome of my psychological advice, I am unsure as to whether it would be a best use of time (as part of the doctorate) to further explore this issue."— Participant 97*

However, with the majority of participants answering yes (73%), five themes were identified regarding what would they like to learn about within further training:

#### Theme 1: common difficulties of ABI and the impact on the child and family

Some of the participants expressed a desire to learn about the basics of ABI, including the common difficulties after an ABI and how an ABI can impact development in CYP.

*“Would like to learn more about key factors e.g., the aforementioned 'common issues'.”-*

*Participant 7*

*“As an EP it is likely that I may become involved again with a child with ABI. Further training would develop my knowledge and practice.”- Participant 25*

*“It is something I am very interested in; particularly how specific areas of the brain affect different skills/lead to certain difficulties.”- Participant 26*

*“Types of acquired brain injury, how to support young people with acquired brain injuries.” – Participant 30*

*“Some indication as to what the long-term impact on the child is in terms of ability to acquire new skills and learning.”- Participant 33*

*“I think all EPs would benefit from basic training in understanding how ABIs can affect children and young people and how we might best help education professionals to understand and support children”—Participant 64*

## Theme 2: Applications to EP practice

Some of the participants expressed a desire to learn about how they could use existing EP skills to support children with an ABI:

*“Personally, I would like to increase some of my BASIC understanding, and how this may fit alongside our understanding of cognitive assessments (memory, concentration, simultaneous processing, language, speech etc)”- Participant 81*

*“I think it is about the unique contribution that an EP could make: training, cognitive processes type assessment, bridging between cog psych/ neuro psych and schools, perhaps dealing more around supporting grief, loss of identity, or facilitating group processes using PATH etc.”- Participant 2*

*“More about the EP role in identifying and supporting children with ABI”- Participant 21*

*“Things I would like to learn would be how ABI can impact on different areas of development, realistic outcomes and provisions that could support young people with ABI”- Participant 31*

*“What strategies have been helpful in supporting staff manage emotional regulation difficulties and overall, which are the key areas that should be considered when carrying out an assessment.”- Participant 33*

### Theme 3: keep up to date with neuropsychological research.

Some of the participants expressed a desire to learn about neuropsychological research and would like to keep up to date with advances within their understanding of the brain. Some participants also expressed a desire to understand the impact of seizures on the brain as they can occur after an ABI:

*“I feel that there is always more to learn, and it is important to keep up-to-date with advances in these areas.”- Participant 6*

*“Because I think we quite often talk a lot about the 'brain' these days, in our practice, and schools expect it to a certain extent, but many assumptions can be made.” – Participant 13*

*“I particularly would be interested in neurological implications of seizures as a few cases have had infantile seizures, which although stopped, seem to have difficulties with executive functioning and this 'feels' like an ABI to some extent, but I would like to be more informed about this.”- Participant 47*

*“I feel it would be beneficial to have training every so often (e.g., 2-3 years) to keep up to date with most recent research and relevant recommendations.”- Participant 50*

*“The field of paediatric brain injury is always changing and emerging and so I feel that training needs to be an ongoing thing.”- Participant 55*

*“I worked with a child who had had a brain tumour...and another who experienced epileptic fits... info re ABI in these cases would have been helpful...More detail around the impact on memory and processing skills would be helpful.”- Participant 72*

#### Theme 4: information about services to be able to signpost for further support.

Some of the participants expressed a desire to learn about services and protocols that exist to support children with an ABI and therefore enable the EP to signpost schools and families so they can receive extra support:

*“Protocol/policies for supporting children with needs in this area. Services for signposting.” – Participant 12*

*“I would like to know what additional support is available for families and where I could signpost them.” – Participant 22*

*“I would like to know what support services are out there and what families have found most helpful in these situations.” – Participant 88*

#### Theme 5: it should be covered in initial training.

Two participants also believed that teaching on this topic should be included within initial training:

*“I feel it should have been covered in initial training. I would like additional training on the impact ABI can have on specific cognitive processes, for example memory” – Participant 68*

*“Hence, maybe. If it were to become as aspect of the doctorate training, I would like to learn more about models of injury, types of ABI, possible severity, impact, how to support/rehabilitate. I would hope that this opens up discussion around EP understanding of ABI and whether/what the role is to support CYP and how, if possible, we maintain the use of social, practical psychology without becoming overshadowed by health/medical models.” – Participant 97*

#### Research question 1e summary of findings:

Research question 1e was concerned with the prevalence of EPs who have accessed CPD on ABI. In order to answer this question, participants were asked where they had gained any knowledge, and how much the topic was included within initial training. Participants were also asked whether they felt that more training on the topic would be beneficial and what they would like to learn. Several

themes were identified in the responses given to the latter question, including training on the common difficulties of ABI, the impact on the child and family, applications to EP practice, information about where they can signpost families to receive further support, keeping up to date with neuropsychological research and learning about the impact of seizures on the developing brain. It is possible that some participants wanted to learn about the impact of seizures due to Epilepsy being the other most common neurological condition an EP is asked to support with (Misheva, 2020).

A few participants also voiced that they believe teaching on this topic should be included within initial training.

## **5.2 Summary of the National Survey findings**

The analysis of the national survey revealed a number of important findings regarding EP experiences, confidence levels and beliefs in providing support to a CYP with an ABI. The results highlighted that the majority of EPs have been called upon to support a CYP with an ABI within their practice (80%). The survey also highlighted that the majority of participants believe that ABI amongst children is uncommon. The findings suggest that although most EPs have provided support, that these cases do not arise frequently and that, for some reason, injury rates may not be translating into incidence rates within EP practice, which may be influencing participants' perception of commonality. It is also possible that EPs have supported children where the ABI has not been disclosed or the school or the family have not recognised its relevance or importance for mentioning. The level of support needed for children with an ABI is rising as survival following a substantial acquired brain damage is becoming a more frequent outcome that would have previously been fatal (Hayes, Shaw, Pearce & Forsyth, 2017). This calls into question why there may be such a low rate of involvement for EPs.

The results of the survey also highlighted what participants felt the role of the EP should be in supporting CYP with an ABI. The unique contribution of the EP was a major theme in many of the responses. It was clear that there was a strong feeling amongst most participants that EPs have something unique to offer that would benefit children's recovery and adaptation to life after a brain injury, independently or alongside other members of the MDT.

When considering the barriers to providing this support, a number of themes emerged from the data, including the fact that an ABI can be a hidden condition and the possibility that school staff may not be aware of the effects of an ABI or what an EP can provide in terms of supporting these young people, leading to low referral rates to the EP service. Another factor identified was limited capacity of EPs and traded models of service delivery limiting the ability for EPs to provide such support. Similarly, the EPs lack of involvement within the wider MDT around a child with an ABI was identified as a barrier, in addition to medical professionals not fully understanding the role of the EP and the support they can offer.

The results of the national survey also generated an understanding of the confidence levels amongst EPs in supporting a child with an ABI. The majority of participants said they felt "somewhat confident", although some said they were not confident at all. Several themes emerged from the data when participants were asked to explain their rating; personal experience, independent research, suggestions from peers, applications of already-developed EP abilities, access to CPD, and amount of professional experience were some of these themes. Some of the findings were contradictory which will be further explored in the discussion chapter (see chapter 6).

Finally, the survey also revealed that the majority of EPs felt further training on ABI would be beneficial to their practice. Several recurring themes were identified, including education on the common difficulties of ABI, the effect on the CYP and their family, applications to EP practice, knowledge of services they can refer families to for additional help, staying current with neuropsychological research, and learning about how seizures affect the developing brain.

While the national survey aimed to provide a generic overview of the EP experiences, confidence levels and beliefs in providing support to a child with an ABI, the second phase of the research focussed on identifying examples of good practice amongst EP practice. The combined results from both phases will then be taken into account in Chapter 6 to provide a thorough summary of the research, including references to its implications for practice and recommendations for future research.

### **5.3 Phase 2: Focus Group**

The second phase of the research aimed to build upon the findings of phase 1 by exploring what is considered as good practice within in EP work when supporting CYP with an ABI. Whilst phase 1 gave an overview of the general practices, beliefs and confidence levels amongst EPs across the UK, the second phase focussed on answering research question 2 by exploring examples of practice where the EP provided support to a CYP with an ABI which had a positive impact. Participants were asked to expand on what their role involved and the impact this had on the CYP and the system around them. Two focus groups were conducted with two EPs in each group (focus group one – participants 48 and 14, focus group two - participants 42 and 94) who volunteered to participate at the end of the survey. All quotes used are written as they were spoken by the participants.

#### **5.3.1 Data analysis**

The focus groups were recorded and transcribed verbatim using the transcription software Otter AI. When thinking about the analysis of the data, a variety of qualitative data analysis strategies were considered before concluding that TA (Braun & Clarke, 2021) would be the best strategy in identifying commonalities within the data. TA is often referred to as “a method for identifying, analyzing, and interpreting patterns of meaning (‘themes’) within qualitative data” (Braun & Clarke, 2006, pg. 79).

TA has broad applications to a variety of different research issues and methodological stances since it is consistent with a number of ontological and epistemological viewpoints. The second research question in this thesis sought to examine the contribution of EPs in supporting a child with an ABI, as well as to search for recurring themes and patterns in the data. As a result, the goal of the research, and the second phase in particular, was to identify repeated patterns of meaning within the data rather than concentrating on how particular participants construct meaning and make sense of their experiences, which would have been suitable for an Interpretative Phenomenological Analysis (IPA) (Larkin et al., 2006). TA was also chosen over IPA as the analytic focus was on identifying themes across the data rather than discovering nuances within individual experiences.

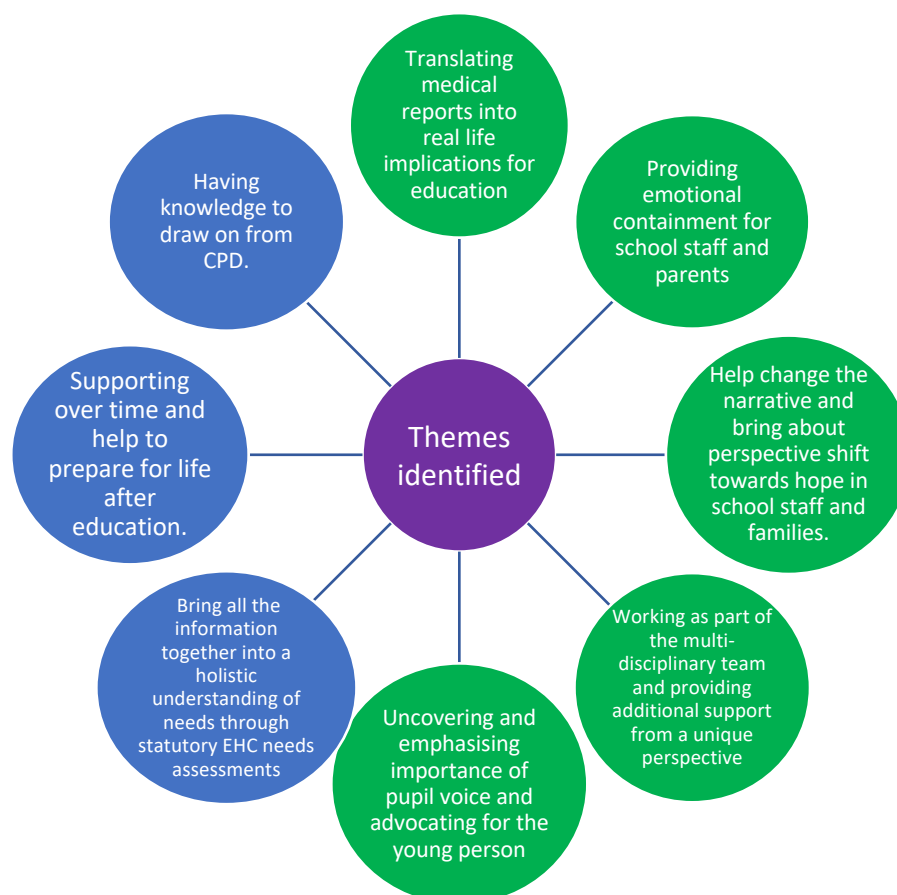
#### **5.3.2 Focus group findings**

In this section, the focus group findings will be reported by outlining the eight main themes that arose within the data when looking at examples of EP practice that can support CYP after an ABI. The

key themes identified were collaboratively shaped by participants and the lead researcher as part of using the NGT (Dunham, 1998) (see chapter 4, section 4.2 for more information). Within this technique, participants voted on which themes they believed were the most important. Participants only voted on the importance of the themes that arose within their focus group, however, a TA was conducted across both focus groups upon completion.

The most important themes voted by participants are represented in green within the image below, and the other identified themes are represented in blue:

*Image 3: Themes voted on by participants:*



### Theme 1: Translating medical reports into implications for education.

The national survey results highlighted 'translating medical reports into implications for education' as one of the themes that arose when looking at how EPs have supported children with an ABI in the past and what they believe their role should be going forward. The focus groups also gave rise to this theme, with participants highlighting it as something that was beneficial to their practice in their experience:



*“The reason I was initially invited was because school was struggling to understand the implications for the ABI. And they'd had a huge wealth of medical reports and information as a result of the investigations and treatment. And really, we're not understanding basically the changes that are had occurred for the young person. And were looking to have advice from our service to be able to achieve that (...)They had been given a, like I said, a wealth of information. And within some of those reports, there were strategies. But those strategies were written from a medical perspective, not an educational perspective (...) In order to go from at that medical viewpoint to a school-based context. So, helping to understand okay, this is this is what the medical report is suggesting, and this is how it translates to a school context.”—Participant 48*

Similarly, one participant highlighted the language use within the medical reports as complex and difficult to understand, and how their EP work supported families and schools to understand the information in simpler terms:

*“It's very jargony. And we had that there. And what I think we managed to do, or I managed to do with the SENCo at that point was to sort of bring that into plain English for the families to understand what that was, and then what that would look like” – Participant 14*

## Theme 2: providing emotional containment and support for school staff and families.

In addition to helping families and schools understand the educational implications of the child's ABI, participants also voiced that providing emotional containment for school staff and families was a very important part of their role:

*“I think some of that was around emotional containment and holding for the staff about their loss of the student they used to know and how that student was then being interpreted” – Participant 48*

One participant shared that they supported the head teacher with their emotions and feelings about whether they could support the child when they left hospital and returned to school:

*“I think people who are feeling a bit scared, quite scared is the head teacher was worried and anxious I think about whether they'd be able to cope with a child when she when she came back to*

*school because the first meeting was before she was before she'd arrived back in school, and she was still in hospital.” – Participant 14*

Another participant shared their experience of medical professionals emphasising the ‘window of opportunity’ during the child’s recovery, and how this can cause a lot of pressure for the school staff to feel that if they don’t provide the right support, the child’s recovery will not be as effective:

*“The window of opportunity that was explained and it really emphasised in that first meeting, I think that really pressured people and they so it became all about that what, what can we what can we do then? (...) What do we need to do to support the maximise opportunities for development for the child? So, there was some containment around that as well and making that more tangible, because it felt like a big pressure and a big fear of what of what if we don't do it right. (...) What if we do the wrong thing? What can we do so, that is a discourse of the window of opportunity became a big thing.” – Participant 14*

Similarly, the participant spoke about the added pressure on schools from parents who emphasise the ‘window of opportunity’, and the importance of support for school staff to help them manage and navigate these complex feelings:

*“If you were a parent that's if you think there's a window of opportunity and you're working within that timescale, you've got that. That's your chance to get your child back. And that felt quite difficult thing for school staff to manage in their head. (...) And I've said supervision, obviously they didn't call it supervision, but they wanted to chat about some of these things, and to support the staff who were also managing their grief but also worried about whether they were going to do enough... So, I do think it was about being there as a partner with them through that process. Because it was a critical incident, wasn't it for that for the school. And so, holding some of that.” – Participant 14*

Participant 48 highlighted the importance of providing emotional containment for parents within their role:

*“...includes the parents because the parent was very much still trying to move on from the loss of effectively one child to then getting another child almost because there was such a dramatic change.” – Participant 48*

Participants also discussed that EPs are suited to provide this emotional containment for school staff and parents as EPs often use a relational approach and have the skills to build supportive connections with people in a short space of time:

*“I think it goes back to what you were saying earlier about the relational aspect and having a good connection with the people that we're working with, or if they're new people being able to invite that connection and foster that within that small space of time, we've got with them is one of the key aspects.” – Participant 48*

### Theme 3: Help change the narrative and bring about perspective shift towards hope in school staff and families.

Participants also voiced that helping school staff to understand that the difficulties the child may be having are unmet needs rather than behavioural difficulties:

*“...supporting adults to view changes in personality and presentation as need and not behaviour” – Participant 94*

*“And it might be about like, communication, you know, they're coming across as rude. Well, they're not actually meaning to be rude. This is actually another kind of impact of this brain injury. And so that's what kind I meant by kind of, you know, shining the light on the other areas and making them maybe go oh, actually reframing.” – Participant 42*

One participant also shared that in their experience, it was beneficial to the system to ask the questions that enable people to reflect on their understanding and beliefs in a sensitive way:

*“...we have that ability to ask those curious questions to come in from a completely different angle, and explore further (...) in the old Socratic method why? And asking an exploring in a real in-depth way, but from a completely different perspective, to help draw things together. So, when I'm talking about curious questions, we're also not afraid to challenge within that and to ask, have you thought about it in this way? Could it be this that's going on, and use those kinds of you know, I wonder phrases to introduce new narratives that might be going on?” – Participant 48*

It was also highlighted that as part of their role as the EP, they sensitively supported the system around the child to shift their perspective to focus on the here and now rather than focussing on before the injury:

*“And what prompted me to write this, about that that perspective shift was that need to support people to look beyond the brain injury, and see the child or student for who they are now they know what their character was like now, and yet kind of yes, acknowledging the changes that had occurred, but rather than dwelling on them as a negative, thinking more about what's the here and now for this young person, what do we now need to consider as their strengths and skill base?” – Participant 48*

In addition to helping the system around the child to recognise strengths and provide optimism that the child will succeed in their own way:

*“...beginning to see not only her flourish, but also the other children in response to her (...). And when I met with her the first time, I don't know what I'd expected, but here was this glorious little girl who was really engaging with the activities that we did together and so I was able to support and just encourage the talk around her. Both in the report that I wrote, but also just thinking in discussions dialogue, to enable and reinforce that sort of optimism around that, you know, here was a child who was going to succeed in her own way.” – Participant 14*

*“having a conversation about strengths and positives, because a lot of the conversations have been about negatives and I think that ties in so well, because after one of these incidences, it's all about what they've lost or what they can't do anymore, or what went wrong and there's all that like, guilt and upset and anger and you know, all of that and then for someone to come in say, so what are their strengths and what what's been going well and what progress have they made and what do they enjoy?” – Participant 42*

#### Theme 4: Working as part of the multi-disciplinary team and providing additional support from a unique perspective.

Another theme that arose within the data was when the EP had the opportunity to work as part of the wider MDT and was able to provide an alternative perspective due to working within a social model of disability compared to a medical model:

*“So, while I might talk about executive functioning and how it evolves and is a dynamic consideration to take on board within an educational context, the more clinical model would look at it in a completely different light about how it impacts on sort of more general functioning. So, I think we can bring a different perspective, which I think helps.” – Participant 48*

*“We are we work within a social model of disability, don't we? It's not the medical model. And I think when it's acquired brain injury, it is very much a medical model then all the people who were initially involved are medical or clinical professionals aren't they. (...) the clinical psychologist give you their advice from their clinical setting where the child's been brought to them for and we're very much looking at them in their social environment, aren't we? We're looking at well, what's it like in the hospital school in the mainstream school back at home with parents as he still got his friendship groups? Is it still accessing his extracurricular stuff? We're very much looking at that, that person with that very medical term acquired brain injury, but in that social model aren't we, and I think who else who else does that? Actually, who else does that?” – Participant 94*

One participant also voiced that as EPs can work on a number of different levels of the system, EPs are able to affect multiple levels of positive change and provide both individual and systemic support:

*“But it also allows us to draw on the different levels at which we work. And within that space, we've got the individual level with our knowledge of the student or student functioning. We've also got our knowledge of working at the consultative level with drawing perspectives together knowledge of systemic level working, and also local authority system within system as it were, so we can pull all that together as part of that discussion to help move things on and help people feel supported, which I think is another key element of that supervisory role that we can take.” – Participant 48*

One participant also shared their experience of being invited to work within the MDT, but shared that they were only invited due to the medical professionals believing the child would need an EHC needs assessment, rather than understanding and acknowledging the other skills the EP can bring to the MDT:

*“I was asked to be invited by the medical team. So, they'd asked if the educational psychologist could attend a multidisciplinary meeting (...) So, I think the reason that they were asking*

*is because they thought that the child would need an EHC(...) I'd love to think that they perceived (...) our role to be doing all the things that we've just been describing, but I suspect it was about EHC (...) Yeah, I mean, I think they did. They still associate educate associated educational psychologists with the EHC process, the statutory role but no, we developed a good relationship.(...) So yeah, I think they perceived a broader role for the educational psychologist following the collaborative work that we engaged in definitely.” – Participant 14*

#### Theme 5: uncovering and emphasising importance of pupil voice and advocating for the young person.

Another theme that was identified within the role of the EP as having a positive impact on supporting children with an ABI was advocating for the child’s voice to keep the child at the focus of the support:

*“Taking our role as being pupil advocate, you know putting forward the things from the pupil view (...) enabling us to step into the shoes of that young person through the discourses that we create in our collaborative discussions. And bringing that view to the table I think is a really key part of our role in any situation.” – Participant 48*

Participant 94 also shared a case study of when they observed another EP prioritise and give space within the meeting so that the young person was able to share their views (see case study below).

#### *Case study of an EP prioritising and advocating for pupil voice.*

*“(...)this was a 19-year-old young person who was in a college, and I really can't remember the details of what the acquired brain injury was that he did have acquired brain injury. There was a progression of the impact, and he was losing skills quite rapidly, incredibly sad really (...) but just the consultation needed to look very different. He needed to be given time to speak. And people who were supporting him weren't doing that not because they weren't kind but it's quite amazing, isn't it when we when we say what listening really is and how, you know, wait for somebody gives them time to give the answer(...) he was rarely having the opportunity to actually say what he wanted to say. And so, eliciting his views was the bit I went along to shadow and my colleagues do it. And it was incredible. Really, and we just (...)created just a wonderful silence and acknowledge that it was there and that we all had to sit with it. And it was a really person centred session and he came through about what was important to him then an acknowledgment about what he was increasingly struggling with, you know, month by month, year on year(...) We are going to have silences and we are going to sit with them because he's absolutely capable and he has things to tell us and we did(...)was quite incredible for everybody in the room to hear that no one had heard his views before mum was really emotional because she'd been losing bits of her son as time has gone on. And but she knew he had his views and he had very strong views about what he wanted his future to look like(...) I don't think that would have happened without that EP doing that.”*

Theme 6: EPs can bring all the information together into a holistic understanding of needs through statutory EHC needs assessments.

Several participants identified that the ability of the EP to draw all the information together, from multiple paradigms, into a holistic understanding of the child is one of the unique contributions of the EP. As CYP with an ABI often having many professionals involved, one participant shared that one EHC needs assessment (referred to by the participant as a 'statutory') they completed for a child with an ABI allowed her to create a shared understanding of needs by combining the numerous reports into one:

*"So, for me this one statutory I'm thinking of it was a traumatic injury, and there were just so many professionals involved, you know, the whole gamut of the NHS, some physio, OT, hospital teacher, you know, vision, clinical psychologist, everybody, and there was all this information and letters flying around everywhere. So, I think it was really useful just to get all of that in one structured document, which I know is what we do anyway. But I just think, especially for a case like that, when there's so much medical input, to just kind of have a piece of paper to say, Okay, this is where we're up to at this point in time and looking at everything." – Participant 42*

*"When you realise that there is so much that needs doing it, no one else is doing this, this family probably had diagnosis and skills lost, like we said, and this is the sort of thing that is missed I think, is really our unique contribution that we use that term to always EPs but what we do bring that's unique, which is pulling everything together." – Participant 94*

Theme 7: supporting over time and help to prepare for life after education.

Several participants commented on their involvement over time through attending annual reviews, acknowledging that a child with an ABI can present very differently a year later with a significant change in their needs:

*"...I think I wrote one about annual review (...)I didn't do the original EHC for this young person. And there was a lot of change. Because the EHC advice had been written at the point of the illness for this young person. So, a very, very different picture. So, the school staff and family were confused, why is it so different and why it why we're seeing what we're seeing. So, I was able to unpick the other piece of advice that was in there from the original assessment and sort of help*

*everyone to understand that that was from a point in time and it's not that we're saying that that's not right, that was right for that situation. But now this presentation is really different.” – Participant 94*

One participant also commented on how they helped the system around the child, in addition to the child themselves, to reframe the future and think about preparation for adulthood (PFA):

*“...supporting key adults to think about factors such as PFA, just (...)thinking about how we have a role in because their adulthood is going to be very different to what they were anticipating it to be. So just using our knowledge of being able to ask those right questions, because we've done maybe lots of post 16 work or things like that, and, you know, just thinking about those different aspects of independence and what that can look like.” – Participant 42*

#### Theme 8: Having knowledge to draw on from CPD.

The final theme that was identified within the data was that the participants felt more confident in providing support to children with an ABI when they had accessed CPD on the topic, or accessed useful resources, therefore enabling them to be more informed in their support:

*“Drew upon whole service and child brain injury training that occurred a couple of years before and that information sharing to enhance your own CPD, and knowledge as well as that change for the young person” – Participant 48*

*“What it did do was I knew that I'd got a resource that could look at which I did before I went to the first meeting (...) I did feel that this was something that so I might have probably felt less anxious than I would have done.” – Participant 14*

One participant shared that they had accessed the training from the CBIT which has enabled them to develop their knowledge on the topic:

*“I did the training with the Child Brain Injury Trust, which was amazing(...) So, when I did that training. I realised I was like, gosh, I didn't know that. Brain injury can affect all these different areas and there are areas that often come through in consultation, and it's Oh, Child's naughty child's misbehaving. And actually, to be able to say, well, no, you know, memory and executive functioning*



*and all these kinds of areas. It might not be that it might actually be this. So just being able to I think I put one about reframing as well, which is a similar thing.” – Participant 42*

The participant went on to share that they were going to share this learning with their colleagues and provide CPD input for their service:

*“So, I'm doing like a, an ABI input (...) And one thing I've said with my group is can we just put this on the initial consultation framework, you know, when you're asking about the background and the context, just put in, has this child ever been in a hospital has this child ever had one of these injuries or meningitis or anything like that, because it can really change everything. So yeah, I think certainly at university, I don't think we've had a single session, not even referred to, and it's huge.” – Participant 42*

### 5.3.3. Summary of the focus group analysis

Overall, phase 2 of the research gave insight into examples of EP practice in supporting CYP with an ABI where they felt their support made a positive difference. Most prominent amongst the data, and voted as most important by the participants, were themes of translating medical reports into real life implications for education, providing emotional containment and bringing about a perspective change for school staff and parents, working as part of an MDT and emphasizing the importance of child voice. The other themes that were identified included the ability of the EP to bring together all of the existing reports into a holistic understanding of the child's needs through an EHCNA and providing support over time and helping the child to prepare for life after education. Some participants also highlighted that accessing CPD and resources helped them to feel more confident in providing support and gave them a knowledge base that was notably helpful. A detailed discussion of how these findings inform the research questions, as well as their broader implication, will be provided in the next chapter.

## **Chapter 6. Discussion**

In order to provide a coherent narrative about the role of the EP in the UK to help CYP with an ABI, the findings from Phases 1 and 2 will be amalgamated in this chapter. Due to the volume of data collected, this chapter will be split into two main sections. The first section will concentrate on how the results from both phases address the research questions, in conjunction with consideration of the background literature, and will go on to discuss the major themes and significant topics that are pertinent to the research. The second section will provide an overview of the research's theoretical and practical implications as well as suggestions and recommendations for future research.

### **6.1 Research question 1: What are EP experiences and practices of working with children post ABI?**

#### **6.1.1 The prevalence of children with ABI within EP work.**

Based upon the prevalence in the general population and the previous research suggesting how EPs could provide support, it could be expected that most EPs would be called upon to provide support to such CYP from time to time. This may involve attendance at the return to school meeting, helping the school to make informed adjustments and support plans, ongoing review of/recommending provision as the child develops and any further implications of the ABI are identified (Glang, Tyler, Pearson, Todis & Morivant, 2004). The results of the national survey completed by 100 EPs revealed that while most had supported a CYP with an ABI in their practice, some EPs have never done so (16%).

The findings also provided some insight into participants' perceptions of how prevalent ABI is in the paediatric population and, consequently, among those in an educational setting. According to the majority of respondents, ABI is still considered as rare or uncommon in children. This is in contrast to Hughes' (2012) research that revealed high prevalence amongst this population. Unfortunately it is not known how often EPs come across such cases and although most participants have supported a child with an ABI, the results indicate that for some reason, the rates of injury may not be translating into the rates of occurrence within EP practice, which may be contributing to participant understanding of the commonality.

The data gathered to answer research question 1c helped shed some light as to why prevalence amongst the population may not be translating into EP practice. One possible explanation is that as

referrals to the EP service come from schools, if school staff are unaware of how an EP could support a CYP with an ABI, they may not complete the referral. For example, the rates of Autism and ADHD within EP work seem high because schools are aware of how the EP can help and therefore make the referral for support. Alternatively, it is possible that schools are unaware of a historical ABI or that knowledge of the ABI isn't passed onto the EP.

In contrast, maybe the medical nature of an ABI results in the assumption that there is no role for the EP. It is also possible that the prevalence rates of ABI amongst EP practices within local authorities are low due to existing specialist public or private services that exist to provide support to CYP with an ABI. Or that EPs have supported children where the ABI has not been disclosed or the school or the family have not recognised its relevance or importance for mentioning. The barriers to meeting the needs of children with an ABI within EP practice are discussed further in section 6.1.3.

Overall, the statistics indicate high prevalence of ABI within CYP, and the majority of participants indicated that they have supported a child with an ABI within their work, however, participants also shared that they do not see these cases very often compared to many other SEND categories, which is not expected based on the statistics.

#### 6.1.2 The existing role of the EP in supporting children post ABI.

Previous research highlighted the potential unique role of the EP in supporting a child with an ABI. Shaughnessy et al. (2006) outlined the challenge that schools can face with this population, including the need for continuous monitoring, unique involvement for learning and behaviour, assessments and developing support plans. Ball & Howe (2013) suggested that EPs are perfectly placed to monitor ongoing changes in need, and provide continued support to children, their families and their school following an ABI. There were many reasons given for this, including the EP's level of extensive training in the identification, assessment and intervention of learning and behavioural difficulties (Davies et al., 2013), and their unique knowledge of the school systems, factors affecting education and strategies that can support individual needs within a school environment (Bozic & Morris, 2005). Bozic & Morris (2005) also highlighted how the EP is well placed to contribute to the rehabilitation process by using the Ecological Transactional Model (Cicchetti & Toth, 1997) (see table 1).

*Table 1: Bozic & Morris' (2005) suggestions for the EP role in supporting children with an ABI, considered within the Ecological Transactional Model (Cicchetti & Toth, 1997)*

<b>Ontological level</b>	<ul style="list-style-type: none"> <li>• Help students develop effective strategies to alleviate the symptoms post brain injury.</li> <li>• Help students develop effective strategies for coping with life post brain injury.</li> </ul>
<b>Microsystemic level</b>	<ul style="list-style-type: none"> <li>• Provide support and advice to school staff and families.</li> <li>• Signpost to support from other agencies and charities.</li> </ul>
<b>Exosystemic level</b>	<ul style="list-style-type: none"> <li>• Support schools and other agencies to develop support plans that take into account individual complex needs and interacting factors e.g. environment.</li> <li>• This can be done through consultation, planning or delivering direct intervention and delivering training.</li> </ul>
<b>Macrosystemic level</b>	<ul style="list-style-type: none"> <li>• Research and project work looking at the wider educational system that children with an ABI are located in.</li> </ul>

Within the current research, I was interested to know whether any of these suggestions are felt to be already a part of EP practice. The role of the EP varies across different LAs, therefore, beliefs may vary around what EPs feel their role should be in providing support. The current research found that, of the 81 participants who indicated methods of support they had used with this population, EPs had provided support to children with an ABI at the ontological level (help students develop effective strategies for coping with life post ABI) within their practice to date. The methods in which support at this level was delivered was through assessment (cognitive or dynamic) (35%) and direct intervention (21%). The results also indicated that some EPs had provided support at the microsystemic level through supporting schools to interpret medical reports (30%) and signposting to other agencies for support (1%).

The results highlighted that support at the exosystemic level was the most common level of support provided amongst the respondents, with 58% indicating they had provided support through completion of an EHC advice, indicating that this is the most common way in which EPs have provided support to CYP with an ABI. The survey demonstrated that the second most common method of support was also at the exosystemic level through conducting consultations (54%). In addition to completing EHC advice and consultation, some EPs indicated that they had been involved at the exosystemic level through attending the 'return to school' meeting (10%), ongoing involvement in an MDT (17%), or through delivering training (5%).

The current research did not investigate whether any of the participants had conducted support at the macrosystemic level by carrying out research in this area as the majority of practicing EPs do not

conduct research alongside their practice. However, this research itself is an example of assistance at the macrosystemic level.

### 6.1.3 Variation in EP work

However, the variation in the types and frequency of support provided by individual respondents indicate that these practices fluctuate across different services and therefore it cannot be assumed that all CYP with an ABI are receiving consistent and equitable support from EP services. For example, 7% of participants shared that their EPS has a specialist EP in this area and 2% of participants shared that their service had a protocol to identify and support children with an ABI. Therefore, it could be assumed that children within these LAs are receiving an increased amount of support than those in other LAs, supporting the notion of a 'postcode lottery' for support (Thomas, Atkinson, & Allen, 2019).

One possible reason for this variation in support may be due to the differences in service delivery models (traded/non-traded) and impact the of rising EHC assessments placing restrictions on the type of support an EP could provide at the time (Lyonette, Atfield, Baldauf & Owen, 2019). This could also explain why completing EHC advice and conducting consultations were the most common methods of support as they allow the EP to give support in a way that meets statutory requirements and provide support in a time efficient way.

For those services still able to offer training, it may be that confidence and knowledge levels on this topic affected the EP's ability to offer training to schools, possibly contributing to the low number of participants that had provided training to schools mentioned above. This notion is supported by research conducted by Misheva (2020) who found that less than a quarter of their EP participants felt confident about their theoretical knowledge of ABI and providing support to a child with an ABI. Further consideration will be given to the confidence and knowledge levels of EPs in section 6.1.5.

### 6.1.4 The barriers to meeting the needs of children post ABI.

Previous research highlighted what EPs believe are some of the barriers to meeting the needs of CYP with an ABI within the USA, including lack of knowledge and training amongst school staff, lack of communication about the injury, perceived lack of importance of the brain injury in understanding the child's difficulties, procedural impediments and lack of resources to help these children (Canto, Chesire, Buckley, Andrews, & Roehrig, 2014). The current research investigated whether these

barriers were also identified within the UK and whether EPs believe there are any other barriers to meeting the needs of children with a brain injury.

A number of themes emerged from the data, including the notion that ABI is a hidden disability, and that school staff may not be aware of the effects of an ABI and potentially misinterpret the child's difficulties. Therefore, children with an ABI may be under-identified and under-referred for support. It was also highlighted that for the EP to know a child has an ABI, the injury must be disclosed by family or school staff, often during initial referral or consultation. However, if there is the belief amongst these people that the ABI is not having an effect on the child's current presentation, particularly if the injury occurred years before when the child was in another academic setting, then the ABI may not be disclosed to the EP. It is also possible that the ABI has been forgotten about or the child is assumed to be fully recovered from it, again due to time since the injury. This could result in the EP's formulation and understanding of the child's needs being misinterpreted and affect the provision recommended to meet these needs. For example, participant 96 shared:

*"Knowing if they have one in the first instance, several cases I have had have come to me due to concerns about behaviour, when I have then tracked back, I have found they have an ABI. Staff and professionals have a limited understanding of this. There is a strong ASC lens when people interpret the behaviour of these c/yp, and they can often go down the wrong route."- Participant 96*

These findings echo those found by Canto, Chesire, Buckley, Andrews, & Roehrig (2014) regarding the perceived lack of importance of ABI and the lack of communication about the injury as barriers to meeting need.

This raises the question as to whether EPs have supported more children with an ABI than they believe, and one reason for the perceived low rates of prevalence amongst EP practice (as discussed in section 6.1.1) is due to a lack of disclosure of the ABI when the child has been referred for EP support. This could have important implications for EP practice in that it is pertinent for EPs to ask within consultations, whether the child has ever had an ABI, at any severity, at any point in their life. The EP would not be asking for the purpose of seeking a label for the child's needs, but to better understand factors that might be contributing to the child's difficulties, leading to a more accurate formulation, and therefore more tailored and appropriate provision. However, this would rely on the EP having knowledge about the various types of ABI and the effects of varying severities.

Two other themes that were identified as barriers to meeting the needs of children with an ABI was the knowledge amongst school staff of ABI and what support an EP could provide to these children.

Regarding school staff knowledge of ABI, some participants shared that in their experience, school staff were not aware of the long-term impact of the ABI or did not understand that the ABI could be contributing to the child's difficulties with learning, regulation and behaviour. In the more extreme cases, as mentioned in the previous research (Jull, 2008), where school staff do not have the knowledge about how such a disability can impact on the child's behaviour, and the behaviour is not seen as a communication of need but rather a choice, children can end up being excluded from schools. Tirraoro from *The Special Needs Jungle* (2019) wrote about the impact of school staff struggling to meet the needs of children with SEND, in that it can cause significant trauma to these CYP. These findings echo those found by Canto, Chesire, Buckley, Andrews, & Roehrig (2014) regarding the lack of training and knowledge amongst school staff as barriers to meeting need.

In regard to school staff not understanding what the EP could offer to support these CYP, it was highlighted that some schools may turn to health professionals or clinical psychologists for support rather than the EP as the ABI is seen as a medical condition. This again links back to understanding of the EP role as discussed in the previous section, in that school staff may not believe the EP could offer anything additional or unique to the help received by other professionals, leading to low referral rates to the EP service. This could contribute to the perceived low prevalence of ABI amongst EPs (see section 6.1.1).

This lack of understanding of the EP role by other professionals was highlighted under the theme that discussed the lack of involvement the EP has within the MDT. Some participants shared that they believe many other services are not aware of the full extent of the EP role, with some seeing the role as quite narrow and only seeing the EP's role as completing EHC advice and cognitive assessments. However, the current research highlights that there is a belief amongst the EPs that they have something unique to offer that warrants invitation to the MDT to help enhance the support for the child with an ABI (see section 6.2.7). In addition to this, one participant highlighted that the poor links between health and education removes the opportunity to provide early support and maximise outcomes for CYP with an ABI. It was also noted that this type of work is important due to the fact that this population is over-represented within the criminal justice system and so not providing adequate support for this population has a wider impact on society (Williams et al, 2018; Menon & Bryant, 2019).

One of the most frequently mentioned barriers amongst the data was the capacity of the EP to pick up such referrals, even if the school were to request EP support, due to the increase in statutory work monopolising most of the EP time. This is congruent with previous research (Thomas & Loxley, 2022) that the increase in EHCP requests has resulted in a restriction on the type of work EPs can

support with. It is therefore understandable that the most frequent way in which EPs have provided support to a child with an ABI is through EHCNAs and advice (see section 6.1.2). Participants also mentioned that because some EPSs operate on a traded or partially traded model and schools must pay for EP engagement, any financial challenges the school is facing may affect their capacity to buy in time from the EP service for a child with an ABI. These findings also echo those found by Canto, Chesire, Buckley, Andrews, & Roehrig (2014) regarding procedural impediments as barriers to meeting need. These findings raise wider concerns about EP flexibility and opportunity to deploy their skills to support all children, due to the current EHCP pressures and difficulties with traded services.

Another theme ascertained from the data was the perceived low incidence of ABI among EP practice as a barrier to serving these children's needs since, in the event that a referral was to come in, they might not have the knowledge or confidence to feel capable of providing this support. This finding echoes the research that highlighted low levels of confidence in knowledge of brain injury amongst EPs (Misheva, 2020; Hooper, 2006). However, other participants felt somewhat confident in their knowledge and ability to provide support to this population through feeling they have transferrable skills despite the absence of specific knowledge. This will be discussed further in the next section (6.1.5).

#### 6.1.5 The perceived knowledge and confidence level of EPs around ABI.

Analysis revealed that the majority of respondents felt 'somewhat confident' (54.7%) in their knowledge and understanding of neuropsychological theory to aid their involvement in supporting children with an ABI. Similarly, 63% of participants felt 'somewhat confident' in supporting a child with an ABI. Although the hope would be that all EPs felt confident in supporting a child with an ABI, it is important to acknowledge the interpersonal differences amongst EPs, and that many EPs may not feel confident about supporting children with other diagnoses, and therefore maybe the majority of participants feeling 'somewhat confident' about providing support to a child with an ABI is, in reality, enough.

However, if it is possible to find ways to boost EPs' confidence in supporting this population, this could, in theory, result in better-informed involvement and recommendations, which would potentially, in turn, improve the outcomes for CYP with an ABI. Therefore, in order to unpick what contributed to these varying levels of confidence, participants were asked to provide a reason as to why they gave the confidence rating they did.



One theme that arose from the data was having personal experience with ABI, whether that be the participant themselves or a family member, helped the participants to understand that not all ABIs are the same, and that quite often their needs can be misinterpreted. One participant spoke of how their own long-term outcomes were very different from those communicated by the medical professionals following their ABI. These experiences contributed to their knowledge and confidence levels in supporting children with an ABI. Although this is not an area of experience that can be replicated to support EP practice and confidence levels, it is still worth highlighting as a contributing factor.

Another theme that was identified as contributing to the confidence levels of EPs was that many participants felt that they could provide support through the application of generic EP skills and that they were confident in their ability to use these skills, in the absence of having or needing to develop specific ABI or neuropsychological knowledge. One participant shared:

*"I have had no experience in this area of EP practice and have very little knowledge. However, I do feel confident that if asked to support a child and family who are experiencing this my skills (e.g., consultation, exploring need, designing provision) would be transferable and provide a valuable contribution alongside medical professionals."- Participant 71*

Similarly, another participant shared:

*"... I don't need to know everything there is to know about everything....I can ask lots of questions and think about the young person holistically in the context they are in."- Participant 70*

This suggests that some participants believe existing EP skills are enough to enable them to feel confident supporting this population as the support provided would be the same as what is offered to other children within EP practice.

Other participants credited their confidence and knowledge levels to the amount of professional experience they had gained. For some participants, this was as a result of working privately within a specialist MDT, setting or company that supports children with ABI rehabilitation. For others, it was working alongside other professionals as part of the MDT within the local authority that helped them feel more confident. Some participants also shared that this professional experience came from completing an EHCNA for a child with an ABI and would therefore inform their work if they were to support another child with an ABI. However, some participants said that they had very little to no experience in this area and would therefore struggle to provide advice regarding what a child's

progress would look like, if the presenting needs related to the ABI or providing evidence-based interventions. This suggests that with more experience comes higher levels of confidence. However, one participant shared that they would feel just as unprepared to support a child with an ABI as they did the first time and that in their case, experience did not help them feel more confident in supporting a child with an ABI in the future. This suggests that maybe something more than experience is needed to increase the confidence of EPs in supporting this population, e.g., further training (Bozic & Morris, 2005).

Another theme identified in contributing to confidence levels of EPs in providing support to this population was whether they had engaged in, or whether they feel they could engage in self-directed exploration and learning. Some participants shared how they have the capacity to explore the topic through reading relevant articles and information, should a case arise in their practice. It was also shared that as part of self-directed learning, some participants have done or would seek support from colleagues through peer supervision or other professionals who have more knowledge on ABI, subsequently using this information to inform their practice. EPs have to develop these skills beyond the initial training course through CPD as the course cannot include teaching on all of the various conditions and diagnoses that the EP would come across throughout their practice. However, some participants believe that accessing training on ABI has or would greatly impact on their confidence levels in supporting this population, which based on the results, some services have provided. It is important to note the variation in reasons for both confidence and lack of confidence, in that it was evident some participants thought that generic EP skills are enough, and others felt that they were not, and further training would be needed to enable them to provide this support confidently. This may be beneficial for specific aspects of the role e.g., assessment (Glang, McCart, Moore & Davies, 2017).

#### 6.1.6 The number of EPs who have accessed CPD on ABI.

With previous research arguing that EPs need to access further training to develop their skills and knowledge in supporting a child with an ABI and enable them to deliver an enhanced range and quality of provision (Bozic & Morris, 2005), the current research looked at whether some EPs had already accessed such training. The research was also interested in whether EPs felt that further training on ABI would be beneficial to their practice and if so, what specifically do they feel they would need further training on.

Some participants who completed the survey shared that the reason they felt confident in providing support to a child with an ABI was due to accessing further training. Similarly, some participants who

had not accessed training shared this as a reason for feeling less confident in providing support. These findings were echoed within the focus groups in which accessing CPD or accessing useful resources helped participants to be more informed in their offer of support. The more detailed observations from phase 2 of the research enabled sense making of the apparent mismatch in findings from phase 1 as it could be the case that most EPs would feel confident in providing support but that in order to provide enhanced support, further CPD would be needed.

Participants within the focus group shared that accessing CPD helped them to consider the needs of the child through an understanding of the common difficulties after ABI, and reframe their own understanding, as well as that of others, of the child's presentation. There was also some consideration given to the implications for EP practice, following CPD, in supporting a child with an ABI. One participant discussed that through accessing CPD, it highlighted the importance of asking about previous ABI during consultation to ensure that the child's needs are not misunderstood through another lens e.g., Autism Spectrum Condition. Participants also discussed the importance of sharing the knowledge gained from training with their colleagues so that it has a wider impact and enables other colleagues to identify and better meet the needs of children with an ABI.

In line with this, the majority of participants who completed the survey (73%) believed that further training on ABI would be beneficial to their practice. When asked to elaborate on what they believe would be useful to learn, four themes were identified. Firstly, participants would like to learn about the common difficulties of ABI and the impact on the child and family. More specifically, some wished to know about how damage to areas of the brain can give rise to various difficulties, the different types and long-term impact of ABI, barriers to learning, and how to support the system around the child. Additionally, some wanted to learn about other services and charities so they can signpost schools and families to further support.

Some participants thought it would be useful to understand how the common difficulties after an ABI may fit alongside their understanding of cognitive assessments (memory, concentration, simultaneous processing, language, speech etc) and what considerations are necessary when conducting such assessments with CYP with an ABI. Some also shared they would like to know how they can use their existing EP skills to support children with an ABI and hear examples of good practice from others. Others shared that having knowledge of outcomes and provision that could support CYP with an ABI would greatly inform their practice.

Another theme that was identified within the data was the hope that CPD would include the latest neuropsychological research. Interestingly, one participant highlighted referencing the brain in other areas of practice and the importance of understanding the neuropsychological research not only to support children with an ABI, but to transfer this knowledge to other areas of practice. Other participants wished to know more about the implications of seizures on the developing brain, a common occurrence after ABI (Jantz, Comerchero, Canto & Pierson, 2015) and the implications for learning. Accessing training on neuropsychology would also help inform EP practice in supporting children with Epilepsy, the other most common neurological condition within EP practice (Misheva, 2020). Additionally, according to Hood (2003), neuropsychology can enhance EP practice and formulations by offering a more thorough interpretation of the relationship between a child's brain development and cognitive function, as well as how these relationships are influenced and moderated by personal, social, and environmental factors. This extensive knowledge can then be applied systematically to support the adults around the child in making the adjustments to the environment and the system that are required to meet the child's individual needs. However, neuropsychology has been considered by many as reductionist and that it promotes a within-person model of the child's difficulties (Rodriguez, 2006; Misheva, 2020). Nevertheless, Misheva (2020) explored the relationship between neuropsychology and educational psychology and found that neuropsychology often works within a bio-psycho-social model that helps psychologists understand that the neurological element is part of the picture but not all of it. This is congruent with the way in which EPs work, by considering the CYP holistically and seeing any diagnosis as part of the child, not the whole picture. Therefore, understanding the neuropsychological factors enables a better understanding of the whole and may aid EPs in their formulation and understanding of the CYP.

Some participants also suggested that ABI should be included within the EP initial training course, supporting the recommendations made by Ball & Howe (2013) that all EP initial training courses should have a module on brain injury and neurological development.

However, there were some participants who felt that further training on this topic might or would not be beneficial to their practice. Some of the reasons given for these answers were due to coming across ABI so infrequently within their practice means it is not a good use of public sector money, they may not have chance to use the information learned if they do not have an opportunity to provide support. There was also the feeling from some participants that CPD on other areas of practice would take priority over CPD on ABI. However, the prevalence of ABI across the population and its impact on the child's cognitive, educational, behavioural, societal and socio-emotional

outcomes, indicate its worthiness of consideration for inclusion in initial training or as an area for CPD.

Therefore, although some participants felt that further training on ABI may not be beneficial to their practice, the majority did and areas for training were identified by the participants. One such request corresponds with research question 2, in wanting to learn about how they can use their existing EP skills to support children with an ABI and hear examples of good practice from others. Examples of good practice are discussed in the next section as part of the consideration of the EP role in supporting CYP with an ABI moving forward.

## **6.2 Research question 2: What is considered good practice in EP work supporting CYP post ABI?**

### 6.2.1 The role of the EP in the future

As part of the survey, participants were asked what they thought the role of the EP should be for children with an ABI in the future. Participants within the focus group were also asked to share examples of good practice so that these could be highlighted as an important part of the EP role in supporting CYP with an ABI going forward.

The analysis identified an overarching theme of supporting the system around the child and having the chance to use key elements of EP practice to provide support e.g., interpreting medical reports, gathering child views, consultation, EHC assessments. The results indicated that some EPs feel they do not need to develop their practice to learn new ways of supporting CYP with an ABI, rather that existing EP skills may be unique compared to those used by other medical services and therefore EPs can offer something unique. This supports previous research that highlighted the EP role differs from other psychological professionals e.g. clinical psychologists, as they have extensive knowledge of the school systems, factors affecting education and strategies that can support individuals in educational settings with their cognition and learning, communication and interaction, in addition to their social, emotional and mental health (Bozic & Morris, 2005). This may be incredibly beneficial for CYP with an ABI who have received support from other services, but particularly for those children that do not receive support from rehabilitation services upon discharge from acute care (Hawley, 2003), potentially filling a gap of support.

The key themes identified within the data regarding examples of good practice and beliefs about the EP role in the future are discussed below.

### 6.2.2 Translating medical reports

The theme of translating medical reports emerged from both the survey and the focus groups, with participants emphasising it as something that, in their observations, was an example of good practice and a helpful part of the EP role when supporting this population.

It was highlighted by participants that there is often a wealth of reports written about the child post injury, however, these reports are written from a medical perspective not an educational perspective. Previous research has shown that some EPs believed it was evident that neuropsychologists did not have a thorough understanding of the reality of schools based on their reports and so it was their role to translate these reports into practical implications for the school (Gelbar & Bray, 2019). The participants discussed how they were able to translate the medical reports into implications for day-to-day school life and state what provision needs to be in place to meet the CYP's needs within the school environment. This supports the research mentioned previously by Davies et al. (2013) who argued that EPs extensive training in understanding children's needs and recommending provision to support access to learning and wellbeing, gave them the skills to help this population.

### 6.2.3 Gathering child views.

Previous research has demonstrated that seeking and representing the views of CYP is a key aspect of the EP role (Farrell et al., 2006) which empowers CYP to contribute to the discussion around improving outcomes in their lives, and make sure their voices are heard and valued (Harding & Atkinson, 2009; Roller, 1998; Todd, 2003). This research was reflected within the data from both phases of the research, which highlighted one way in which EPs have and can continue to support CYP with an ABI is through being an advocate for their views, uncovering and emphasising the importance of their voice being heard amongst the typically adult discussions about the child's life.

One participant from the focus group shared their experience of observing another EP advocate for a CYP with an ABI during consultation with school staff and parents. They did this by understanding his needs and abilities, then using this information to ensure that the young person had the space and time they needed to share their views (see section 5.3.2, theme 5 case study). It was apparent within the participant's telling of this story that they did not believe the young person would have been able to share his voice without the EP giving them the time and space to do so, and the impact that hearing the young person's voice had on outcomes and provision as they had a clear view of what

they wanted their future to look like. The EP was able to empower the young person by demonstrating the importance of their views and allow them to feel heard in a way that they had not done before. Evidently, the EP role had a positive impact on this young person and the system around them, therefore indicating the worthiness of 'gathering child views' as a key element of EP practice that can support CYP with an ABI in the future.

#### 6.2.4 Changing the narrative through consultation.

As mentioned earlier, the survey demonstrated that the second most common method of support EPs utilise to support CYP with an ABI is conducting consultations (54%). Participants from the focus group expanded upon what it is about the consultation that demonstrates why it has been identified as an example of good practice when supporting children with an ABI. It was also voted as one of the most important role aspects within the focus groups.

EPs often do not focus on the label of a diagnosis, rather exploring the experiences of the CYP, with the diagnosis being one part of the larger picture. This is because labelling a young person and seeing them through one lens can provoke limited thinking from the system around the child (Solomon, 2015). Participants discussed how using consultation to help change the narrative around the child with an ABI appeared helpful for school staff and families. Participants identified that EPs could do this by asking questions that enabled reflection on their understanding and beliefs around the child in a sensitive way. By having these discussions, it also helped those around the child to understand that the presenting difficulties are as a result of unmet needs rather than behavioural choices. This is important as, as the research shows, quite often challenging behaviours in schools are met with punishment and sanctions as an attempt to reduce the behaviours (O'Hagan & Kingdom, 2020). However, many children with SEND struggle to operate within the confines of a behaviour policy based on behaviourism psychology which does not consider individual needs, leading to a lack of equity of response to behaviour and feeding into exclusions (Emerson, 2016). Participants spoke about how by identifying areas of need, provision can be put in place to meet these needs. Also, the EP can help those around the child understand that rewards and punishments may not be effective and that coaching the child through their difficulties and teaching new skills may be more effective.

Another way in which participants had provided support through consultation was by bringing about a perspective shift amongst the school staff and family. One participant shared that whilst acknowledging the changes that had occurred for the child, they were able to help the family and

school staff move from a place of dwelling on the past to focussing on the present and what needs to happen to help improve the future. Taking this holistic approach has been highlighted amongst participants' experience to be important for CYP and their families and a key part of the EP role. Part of this was to recognise the strengths and provide optimism that the child would succeed in their own way. This method of working is utilising positive psychology methods, looking at the child's Signature Strengths (Seligman, 2002) and focusing on 'what is right with people' rather than 'what is wrong with people' (Linley et al., 2010). Focussing on people's strengths rather than their difficulties has been shown to be a key support in the attainment of goals by giving support for objectives and increasing need satisfaction and wellbeing (Linley et al., 2010); something of which is important for CYP with an ABI due to the effect an ABI can have on mental health (Schachar, Park & Dennis, 2015).

It was stressed by participants that it was not about providing false hope but working ethically to help reframe the narrative around the child and explicitly consider the child's strengths. This was seen as important as there was the recognition that many of the conversations parents and families have had may have primarily focussed on lost functions due to the ABI and what the child cannot do at that time. It also supports previous research that highlighted parents' need for professionals to acknowledge the uncertainty of their child's recovery but at the same time, respect their need to maintain hope and positive thinking in regard to possible outcomes for their child (Guerriere & McKeever, 1997; Robson, Ziviani & Spina, 2005; Roscigno & Swanson, 2011; Norberg & Steneby, 2009). Therefore, school staff and families may have not had the opportunity to think about the child's strengths and positives within a very difficult situation. The participants shared that through this work, they were able to bring about a perspective change and a sense of hope for the system around the child and subsequently the child themselves, therefore demonstrating this theme as another area of good practice when supporting this population.

#### 6.2.5 EHC Assessments

Previous research has suggested that EPs can support CYP with an ABI at the exosystemic level by supporting schools and other agencies to develop plans that consider the child's complex needs and the interacting factors affecting need e.g., environment (Bozic & Morris, 2005). One way in which participants identified EPs can do this is through EHCNA and the creation of an EHCP. Participants shared that EPs have the ability to draw all of the information together, from multiple paradigms, into a holistic understanding of the child, and that this is another one of the unique contributions an EP can offer to support a child with an ABI. These findings, gathered from both phases of the research, highlight the EHCNA as a key method of support when assisting children with an ABI,



despite the volume of EHCNAs limiting the EPs from being able to offer support in other, potentially more beneficial, ways.

One participant within the focus group spoke about how, in their experience of supporting a child with an ABI, there were a whole host of professionals involved and that there was a lot of disconnected information from different services. They shared how it was a beneficial contribution for them to collate all the reports from different services, in addition to their own information gathering, to have a holistic understanding of the child at that point in time which informed the recommendations of holistic provision and outcomes:

*“So, for me that this the one statutory I'm thinking of it was a traumatic injury, and there were just so many professionals involved, you know, the whole gamut of the NHS, some physio, OT, hospital teacher, you know, vision, clinical psychologist, everybody, and there was all this information and letters flying around everywhere. So, I think it was really useful just to get all of that in one structured document, which I know is what we do anyway. But I just think, especially for a case like that, when there's so much medical input, to just kind of have a piece of paper to say, okay, this is where we're up to at this point in time and looking at everything.” – Participant 42*

#### 6.2.6 Providing emotional containment and support for school staff and families.

As discussed in chapter 1, schools regularly experience a lack of preparedness and knowledge around ABI, with the burden for rehabilitation on teachers who are often not educated in the needs of children with an ABI (Linden, Braiden & Miller, 2013). It is therefore not surprising that this can take an emotional toll on school staff. Similarly, the emotional impact on the family can be immeasurable, with research showing that stress, anguish, grief, helplessness and aggravation due to role alteration and loss of control are all common amongst parents of children with an ABI (Wade et al., 1996; Hawley, Ward, Magnay & Long, 2003; Shudy et al., 2006).

Participants within the focus groups identified that providing emotional containment and support for school staff and families was a key part of the EP role in supporting this population. This theme was also voted by participants as one of the most important aspects of the role in supporting children with an ABI. Although this theme was not mentioned specifically by participants in the survey, providing support to school staff and families was highlighted.

Participants spoke about some of the emotional containment for parents and school staff was around grief and supporting them through the loss of the child they used to know and helping them to understand the child post-injury. Supporting the headteacher's emotions was also discussed as one participant shared that the headteacher they spoke with felt scared, worried and anxious about whether the school would be able to cope when the child returned to education.

One of the reasons highlighted as causing feelings of pressure amongst school staff was the emphasis from medical professionals on the 'window of opportunity' for rehabilitation and recovery during the early stages post-ABI. It was discussed by one participant that in their experience, emphasis on the 'window of opportunity' caused a lot of pressure for school staff to feel that if they did not provide the right support, the child's recovery would not be as effective. This pressure was also further placed upon school staff by parents who believed the right support during this 'window of opportunity' was the best chance at getting their child back. Whilst the school staff understood why the parents were focussing on this, it was acknowledged that this provided an additional element of pressure and stress.

The discussions around this topic support the notion from Bozic & Morris (2005) who put forward that EPs can support CYP with an ABI at the microsystemic level of the Ecological-transactional model (Cicchetti & Toth, 1997) through providing advice and support to school staff and families, a key part of which, the participants in the focus group believed to be emotional and relational in nature. The focus group members highlighted that as EPs frequently employ a relational approach and have the capacity to forge supportive bonds with people in a little amount of time, they are well-suited to offer this emotional containment for school staff and parents.

#### 6.2.7 Involvement within the MDT

As mentioned earlier, research has suggested that EPs are uniquely placed to support students with an ABI throughout their education due to having extensive training in the identification, assessment and intervention of learning and behavioural difficulties (Davies et al., 2013). Bozic and Morris (2005) and Misheva (2020) also spoke about how the EP role differs from that of other psychology professionals, in that clinical psychologists had a critical role in facilitating therapeutic interventions for people with diagnosable mental health issues, whereas the EP's expertise lay in systemic working and knowledge (Bozic & Morris, 2005). EPs also have knowledge of the school systems in place, factors affecting education and strategies that can support individual needs within an educational setting (Bozic & Morris, 2005; Gelbar & Bray, 2019; Sales & Vincent, 2018; Smillie & Newton, 2020).

Most EPs within this research believed that the EP should work alongside other professionals as part of an MDT, not in isolation in the absence of other support. Congruent with the findings from the survey, participants in the focus groups spoke about the unique skills of the EP and that working as part of the wider MDT around the child gives the EP the opportunity to voice an alternative perspective to the medical model. One participant spoke about how EPs work within a social model of disability:

*“We are we work within a social model of disability, don't we? It's not the medical model. And I think when it's acquired brain injury, it is very much a medical model then all the people who were initially involved are medical or clinical professionals aren't they. Who give you the clinical psychologist give you their advice from their clinical setting where the child's been brought to them for and we're very much looking at them in their social environment, aren't we? We're looking at well, what's it like in the hospital school in the mainstream school back at home with parents has he still got his friendship groups? Is it still accessing his extracurricular stuff? We're very much looking at that, that that person with that very medical term acquired brain injury, but in that social model aren't we, and I think who else who else does that? Actually, who else does that?” – Participant 94*

As stated in the research, clinical services often operate from a medical model which reduces the complex problems of disabled people to issues of medical prevention, cure or rehabilitation (Shakespeare, 2006), focussing on trying to fix the problem. However, the participants discussed how EPs work within a social model of disability which looks at the child within their social context, how the social environment helps or hinders the child and thoughts centre around removing barriers to learning and making adaptations to meet the needs of the child. Although rehabilitation is the main focus after brain injury, and naturally the work of the EP will help with this process through teaching of new skills and recommending provision, the focus isn't necessarily on the recovery but understanding need at that time and ensuring support is in place within the environment to meet these needs. In other words, the EP works to create change within the environment around the child to have a positive impact on the child, rather than working to change things within the child.

Other participants spoke about how EPs can contribute to the MDT by working across many levels of the system around the child to bring about positive change through individual and systemic support. One participant spoke about how they had worked at the individual level through directly supporting the child, and at the consultative level by bringing together different perspectives and enabling discussion to create a perspective shift and bring about positive change for the child. This

demonstrates that Bozic & Morris' (2005) suggestions of how EPs can work at varying levels of the Ecological-transactional model, may in some cases, already be in practice.

However, EPs being invited to work within the MDT relies on other professionals understanding what the EP could offer. Many professionals often assume that the only work an EP engages in is conducting EHCNAs, rather than acknowledging the breadth of consultative and supportive skills they can deliver. One participant shared that in their experience, when they had been invited to work as part of the MDT around a child with an ABI, they were only invited due to the belief that the child would need an EHCP, rather than understanding the other skills the EP could bring as part of the collaborative work. However, this changed as the participant worked within the MDT and was able to communicate and offer methods of support to the school and family:

*"I was asked to be invited by the medical team. So, they'd asked if the educational psychologist could attend a multidisciplinary meeting, but the school would have asked me anyway, so that would have happened (...) So, I think the reason that they were asking is because they thought that the child would need any EHC(...) I'd love to think that they perceived educational psychologists our role to be doing all the things that we've just been describing, but I suspect it was about EHC (...) Yeah, I mean, I think they did. They still associate educate associated educational psychologists with the EHC process, the statutory role but no, we developed a good relationship. And I think partly that was because of the way the school functions as well and creating the space for that to happen. And we maintain dialogue for quite a long time in formal dialogue that was on another post it so there's quite a lot of communication. So yeah, I think they perceived a broader role for the educational psychologist following the collaborative work that we engaged in definitely."* –

*Participant 14*

Lack of involvement within the wider MDT was also identified as a barrier to meeting the needs of CYP with an ABI (see section 6.1.4), with participants commenting on how poor communication with health professionals and the other professionals within the MDT not understanding the role of the EP, often leading to the absence of an invitation for the EP to join the MDT. This suggests that the role of the EP in general needs explaining to medical professionals to enable them to recognise when support from the EP may be valuable.

However, thinking about the current capacity issues for EPs, it is likely that they would not have time to be involved in an ongoing MDT and it also raises the question of whether MDT work is really the

best way for EPs to support. When considering who EPs need to communicate with to support a child with a medical condition, often EPs will review the medical reports but due to communication difficulties, may not speak directly to medical professionals, despite needing to further understand aspects of the report. However, EPs are still able to offer high quality support to CYP by considering them holistically and therefore, in the case of ABI, EPs may not need to work as part of an MDT to provide support. Future research may wish to explore the benefits and drawbacks of EP involvement within the MDT for CYP with an ABI.

#### 6.2.8 Supporting over time and help to prepare for life after education.

Prior research has demonstrated that child ABI survivors' healthcare demands are likely to change as the brain regions develop and mature (McKinlay et al., 2016). Therefore, support plans must be updated frequently, with special focus placed on key educational and social transitional points, such as preschool, primary school, secondary school, and the workplace, to prevent interventions from becoming redundant (McKinlay et al., 2016).

The focus group participants noted that providing support over time, through assisting with reviewing support plans at key transition points, was one of the ways they provided support to a child with an ABI. For example, by attending annual reviews and helping to review and change key documentation to reflect the child's changing needs. These findings echo those found within the analysis of the survey data (see 5.1.2 and 6.1.2).

Earlier research also suggests that difficulties following an ABI can continue into adulthood, even after what might be seen as a relatively mild ABI (McKinlay, Corrigan, Horwood & Fergusson, 2014). Therefore, research recommends that all intervention plans for the CYP should account for long-term outcomes and should acknowledge that the CYP's rehabilitation may necessitate interventions that last into adulthood (McKinlay et al., 2016).

This research identified that supporting with preparation for adulthood is another way that EPs can support children with an ABI, as EPs support CYP from 0-25 years old. According to Hayton (2009), EPs are in a unique position to help young adults build personal skills that they may use outside of the classroom. These skills include raising ambitions, enhancing self-awareness, fostering a positive sense of identity, and identifying strengths and skills. EPs can also help children with an ABI prepare for their future by using the "Preparing for Adulthood" (2013) framework, which identifies four

outcomes, devised following consultation with CYP, which should be addressed in preparing for adulthood: Paid employment; Good health; Independent living; and Community inclusion. EPs work collaboratively to consider the young person's needs within this framework to recommend suitable provision and aspirational outcomes (Atkinson et al., 2015) to support the child with their development into adulthood and their long-term goals. This would have implications for schools and the provision they offer for children with an ABI as they may need enhanced support to help them learn key skills and prepare for adult life.

### 6.3 Integrative statement, implications for practice and future research

This section will give an overview of the research's findings and practical implications. The research's advantages and disadvantages will next be discussed, along with suggestions for further research.

#### 6.3.1 Integrative statement and recommendations for practice

Prior to the present research, many other researchers have discussed the role of the EP in supporting children with an ABI and suggestions made on how the EP is uniquely positioned to offer support due to their influence at many levels of the system around the child, their knowledge of the school system, and their extensive training in the identification, assessment and intervention with learning and behavioural difficulties (Davies et al., 2013). However, it had not been investigated whether these recommendations were currently in place within the UK. Therefore, this research aimed to fill this gap by developing an understanding about the current practices of EPs in supporting children with an ABI and build upon the existing research that looks at the role of the EP and the current barriers to meeting the needs of children with an ABI within EP practice.

The national survey revealed that the majority of participants have provided support to a child with an ABI at some point in their practice, however there were a sizeable number of participants who shared that they had never done so. Participants also shared that they do not see these cases very often compared to many other SEND categories, which is not expected based on the statistics. The analysis also revealed that the majority of participants felt 'somewhat confident' in supporting children with an ABI, and that many EPs do not feel they need to learn new ways of supporting children with an ABI, rather that existing EP skills may be unique compared to other psychological services and therefore EPs are able to offer something additional. This research explored the unique way in which EPs have provided such support, and how EPs can support CYP with an ABI in the

future. Participants gave examples and suggestions of practice at most levels of the ecological-transactional model (Cicchetti & Toth, 1997), supporting previous research (Bozic & Morris, 2005).

However, some felt that in order to use their EP skills and offer support to a child with an ABI, they would need to access further training on the topic through CPD. Additionally, the majority of participants felt that CPD on this topic would be beneficial to their practice. Participants also discussed the importance of sharing the knowledge gained from training with their colleagues so that it has a wider impact and enables other colleagues to identify and better meet the needs of children with an ABI. This research was able to identify what participants felt would be useful to know in relation to their practice. Some of the common requests for training centred around understanding the common difficulties following ABI, the different types of ABI, the impact of seizures on the brain and learning, neuropsychological research, and implications for EP practice. EP services therefore may wish to consider supporting their EPs to access CPD on child ABI or identify a member of the team to be a specialised EP in this area who can provide such support or assist other EPs when they receive a referral for support.

Additionally, the research has highlighted some potential barriers related to EPs providing support to CYP with an ABI, one of which was that ABI can be seen as a hidden disability and that it is not always thought of as important to mention to the EP during initial consultation. This raises the question as to whether EPs have supported more children with an ABI than they first believed, and whether needs have been misinterpreted as a result of not knowing about the ABI. This could have important implications for EP practice in that it is pertinent for EPs to ask within consultations, whether the child has ever had a brain injury, at any severity, at any point in their life. The EP would not be asking for the purpose of seeking a label for the child's needs, but to better understand factors that might be contributing to the child's difficulties, leading to a better informed and more accurate formulation, and therefore more tailored provision. For example, participant 42 shared that having knowledge that the ABI had happened allowed them to understand the child's needs in relation to the ABI and help the adults reframe their understanding of the child and what they can do to help:

*“And it might be about like, communication, you know, they're coming across as rude. Well, they're not actually meaning to be rude. This is actually another kind of impact of this brain injury. And so that's what kind I meant by kind of, you know, shining the light on the other areas and making them maybe go oh, actually reframing.”*

Other barriers included school staff knowledge of ABI, knowledge of what the EP can offer in support, lack of understanding of the role of the EP within the wider MDT resulting in EPs not being invited to work within the MDT. Therefore, it may be important for EPs to open a dialogue with school staff and other professionals that raises the awareness of the wide variety of support they can offer within their role, in addition to EHCNAs, so that they know what unique support the EP could offer to a child with an ABI.

However, the biggest barrier to the EP providing support to a child with an ABI appears to be time and capacity to offer such support within the current SEN climate. The results revealed variation in types and frequency of support offered by EPs and therefore it cannot be assumed that all children with an ABI are receiving consistent and equitable support. Possible reasons for this variation identified within the data included difference in service delivery models (traded/non-traded), the rising number of EHCNAs limiting variation of work within services, and confidence/knowledge levels of school staff and EPs, supporting the notion of a postcode lottery for support (Thomas, Atkinson, & Allen, 2019). This means that even if EPs are called upon to provide support to a child with an ABI, they may not be able to do so due to the limitations of their service offer.

However, in order to inform the understanding of what the EP role could be in supporting children with an ABI going forward, the research explored examples of good practice amongst the experiences of a small selection of participants who had had previous involvement with a child with an ABI. The focus groups revealed that translating medical reports into implications for education, providing emotional containment for schools and families, helping to change the narrative and perspectives about the child by looking beyond the medical diagnosis, working as part of the wider MDT, and uncovering and emphasising the importance of child voice were all examples of good practice that EPs felt had a positive impact on the situation. Also, the EP's ability to bring all of the information together, from different paradigms, into a holistic understanding of the child's needs was also seen as incredibly beneficial by participants, as was providing support over time and supporting with preparation for adulthood. Finally, participants also commented on the benefit of accessing CPD on their practice as it allowed them to provide support with a stronger knowledge and theoretical understanding of ABI, again supporting the notion that EP service may wish to consider investing in training to support their EPs to better support children with an ABI.



### 6.3.2 Directions for future research

The current study has offered a comprehensive analysis of a variety of issues and topics pertinent to the work of the EP with CYP with an ABI. As mentioned earlier, future research may wish to explore the benefits and drawbacks of EP involvement within the MDT for CYP with an ABI. Future studies may also wish to expand on the research established by this thesis by concentrating on particular themes that arose from Phases 1 and 2 and looking at their impact on EP practice when supporting a child with an ABI.

It may also be interesting to conduct longitudinal research to see whether prevalence of ABI amongst EP practice is increasing each year, reflecting the national statistics. In addition to this, CPD was highlighted by EPs as something they believe would be beneficial to their practice in supporting this population. Therefore, future research may wish to build upon previous research (Ylvisaker et al., 2001) by focussing on the efficacy and impact of training for EPs, including the topics that participants voiced they would like to know more about. This CPD may also have a positive impact on the support they provide for other children.

### 6.4 Strengths and limitations

Conducting real world research emphasises the significance of desired effects and what they may accomplish. There is focus on problem-solving and the identification of aspects of the research that can be actioned within the real world (Robson, 2016). In order to appraise this real world research, the integrity, strengths and limitations were reflected on using Robson's (2016) Real World Research framework.

#### 6.4.1 Strengths

The use of a mixed methods design was aligned with the research questions, allowing for the collection of both quantitative and qualitative data. The use of quantitative techniques made it possible to gather data from a larger number of participants and to identify general national trends, which would not have been possible with a strictly qualitative strategy. In contrast, the second phase of the research's use of qualitative methods allowed for a more in-depth investigation of EPs' experiences assisting CYP with an ABI. As a result, a thorough exploratory investigation from various

perspectives was made possible, and it was possible to gain further understanding by cross referencing between different types of data in accordance with my critical realist world view.

Using mixed methods also helps to increase the validity, reliability, integrity of the research as a mixed method approach, allows the opportunity to balance the strengths and weaknesses of using surveys or focus groups alone (Abowitz & Toole, 2010). In addition to this, in order to ensure the validity of the survey and the focus groups, pilot studies were conducted to ensure that the wording of the questions was understandable and gathered the data relevant to the research.

I also took steps to reduce the potential for researcher bias within the research. These steps included:

- Seeking supervision and reflecting on researcher bias, when it could occur and how to reduce it.
- During the focus group, I ensured that the themes were co-constructed with the participants and checked that the participants felt that the themes were reflective of the discussion. This also helped to improve the validity of the focus group data.
- I also chose to conduct focus groups rather than interviews as I wanted to reduce researcher bias by not asking specific questions that could be leading, instead allowing the participants to shape the discussion points.

Another strength of the research that improved the quality of the data was that feedback was gathered from participants. Through the use of pilot studies and feedback from participants, this research was also able to test the authenticity of survey and focus group questions, prior to participants accessing them, to ensure that the questions being asked were generating the most relevant answers. In addition to this, through using NGT, participants were able to help identify themes arising in the focus groups and vote on which area of practice they believed were most important, helping to ensure that the themes identified during the focus group reflected their discussions.

This research also ensured that the outliers within the data were accounted for and valued. For example, even though the majority of participants believed that accessing further training on ABI would be beneficial for their practice, a minority of participants believed it would not. Paying attention to the outliers helped to strengthen the holistic understanding of the beliefs of EPs regarding this topic and reduce bias within the data.

The current research also identified new barriers to supporting children with an ABI, building upon the barriers identified in previous research. The research identified that many EPs have a reduced offer of support at present due to the increasing number of EHCP applications putting pressure on the EP system. This has resulted in a reduction in the ways in which EPs can offer support to children outside of the services' core offer.

This research also observed ethical standards by adhering to the procedure approved by the ethics committee.

#### 6.4.2 Limitations

When evaluating the current research and its conclusions, a number of limitations need to be considered. Despite my best efforts to reach out to as many EPSs as I could in the UK in order to ensure that the participant pool in the National Survey represented the EP population nationally, not all services in the UK were represented among respondents, which raises the first concern about the data's representativeness. Also, as mentioned earlier, the response rate to the survey was low, which limits the generalizability of the findings, and subsequently reduces the external validity of the research. Similarly, as respondents were volunteers, the sample is not necessarily representative of the wider population. Therefore, the research may be missing key practices in place within some EP services in supporting a CYP with an ABI and therefore reduce the generalizability of these findings to the EP population. Further to this, selection bias may have had an impact on the sample of participants as it is possible that the EPs who responded already had an interest in child ABI. I also have to recognise 'research effects' and that my own bias and interest in the topic could have influenced the data. This could have skewed the findings and again reduced the generalisability.

Similarly, the research only managed to recruit a small number of participants for the focus groups and I would have preferred the opportunity to gather more viewpoints through having a larger number of participants. Therefore, whilst the focus groups were informative and congruent with the survey findings, it is acknowledged that more in-depth research, expanding the focus to look at the impact of EP support for a child with an ABI, is needed to gather evidence regarding the importance of EP involvement for this population.

In addition to this, the current research did not examine the relationship between how long respondents had been practicing as an EP and the number of children with an ABI they had

supported. This may have revealed whether the number of cases is increasing over the years, in line with the national statistics that suggest ABI in children is on the rise. Therefore, if the research were to be repeated, it might look to see if there was a relationship between how long EPs have been qualified and the number of children they have seen. It would also investigate whether the frequency of support has increased in recent years or decreased due to the barriers to support.

### 6.5 Summary and conclusions

A mixed methods design was used in this research to examine the role of the EP in supporting children with an ABI in the UK. The first phase of the research has improved our understanding of the experiences of supporting a child with an ABI from the perspective of EPs. Specifically, the national survey results indicated that a significant proportion of the 100 respondents believed that EPs have unique skills that can support children with an ABI, their school system and their families. However, the majority also felt that accessing CPD on brain injury would be beneficial to their practice and enable them to provide a better-informed package of support.

Similarly, the national survey findings identified that EP work with ABI may be under-represented due to a number of identified barriers, highlighting those that are congruent with previous research but also identifying new barriers. The research identified that many EPs have a reduced offer of support at present due to the increasing number of EHCP applications putting pressure on the EP system. This has resulted in a reduction in the ways in which EPs can offer support to children outside of the services' core offer, therefore impacting on the EPs ability to support children with an ABI, despite methods within their unique role being highlighted as having benefits to children with an ABI. This finding offers a potential explanation for why EPs are seeing low rates of ABI amongst their practice, compared to the prevalence amongst the general child population.

The second phase of the research provided further investigation into examples of good practice within the role of the EP working with children with an ABI. The focus groups highlighted that translating medical reports into implications for education, offering emotional containment to schools and families, assisting in changing the narrative and perspectives about the child, participating in the larger MDT, and identifying and highlighting the value of child voice were all seen as examples of good practice. Participants also viewed the EPs' capacity to integrate information from several perspectives into a comprehensive picture of the child's needs as being extremely valuable for the child, as well as their ability to support children over time and help them get ready

for adulthood. Participants additionally mentioned the value of CPD in their practice, sharing that it helped them to support children with ABI with a deeper theoretical and practical understanding.

It is hoped that, by building upon previous research into the unique role of the EP in supporting children with an ABI, this thesis has offered a deeper and fuller understanding on the topic at this time and has paved the way for future research in this field. The ultimate hope is that this research can contribute to improving the support offered to children with an ABI by EPs assisting from a unique perspective and increase the number of positive outcomes for these children in their future, helping to prepare them for a happy adulthood and helping them to integrate successfully within society.

Implications for EP practice:

- EP services may wish to consider supporting their EPs to access CPD on child ABI or identify a member of the team to be a specialised EP in this area who can provide such support or assist other EPs when they receive a referral for support.
- EPs should ask within consultations whether the child has ever had a brain injury, at any severity, at any point in their life. This would not be asking for the purpose of seeking a label for the child's needs, but to better understand factors that might be contributing to the child's difficulties, leading to a better informed and more accurate formulation, and therefore more tailored provision.
- EPs to open a dialogue with school staff and other professionals that raises the awareness of the wide variety of support they can offer within their role, in addition to EHCNAs, so that they know what unique support the EP could offer to a child with an ABI.
- Examples of good practice when working with CYP with an ABI, and ways in which an EP can support in the future include, but not limited to:
  - EHC needs assessments.
  - Changing the narrative through consultation
  - Gathering child voice
  - Accessing CPD on the topic
  - Translating medical reports into implications for education
  - Providing emotional containment for schools and families
  - Working as part of the wider MDT

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Appendix 1: National Survey

*(Questions 1-13 were digitised consent form questions)*

**Survey**

14. I am \*

*Mark only one oval.*

- Maingrade Educational Psychologist in the UK
- Specialist Educational Psychologist in the UK
- Senior Educational Psychologist in the UK
- Principle Educational Psychologist in the UK

15. I have been qualified for \*

*Mark only one oval.*

- 0-3 years
- 3-6 years
- 6-9 years
- 9-15 years
- longer than 15 years

16. I am currently based in \*

*Mark only one oval.*

- London
- South East
- South West
- East of England
- East Midlands
- West Midlands
- Yorkshire and Humber
- North East
- North West
- Northern Ireland
- Scotland
- Wales
- Other: \_\_\_\_\_

17. How common do you feel Acquired Brain Injury is within children and young people within education? \*

*Mark only one oval.*

- Very common
- Common
- Uncommon
- Rare

18. Do you believe you have a good understanding of the most common difficulties children face after a brain injury?

*Mark only one oval.*

- Yes I believe I have a good understanding
- I believe I have some knowledge
- I am not sure about what the common difficulties are

19. Have you ever supported a child with an Acquired Brain Injury within your practice? \*

*Mark only one oval.*

- Yes- 15+ children
- Yes- 10-14 children
- Yes- 5-9 children
- Yes- 3 or 4 children
- Yes- Less than 2 children
- No
- Not sure

20. If yes, what age groups did the children fall into? (you can choose multiple options)

*Tick all that apply.*

- Early years
- Primary school age
- Secondary school age
- Post-16

21. How recent was your most recent case

*Mark only one oval.*

- Within the past month
- Within the past 3 months
- Within the past 6 months
- Within the past year
- Within the past 2 years
- 2-5 years ago
- 5 years +

22. In which capacity did you provide support? (you can choose multiple options)

*Tick all that apply.*

- EHC psychological advice
- Consultation
- Attendance at the 'return to school' meeting following discharge from hospital
- Ongoing involvement as part of a multi-disciplinary team (MDT) meeting
- Delivered training to school on acquired brain injury in children
- Attendance at regular annual reviews
- Attendance at annual reviews at key transition points
- Cognitive assessment
- Direct intervention with the child
- Systemic therapeutic Support
- Supporting school to interpret reports from other agencies e.g. psychological or medical
- Other: \_\_\_\_\_

23. How confident were you in your knowledge and understanding of neuropsychological theory to support your work on these cases

*Mark only one oval.*

- Not confident at all
- Not confident
- Somewhat confident
- Confident
- very confident

24. Where did you gain any knowledge on the topic?

*Tick all that apply.*

- Initial training
- CPD
- Self-directed exploration
- Previous experience
- Other: \_\_\_\_\_



25. What level of coverage on acquired brain injury was given during initial training

*Mark only one oval.*

- High coverage  
 Some coverage  
 Very limited coverage  
 No coverage

26. How confident would you feel in supporting a child who had an Acquired Brain Injury? \*

*Mark only one oval.*

- Not at all confident  
 Not confident  
 Somewhat confident  
 Confident  
 Very confident  
 Other: \_\_\_\_\_

27. Please explain why you gave this answer

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28. How confident would you feel in sign-posting schools and families to where they could receive further support?

*Mark only one oval.*

- Not at all confident  
 Not confident  
 Somewhat confident  
 Confident  
 Very confident

29. Do you believe further training on this topic would be beneficial to your practice? \*

*Mark only one oval.*

- Yes  
 No  
 Maybe

30. Please state why you have given this answer and include detail of what you would like to learn

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31. Does your service have an EP who specialises in child acquired brain injury?

*Mark only one oval.*

- Yes  
 No  
 Not sure

32. Does your service have a protocol for identifying and supporting children with an acquired brain injury?

*Mark only one oval.*

- Yes  
 No  
 Not sure

33. What do you believe the Educational Psychologist's role in supporting children with an Acquired Brain Injury should be? e.g. statutory, therapeutic, individual, systemic, as part of an MDT...

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34. What do you feel are barriers to supporting children with an acquired brain injury?

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35. Do you feel that you have an example of good practice in supporting children with an acquired brain injury? This can be at any level of support where you feel your role was beneficial.

*Mark only one oval.*

- Yes  
 No

36. Would you be interested in attending a virtual focus group aimed at sharing examples of good practice in supporting children with acquired brain injuries?

*Mark only one oval.*

- Yes- I consent to my email being used to contact me regarding the focus group  
 No

Message upon survey submission:

*Thank you very much for completing the survey! If you would like further information on supporting children with an Acquired Brain Injury, please go to <https://childbraininjurytrust.org.uk>.*

## Appendix 2: Participant Information Sheets

### **Information letter – Pilot Survey**

#### **A Mixed-Methods Exploration into the Educational Psychologist's role in supporting children post Acquired Brain Injury**

*You are being invited to take part in a pilot research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.*

#### **What is the project's purpose?**

I am a second-year student on the Doctorate of Child and Educational Psychology course and am carrying out this research as part of the course. One of the most common neuropsychological conditions that Educational Psychologists (EP) come across in their practice is paediatric Acquired Brain Injury (Misheva, 2020). Acquired Brain Injury (ABI) is the term used to refer to non-degenerative damage to the brain after birth (Headway, 2018) and can be divided into traumatic and non-traumatic categories. Previous research has noted the importance of education and the school setting within the rehabilitation process, with students spending a large amount of time there (CBIT & Nasen, 2018). Supporting a student with an ABI can be challenging for schools with the child requiring unique support, assessments continuous monitoring of need and individualised support plans (Shaughnessy et al., 2006). It has been suggested that Educational Psychologists (EP) are well placed to provide continued support to schools in order to support these pupils (Ball & Howe, 2013).

Within the current research, I am interested to find out what is currently happening across the UK within EP practice regarding supporting children post brain injury. This research plans to use a mixed methods approach by conducting a nationwide survey and focus groups. Through the data I gather, I plan to explore whether the recommendations from previous research regarding the EP role are already in practice or what EPs feel the barriers are regarding meeting the needs of these young people. I also plan to look at the perceived knowledge base, confidence levels, whether EPs have accessed any training on the topic either through initial training or CPD, and how prevalent supporting this population is within their work. In summary, I would like to know whether there is a role for the EP in supporting young people with an ABI and if so, begin to look at what might be needed in order for it to happen.

The purpose of this pilot study is for you to complete the survey so I can look at the validity of the questions to ensure they reflect the data I am interested in gathering. I am also interested in any feedback you have regarding the content or wording of the questions within the survey.

**Why have I been chosen?**

You have been chosen as I am currently on placement within the local authority you are employed by and therefore have good access to potential participants to complete a pilot survey.

**Do I have to take part?**

No, you do not have to take part. We would be really interested in finding out your views and would value your contribution into this research, but your participation is entirely voluntary. If you do decide to take part, please complete the consent form on the next page. You can still withdraw at any time without giving a reason and this will not affect you in any way. If you wish to withdraw from the research, please contact Charlotte Kilroy ([ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)).

**What do I have to do?**

If you agree to participate in this study, you will be asked to complete a questionnaire (lasting approximately 10 minutes) looking at EP experiences of supporting a child with an acquired brain injury. During the questionnaire you will also be asked about the prevalence of this work within your role, your opinion on the role of the EP in supporting these children and what you think the barriers are in preventing this type of work. Following your completion of the questionnaire, I will ask to speak to you to find out what you thought about the questionnaire, whether you found anything difficult or unclear and whether you would add anything. This conversation should take between 15-30 minutes.

**What are the possible disadvantages and risks of taking part?**

We hope that you will enjoy the opportunity to reflect on your experiences working with children post Acquired Brain Injury. However, we understand that reflecting on these experiences can bring to the surface positive and negative feelings. If you wish to discuss any of the topics which arise in the questionnaire, my contact details are listed below so that you can discuss this further if you wish to.

**What are the possible benefits of taking part?**

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be beneficial for children and young people with an Acquired Brain Injury, their families and their schools as it will inform the practice of EPs in regard to the support they give to the child and the system around them. The aim of the research being to ensure appropriate support is given to children post acquired brain injury.

**Will my taking part in this project be kept confidential?**

All the information that we collect about you during the research will be kept strictly confidential and will only be accessed by the researchers. You will not be mentioned by name and any personal details will be changed so you cannot be identified in any research or publications. You will only be acknowledged by name if you explicitly ask for this.

You are also asked to refrain from naming any children or young people that you have worked with previously when describing your experiences to ensure their anonymity and confidentiality.

**What is the legal basis for processing my personal data?**

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

**What will happen to the data collected, and the results of the research project?**

Data from the questionnaire will only be available to researchers for the purpose of data analysis and will not contain your name. Your data will not be used to write up the report or other research as the aim is to explore the questionnaire quality. Any data will be stored on a secure file storage drive online until September 2023, when it will be deleted.

**Who is organising and funding the research?**

The thesis research is being organised by a second-year student on the Doctorate in Educational and Child Psychology course at the University of Sheffield.

**Who is the Data Controller?**

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

**Who has ethically reviewed the project?**

This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Educational and Child Psychology department- School of Education. The University's Research Ethics Committee monitors the application and delivery of the University's Ethics Review Procedure across the University.

**What if something goes wrong and I wish to complain about the research?**

In the first instance you should the researcher should you wish to raise a complaint (Principal investigator – Charlotte Kilroy – [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)). Should you feel that your complaint has not been handled to your satisfaction, you may contact the project supervisor Dr Lorraine Campbell, or the DEdCPsy Course Director (Dr Anthony Williams- [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)), who will then contact you to discuss your concerns and escalate the complaint through the appropriate channels. If the complaint relates to how the participants' personal data has been handled, information about how to raise a complaint can be found in the University's Privacy Notice: <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

**Thank you for taking part!**

**Project contact details for further information:**

Charlotte Kilroy (Researcher) – [Ckilroy1@sheffield.ac.uk](mailto:Ckilroy1@sheffield.ac.uk)

Dr Lorraine Campbell (Project Supervisor) - [l.n.campbell@sheffield.ac.uk](mailto:l.n.campbell@sheffield.ac.uk)

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## Information letter – Pilot Focus Group

### **A Mixed-Methods Exploration into the Educational Psychologist's role in supporting children post Acquired Brain Injury**

*You are being invited to take part in a pilot research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.*

#### **What is the project's purpose?**

I am a second-year student on the Doctorate of Child and Educational Psychology course and am carrying out this research as part of the course. One of the most common neuropsychological conditions that Educational Psychologists (EP) come across in their practice is paediatric Acquired Brain Injury (Misheva, 2020). Acquired Brain Injury (ABI) is the term used to refer to non-degenerative damage to the brain after birth (Headway, 2018) and can be divided into traumatic and non-traumatic categories. Previous research has noted the importance of education and the school setting within the rehabilitation process, with students spending a large amount of time there (CBIT & Nasen, 2018). Supporting a student with an ABI can be challenging for schools with the child requiring unique support, assessments continuous monitoring of need and individualised support plans (Shaughnessy et al., 2006). It has been suggested that Educational Psychologists (EP) are well placed to provide continued support to schools in order to support these pupils (Ball & Howe, 2013).

Within the current research, I am interested to find out what is currently happening across the UK within EP practice regarding supporting children post brain injury. This research plans to use a mixed methods approach by conducting a nationwide survey and focus groups. Through the data I gather, I plan to explore whether the recommendations from previous research regarding the EP role are already in practice or what EPs feel the barriers are regarding meeting the needs of these young people. I also plan to look at the perceived knowledge base, confidence levels, whether EPs have accessed any training on the topic either through initial training or CPD, and how prevalent supporting this population is within their work. In summary, I would like to know whether there is a role for the EP in supporting young people with an ABI and if so, begin to look at what might be needed in order for it to happen.



The purpose of the pilot focus group is to test the question style I am using for the main study focus group. The aim is for participants to share examples of perceived good practice so we can learn from them, analyse whether the role the EP took was similar to those suggested in previous research and finally to inform future research. Within the pilot focus group, the topic focussed on will be experiences of working with children in care as it is the structure I am testing and I am not looking to gather any data other than feedback on questions and structure during this process.

**Why have I been chosen?**

You have been chosen as you are a trainee Educational Psychologist within the UK who has volunteered to take part in a pilot focus group.

**Do I have to take part?**

No, you do not have to take part. We would be really interested in finding out your views and would value your contribution into this research, but your participation is entirely voluntary. If you do decide to take part, please complete the consent form on the next page. You can still withdraw at any time without giving a reason and this will not affect you in any way. If you wish to withdraw from the research, please contact Charlotte Kilroy ([ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)).

**What do I have to do?**

If you agree to participate in this study, you will be asked to participate in an online focus group looking at EP experiences of supporting a child in care. During the focus group you will be asked to share any examples of good practice you believe you have been involved with, your opinion on the role of the EP in supporting these children and what you think the barriers are in preventing this type of work. The focus group should last approximately 1 hour- 1 hour 30 minutes.

**What are the possible disadvantages and risks of taking part?**

We hope that you will enjoy the opportunity to reflect on your experiences working with children in care. However, we understand that reflecting on these experiences can bring to the surface positive and negative feelings. If you wish to discuss any of the topics which arise in the questionnaire, my contact details are listed below so that you can discuss this further if you wish to.

**What are the possible benefits of taking part?**

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be beneficial for children and young people with an Acquired Brain Injury, their

families and their schools as it will inform the practice of EPs in regard to the support they give to the child and the system around them. The aim of the research being to ensure appropriate support is given to children post acquired brain injury.

**Will my taking part in this project be kept confidential?**

All the information that we collect about you during the research will be kept strictly confidential and will only be accessed by the researchers. You will not be mentioned by name and any personal details will be changed so you cannot be identified in any research or publications. You will only be acknowledged by name if you explicitly ask for this.

You are also asked to refrain from naming any children or young people that you have worked with previously when describing your experiences to ensure their anonymity and confidentiality.

**What is the legal basis for processing my personal data?**

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

**What will happen to the data collected, and the results of the research project?**

Data from the focus groups will only be available to researchers for the purpose of data analysis and will not contain your name. The focus group will be recorded and then transcribed. Post-transcription, the initial recording will be deleted. Any data will be stored on a secure file storage drive online until September 2023, when it will be deleted.

**Who is organising and funding the research?**

The thesis research is being organised by a second-year student on the Doctorate in Educational and Child Psychology course at the University of Sheffield.

**Who is the Data Controller?**

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

**Who has ethically reviewed the project?**

This project has been ethically approved via the University of Sheffield's Ethics Review Procedure, as administered by the Educational and Child Psychology department- School of Education. The University's Research Ethics Committee monitors the application and delivery of the University's Ethics Review Procedure across the University.

**What if something goes wrong and I wish to complain about the research?**

In the first instance you should the researcher should you wish to raise a complaint (Principal investigator – Charlotte Kilroy – [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)). Should you feel that your complaint has not been handled to your satisfaction, you may contact the project supervisor Dr Lorraine Campbell, or the DEdCPsy Course Director (Dr Anthony Williams- [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)), who will then contact you to discuss your concerns and escalate the complaint through the appropriate channels. If the complaint relates to how the participants' personal data has been handled, information about how to raise a complaint can be found in the University's Privacy Notice: <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

**Thank you for taking part!**

**Project contact details for further information:**

Charlotte Kilroy (Researcher) – [Ckilroy1@sheffield.ac.uk](mailto:Ckilroy1@sheffield.ac.uk)

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## Information letter - Survey

### **A Mixed-Methods Exploration into the Educational Psychologist's role in supporting children post Acquired Brain Injury**

*You are being invited to take part in a pilot research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.*

#### **What is the project's purpose?**

I am a second-year student on the Doctorate of Child and Educational Psychology course and am carrying out this research as part of the course. One of the most common neuropsychological conditions that Educational Psychologists (EP) come across in their practice is paediatric Acquired Brain Injury (Misheva, 2020). Acquired Brain Injury (ABI) is the term used to refer to non-degenerative damage to the brain after birth (Headway, 2018) and can be divided into traumatic and non-traumatic categories. Previous research has noted the importance of education and the school setting within the rehabilitation process, with students spending a large amount of time there (CBIT & Nasen, 2018). Supporting a student with an ABI can be challenging for schools with the child requiring unique support, assessments continuous monitoring of need and individualised support plans (Shaughnessy et al., 2006). It has been suggested that Educational Psychologists (EP) are well placed to provide continued support to schools in order to support these pupils (Ball & Howe, 2013).

Within the current research, I am interested to find out what is currently happening across the UK within EP practice regarding supporting children post brain injury. This research plans to use a mixed methods approach by conducting a nationwide survey and focus groups. Through the data I gather, I plan to explore whether the recommendations from previous research regarding the EP role are already in practice or what EPs feel the barriers are regarding meeting the needs of these young people. I also plan to look at the perceived knowledge base, confidence levels, whether EPs have accessed any training on the topic either through initial training or CPD, and how prevalent supporting this population is within their work. In summary, I would like to know whether there is a role for the EP in supporting young people with an ABI and if so, begin to look at what might be needed in order for it to happen.

**Why have I been chosen?**

You have been chosen as you are a qualified Educational Psychologist currently employed by a local authority within the UK.

**Do I have to take part?**

No, you do not have to take part. We would be really interested in finding out your views and would value your contribution into this research, but your participation is entirely voluntary. If you do decide to take part, please complete the consent form on the next page. You can still withdraw at any time without giving a reason and this will not affect you in any way. If you wish to withdraw from the research, please contact Charlotte Kilroy ([ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)).

**What do I have to do?**

If you agree to participate in this study, you will be asked to complete a questionnaire (lasting approximately 10 minutes) looking at EP experiences of supporting a child with an acquired brain injury. During the questionnaire you will also be asked about the prevalence of this work within your role, your opinion on the role of the EP in supporting these children and what you think the barriers are in preventing this type of work.

**What are the possible disadvantages and risks of taking part?**

We hope that you will enjoy the opportunity to reflect on your experiences working with children post Acquired Brain Injury. However, we understand that reflecting on these experiences can bring to the surface positive and negative feelings. If you wish to discuss any of the topics which arise in the questionnaire, my contact details are listed below so that you can discuss this further if you wish to.

**What are the possible benefits of taking part?**

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be beneficial for children and young people with an Acquired Brain Injury, their families and their schools as it will inform the practice of EPs in regard to the support they give to the child and the system around them. The aim of the research being to ensure appropriate support is given to children post acquired brain injury.

**Will my taking part in this project be kept confidential?**

All the information that we collect about you during the research will be kept strictly confidential and will only be accessed by the researchers. You will not be mentioned by name and any personal details will be changed so you cannot be identified in any research or publications. You will only be acknowledged by name if you explicitly ask for this.

You are also asked to refrain from naming any children or young people that you have worked with previously when describing your experiences to ensure their anonymity and confidentiality.

### **What is the legal basis for processing my personal data?**

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

### **What will happen to the data collected, and the results of the research project?**

Data from the questionnaire will only be available to researchers for the purpose of data analysis and will not contain your name. Your anonymised data will be used during analysis and to write up the report. Any data will be stored on a secure file storage drive online until September 2023, when it will be deleted.

### **Who is organising and funding the research?**

The thesis research is being organised by a second-year student on the Doctorate in Educational and Child Psychology course at the University of Sheffield.

### **Who is the Data Controller?**

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

### **Who has ethically reviewed the project?**

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**Thank you for taking part!**

**Project contact details for further information:**

Charlotte Kilroy (Researcher) – [Ckilroy1@sheffield.ac.uk](mailto:Ckilroy1@sheffield.ac.uk)

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## Information letter – Focus Group

### **A Mixed-Methods Exploration into the Educational Psychologist's role in supporting children post Acquired Brain Injury**

*You are being invited to take part in a pilot research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.*

#### **What is the project's purpose?**

I am a second-year student on the Doctorate of Child and Educational Psychology course and am carrying out this research as part of the course. One of the most common neuropsychological conditions that Educational Psychologists (EP) come across in their practice is paediatric Acquired Brain Injury (Misheva, 2020). Acquired Brain Injury (ABI) is the term used to refer to non-degenerative damage to the brain after birth (Headway, 2018) and can be divided into traumatic and non-traumatic categories. Previous research has noted the importance of education and the school setting within the rehabilitation process, with students spending a large amount of time there (CBIT & Nasen, 2018). Supporting a student with an ABI can be challenging for schools with the child requiring unique support, assessments continuous monitoring of need and individualised support plans (Shaughnessy et al., 2006). It has been suggested that Educational Psychologists (EP) are well placed to provide continued support to schools in order to support these pupils (Ball & Howe, 2013).

Within the current research, I am interested to find out what is currently happening across the UK within EP practice regarding supporting children post brain injury. This research plans to use a mixed methods approach by conducting a nationwide survey and focus groups. Through the data I gather, I plan to explore whether the recommendations from previous research regarding the EP role are already in practice or what EPs feel the barriers are regarding meeting the needs of these young people. I also plan to look at the perceived knowledge base, confidence levels, whether EPs have accessed any training on the topic either through initial training or CPD, and how prevalent supporting this population is within their work. In summary, I would like to know whether there is a role for the EP in supporting young people with an ABI and if so, begin to look at what might be needed in order for it to happen.



The purpose of the focus group is to explore EP perceived positive experiences of supporting a child with an acquired brain injury in more detail. The aim is for participants to share examples of perceived good practice so we can learn from them, analyse whether the role the EP took was similar to those suggested in previous research and finally to inform future research.

### **Why have I been chosen?**

You have been chosen as you are a qualified Educational Psychologist currently employed by a local authority within the UK who has volunteered to take part in a focus group after completing the survey.

### **Do I have to take part?**

No, you do not have to take part. We would be really interested in finding out your views and would value your contribution into this research, but your participation is entirely voluntary. If you do decide to take part, please complete the consent form on the next page. You can still withdraw at any time without giving a reason and this will not affect you in any way. If you wish to withdraw from the research, please contact Charlotte Kilroy ([ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)).

### **What do I have to do?**

If you agree to participate in this study, you will be asked to participate in an online focus group looking at EP experiences of supporting a child with an acquired brain injury. During the focus group you will be asked to share any examples of good practice you believe you have been involved with, your opinion on the role of the EP in supporting these children and what you think the barriers are in preventing this type of work. The focus group should last approximately 1 hour- 1 hour 30 minutes.

### **What are the possible disadvantages and risks of taking part?**

We hope that you will enjoy the opportunity to reflect on your experiences working with children post Acquired Brain Injury. However, we understand that reflecting on these experiences can bring to the surface positive and negative feelings. If you wish to discuss any of the topics which arise in the questionnaire, my contact details are listed below so that you can discuss this further if you wish to.

### **What are the possible benefits of taking part?**

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be beneficial for children and young people with an Acquired Brain Injury, their

families and their schools as it will inform the practice of EPs in regard to the support they give to the child and the system around them. The aim of the research being to ensure appropriate support is given to children post acquired brain injury.

**Will my taking part in this project be kept confidential?**

All the information that we collect about you during the research will be kept strictly confidential and will only be accessed by the researchers. You will not be mentioned by name and any personal details will be changed so you cannot be identified in any research or publications. You will only be acknowledged by name if you explicitly ask for this.

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**What will happen to the data collected, and the results of the research project?**

Data from the focus groups will only be available to researchers for the purpose of data analysis and will not contain your name. The focus group will be recorded and then transcribed. Post-transcription, the initial recording will be deleted. Any data will be stored on a secure file storage drive online until September 2023, when it will be deleted.

**Who is organising and funding the research?**

The thesis research is being organised by a second-year student on the Doctorate in Educational and Child Psychology course at the University of Sheffield.

**Who is the Data Controller?**

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**Who has ethically reviewed the project?**

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**What if something goes wrong and I wish to complain about the research?**

In the first instance you should the researcher should you wish to raise a complaint (Principal investigator – Charlotte Kilroy – [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)). Should you feel that your complaint has not been handled to your satisfaction, you may contact the project supervisor Dr Lorraine Campbell, or the DEdCPsy Course Director (Dr Anthony Williams- [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)), who will then contact you to discuss your concerns and escalate the complaint through the appropriate channels. If the complaint relates to how the participants' personal data has been handled, information about how to raise a complaint can be found in the University's Privacy Notice: <https://www.sheffield.ac.uk/govern/data-protection/privacy/general>.

**Thank you for taking part!**

**Project contact details for further information:**

Charlotte Kilroy (Researcher) – [Ckilroy1@sheffield.ac.uk](mailto:Ckilroy1@sheffield.ac.uk)

Dr Lorraine Campbell (Project Supervisor) - [l.n.campbell@sheffield.ac.uk](mailto:l.n.campbell@sheffield.ac.uk)

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## Appendix 3: Participant consent forms

**A Mixed-Methods Exploration into the Educational Psychologist's role in supporting children post Acquired Brain Injury**  
**Pilot Consent Form**

<i>Please tick the appropriate boxes</i>	Yes	No
<b>Taking Part in the Project</b>		
I have read and understood the project information sheet dated 20/04/2022 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	<input type="checkbox"/>	<input type="checkbox"/>
I have been given the opportunity to ask questions about the project and I am satisfied with the answers..	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project. I understand that taking part in the project will include completion of a questionnaire that asks questions about my experiences, knowledge, and beliefs about the Educational Psychologist's role in supporting children following an Acquired Brain Injury.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my responses will be used to alter and develop questions for a wider project based on the same research title.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that by choosing to participate as a volunteer in this research, this does not create a legally binding agreement nor is it intended to create an employment relationship with the University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	<input type="checkbox"/>	<input type="checkbox"/>
<b>How my information will be used during and after the project</b>		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that only the authorised researchers will have access to this data.	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for this signed consent form and questionnaire responses to be retained in a secure U: drive until the end of September 2023 upon which they will be deleted.	<input type="checkbox"/>	<input type="checkbox"/>
<b>So that the information you provide can be used legally by the researchers</b>		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>

Name of participant [printed]

Signature

Date

Name of Researcher [printed]

Signature

Date

**Project contact details for further information:**Lead Researcher: Charlotte Kilroy, [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)Project Supervisor: Dr. Lorraine Campbell, [l.n.campbell@sheffield.ac.uk](mailto:l.n.campbell@sheffield.ac.uk)Head of Department: Dr. Anthony Williams, [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)

Address for all above: University of Sheffield, The University of Sheffield, Western Bank, Sheffield, S10 2TN, UK

**A Mixed-Methods Exploration into the Educational Psychologist's role in supporting  
children post Acquired Brain Injury**

**Consent Form – pilot focus group**

<i>Please tick the appropriate boxes</i>	Yes	No
<b>Taking Part in the Project</b>		
I have read and understood the project information sheet dated 20/04/2022 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	<input type="checkbox"/>	<input type="checkbox"/>
I have been given the opportunity to ask questions about the project and I am satisfied with the answers.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project. I understand that taking part in the project will include participating in a focus group that asks questions about my positive experiences as a trainee Educational Psychologist in supporting children in care.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that when referring to examples, I should maintain confidentiality and refrain from using any language that may identify a child or their family.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that the online focus group will be audio recorded, stored securely, and deleted by September 2023.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that by choosing to participate as a volunteer in this research, this does not create a legally binding agreement nor is it intended to create an employment relationship with the University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	<input type="checkbox"/>	<input type="checkbox"/>
<b>How my information will be used during and after the project</b>		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that only authorised researchers will have access to this data.	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for this signed consent form and questionnaire responses to be retained in a secure U: drive until the end of September 2023 upon which they will be deleted.	<input type="checkbox"/>	<input type="checkbox"/>
<b>So that the information you provide can be used legally by the researchers</b>		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>

Name of participant [printed]

Signature

Date

Name of Researcher [printed]

Signature

Date

**Project contact details for further information:**Lead Researcher: Charlotte Kilroy, [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)Project Supervisor: Dr. Lorraine Campbell, [l.n.campbell@sheffield.ac.uk](mailto:l.n.campbell@sheffield.ac.uk)Head of Department: Dr. Anthony Williams, [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)

Address for all above: University of Sheffield, The University of Sheffield, Western Bank, Sheffield, S10 2TN, UK

**A Mixed-Methods Exploration into the Educational Psychologist's role in supporting  
children post Acquired Brain Injury**  
**Main survey Consent Form**

<i>Please tick the appropriate boxes</i>	Yes	No
<b>Taking Part in the Project</b>		
I have read and understood the project information sheet dated 20/04/2022 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	<input type="checkbox"/>	<input type="checkbox"/>
I have been given the opportunity to ask questions about the project and I am satisfied with the answers..	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project. I understand that taking part in the project will include completion of a questionnaire that asks questions about my experiences, knowledge, and beliefs about the Educational Psychologist's role in supporting children following an Acquired Brain Injury. I understand that I will also be given the opportunity to sign up to participate in a focus group but that this is optional.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that by choosing to participate as a volunteer in this research, this does not create a legally binding agreement nor is it intended to create an employment relationship with the University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	<input type="checkbox"/>	<input type="checkbox"/>
<b>How my information will be used during and after the project</b>		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that only the authorised researchers will have access to this data.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>



I give permission for this signed consent form and questionnaire responses to be retained in a secure U: drive until the end of September 2023 upon which they will be deleted.	<input type="checkbox"/>	<input type="checkbox"/>
<b>So that the information you provide can be used legally by the researchers</b>		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>

Name of participant [printed]

Signature

Date

Name of Researcher [printed]

Signature

Date

**Project contact details for further information:**Lead Researcher: Charlotte Kilroy, [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)Project Supervisor: Dr. Lorraine Campbell, [l.n.campbell@sheffield.ac.uk](mailto:l.n.campbell@sheffield.ac.uk)Head of Department: Dr. Anthony Williams, [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)

Address for all above: University of Sheffield, The University of Sheffield, Western Bank, Sheffield,  
S10 2TN, UK

**A Mixed-Methods Exploration into the Educational Psychologist's role in supporting  
children post Acquired Brain Injury**

**Consent Form – focus group**

<b><i>Please tick the appropriate boxes</i></b>	<b>Yes</b>	<b>No</b>
<b>Taking Part in the Project</b>		
I have read and understood the project information sheet dated 20/04/2022 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	<input type="checkbox"/>	<input type="checkbox"/>
I have been given the opportunity to ask questions about the project and I am satisfied with the answers.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project. I understand that taking part in the project will include participating in a focus group that asks questions about my positive experiences as an Educational Psychologist in supporting children following an Acquired Brain Injury.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that when referring to examples, I should maintain confidentiality and refrain from using any language that may identify a child or their family.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that the online focus group will be audio recorded, stored securely, and deleted by September 2023.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that by choosing to participate as a volunteer in this research, this does not create a legally binding agreement nor is it intended to create an employment relationship with the University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	<input type="checkbox"/>	<input type="checkbox"/>
<b>How my information will be used during and after the project</b>		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that only authorised researchers will have access to this data.	<input type="checkbox"/>	<input type="checkbox"/>

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<b>So that the information you provide can be used legally by the researchers</b>		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>

Name of participant [printed]

Signature

Date

Name of Researcher [printed]

Signature

Date

**Project contact details for further information:**Lead Researcher: Charlotte Kilroy, [ckilroy1@sheffield.ac.uk](mailto:ckilroy1@sheffield.ac.uk)Project Supervisor: Dr. Lorraine Campbell, [l.n.campbell@sheffield.ac.uk](mailto:l.n.campbell@sheffield.ac.uk)Head of Department: Dr. Anthony Williams, [anthony.williams@sheffield.ac.uk](mailto:anthony.williams@sheffield.ac.uk)

Address for all above: University of Sheffield, The University of Sheffield, Western Bank, Sheffield, S10 2TN, UK

#### Appendix 4: National Survey Invitation Email

Good afternoon

My name is Charlotte Kilroy and I am a second-year student on the Doctorate of Child and Educational Psychology course at the University of Sheffield. As part of the course, I am completing a piece of research into supporting children with an Acquired Brain Injury within Educational Psychology practice. I am interested to find out what is currently happening across the UK within Educational Psychology practice regarding supporting children post brain injury, whether there is a role for the Educational Psychologist in supporting young people with an Acquired Brain Injury and if so, begin to look at what might be needed in order for it to happen.

I would be extremely grateful if you could forward this email to all of the Educational Psychologists within your Educational Psychology Service so they have an opportunity to complete the survey, even if they feel they have had no experience to date with this population.

Below is a link to my survey which should take approximately 10-15 minutes to complete.

Link to survey:

[https://docs.google.com/forms/d/e/1FAIpQLScI5qKju\\_3luyvcV7W0myKjbKMxgnK788nWswTuhpFPh\\_tExlw/viewform?usp=sf\\_link](https://docs.google.com/forms/d/e/1FAIpQLScI5qKju_3luyvcV7W0myKjbKMxgnK788nWswTuhpFPh_tExlw/viewform?usp=sf_link)

Thank you in advance.

Please feel free to contact me on this email if you have any questions regarding the research.

Kind regards

Charlotte Kilroy  
Trainee Educational Psychologist  
University of Sheffield

Appendix 5: Focus group invitation email and preparation email

Invitation:

Good Morning

You are receiving this message as you agreed to be contacted regarding participation in a focus group when you completed the first part of this research- the survey.

I am writing to invite you to participate in an online focus group that will give you the opportunity to share your experiences of supporting children with an acquired brain injury in your capacity as an Educational Psychologist.

Please use the link below to sign up to one of the three time slots available. If you are unable to attend any of the time slots please let me know via email and I will let you know if another time slot is offered.

Doodle poll link: XXXXXXXX

Below is a link to the information sheet and consent form for the focus group. Please read and complete the consent form if you are happy to participate and are able to attend one of the time slots offered on the doodle poll.

Consent form link : XXXXXXXXX

If you no longer wish to participate in the focus group, please reply to this email to let me know and I will remove you from future communications regarding the focus groups.

Thank you in advance for your time. If you have any questions please do not hesitate to ask.

Kind regards

Charlotte Kilroy

Preparation:

Good morning

Hope you are well. In preparation for the focus group on Friday 28th October, please ensure you have completed the consent form via the link below:

XXXXXXXXXX

We will be using google meet for the focus group- the link to join the meeting is below:

Focus group 1

Friday, 28 October · 1:30 – 3:00pm

Google Meet joining info

Video call link: XXXXXXXX

So you can begin to have a think about the topic of the focus group, the question I will be asking is as follows:

"Thinking about your work with children with an Acquired Brain Injury, how has your role made a difference to the situation/support?

(What did it involve? How did it help? What was the outcome?)"

Please don't feel you need to do any preparation before the focus group. I have only sent the question to give the opportunity to those who wish to think about the question in advance.

We will be using Jamboard in the focus group which is a virtual post-it note board. If you are joining the focus group from a tablet, it may be useful if you download the Jamboard app in advance. You do not need to do this if you are joining from a laptop or desktop. If you have never used a Jamboard before, below is a link to a test Jamboard if you would like to have a look at how to use it before the focus group. However, this is not compulsory as I will give an overview of how to use a Jamboard at the beginning of the focus group.

XXXXXXXXXX- Jamboard link

If you have any questions, please do not hesitate to ask.

Kind regards, Charlotte Kilroy

## Appendix 6: Ethical Approval Letter



Downloaded: 23/06/2022

Approved: 31/05/2022

Charlotte Kilroy  
 Registration number: 200112699  
 School of Education  
 Programme: Doctorate in Child and Educational Psychology

Dear Charlotte

**PROJECT TITLE:** A Mixed-Methods Exploration into the Educational Psychologist's role in supporting children post Acquired Brain Injury

**APPLICATION:** Reference Number 046152

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 31/05/2022 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 046152 (form submission date: 31/05/2022); (expected project end date: 01/10/2023).
- Participant information sheet 1104837 version 2 (26/04/2022).
- Participant information sheet 1104838 version 3 (18/05/2022).
- Participant information sheet 1104840 version 3 (18/05/2022).
- Participant information sheet 1104839 version 2 (26/04/2022).
- Participant consent form 1104844 version 3 (31/05/2022).
- Participant consent form 1104843 version 2 (31/05/2022).
- Participant consent form 1104842 version 2 (31/05/2022).
- Participant consent form 1104841 version 2 (31/05/2022).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Anna Weighall  
 Ethics Administrator  
 School of Education

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/approval-procedure>
- The project must abide by the University's Good Research & Innovation Practices Policy: [https://www.sheffield.ac.uk/polopoly\\_fs/1.6710661/file/GRIPPolicy.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.6710661/file/GRIPPolicy.pdf)
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

## Appendix 7- Focus group nominal group technique script

Focus group using nominal group technique – Script generated using “Nominal group technique: a users' guide” (Dunham, 1998).

\*Set off OTTER AI and voice recorder\*

Introduction:

“I would like to thank each of you for attending this focus group that is focussed on identifying ways in which the EP role can make a difference in supporting children with an acquired brain injury. In this focus group, each of you is an important resource and I am looking forward to hearing from each of you about your experiences.

Just a reminder that I will be recording the audio from the focus group for transcription. It is your choice whether you have your camera on or not. The focus group is expected to last between 1- 1.5 hours. Please remember to keep what you share anonymous and refrain from mentioning any names of children or families.

If you no longer wish to participate in the focus group at any time, please feel free to leave the meeting. You will not be required to give a reason.

We will be using jam board to assist us with the focus group. I have posted a link to the Jamboard in the chat if you could all click the link.

\*Explain how to use Jamboard\*

Are there any questions?

Let's begin.

### Step 1

\*Read question on jam board\*

I would like each of you to take 5 minutes to list your ideas in response to this question. Describe each idea in a brief phrase or a few words on the virtual post it notes. This is an opportunity to



reflect on your practice and begin to generate ideas. At the end of the 5 minutes, I will call time and suggest how we proceed to share our ideas.

Any questions?

Okay, please begin to share your ideas on post it notes.

### Step 2

Now we have listed our ideas, I want us to take time to go back and briefly discuss each idea. The purpose of this discussion is to clarify the meaning of each item on our jam board. It is also the opportunity to express our understanding of what your role involved and the level of impact it had on the situation. We should feel free to express varying points of view or to disagree. We will however want to pace ourselves so that each of the items on the jam board receives the opportunity for some attention, so I may sometimes ask the group to move on to further items. Finally, let me point out that the creator of the idea being discussed need not feel obliged to clarify or explain an item. Any member of the group can play that role.

As the discussion happens, I will begin to move the post it notes into identified themes. If any of you identify any themes arising within the answers, please feel free to voice this.

You can add post it notes with more ideas throughout this process.

If anyone would like to make a comment via the google meet chat, I can read it out.

Are there any questions or comments group members would like to make about this first item?

### Step 3

We have now completed our discussion of the entire list of ideas, have clarified the meaning of each idea, and have discussed the areas of agreement and disagreement. At this time, I would like to have the judgement of each group member concerning the most important and impactful ideas/themes on the list. To accomplish this step, you should each move 3 votes (in the bottom left-hand corner) over the ideas/themes you think are most important and impactful in our work with children with an acquired brain injury.

Any clarification necessary

Closing remarks :

Thank you so much for giving up your time to participate in my research. I will stay on the call for a bit longer in case anyone has any questions.

Appendix 8: Details of the thematic analysis of the data from the open-ended survey questions.

Survey question: What do you believe the Educational Psychologist's role in supporting children with an Acquired Brain Injury should be? e.g. statutory, therapeutic, individual, systemic, as part of an MDT...

<b>Superordinate Theme</b>	<b>Subordinate theme</b>	<b>Excerpt</b>
Utilising existing skills that EPs have and applying them to offer systemic and holistic support	Consultation	<p><i>"I believe the EP role for children with ABI would not be different to any other child. It would be taken into account when exploring their needs in the school and follow the consultation model to trial approaches and consider what works best for the child as an individual."</i></p> <p><i>"Consultation with schools to develop their understanding of ABI and its effects, and jointly plan ways forward."</i></p> <p><i>"Consultation to help the family and school to reach a shared understanding of the ABI and the impact upon the child in different contexts was previously described as helpful by both family and school."</i></p> <p><i>"Also, through training we can help schools and parents realise that X isn't being naughty etc, but that X's behaviour is in fact a response to a brain injury."</i></p> <p><i>"There would also be a role in supporting a school and family to plan for the child's support needs, help them understand their learning and social and emotional needs."</i></p> <p><i>"I often find a key part of the role is supporting adults to support the young person. For this group of young people, a part of this involves listening to and containing the emotions of the adults around them."</i></p>
	Identify holistic strengths and needs	<p><i>"An EP could help identify the holistic strengths &amp; needs of the child and support the school &amp; family."</i></p>

	Working systemically	<i>“Key for me was working with school staff, the child and family to improve educational outcomes and monitor the social and emotional wellbeing of the child once she had returned to school.”</i>
	Statutory work	<p><i>“Statutory is of course a very important part of our work - for example through my cases the child could no longer attend or access as mainstream environment and so through a well written EP advice we can support the child to access a specialist provision.”</i></p> <p><i>“I also think perhaps the most important part of the role is to gather all threads (speech therapist, OT, physio, hospital teacher, clinical psych, optometry etc) and weave these together into a holistic understanding and narrative of what this child may need to thrive”.</i></p>
	Working as part of MDT	<p><i>“The unique perspective we can provide to a child / young person's situation adds value to the process as part of a MDT around them, providing an educational view to what might otherwise be a medicalise view; a pupil is more than their brain injury. There is also value to be added through helping others to understand the trauma and bereavement (in terms of accepting the losses of functioning and changes to personality and character that can result from an ABI) the pupil and their family are likely to have been through as a result of an injury”.</i></p> <p><i>“Involvement as part of multidisciplinary working would be a clear role for EPs as I was able to offer some reflections upon why the assessment scores may have varied which other professionals had not considered. I feel that we have a valuable role in supporting children with ABIs right from the initial injury, through hospitalisation (including ensuring access to appropriate educational resources and teaching when they are ready), to transition back into an educational setting and onwards.”</i></p>

		<p><i>“Part of an MDT - focusing systemically on how the school can interact with the specialists involved/family/child in the most empathetic, positive and helpful way (taking practical strategic into account, thinking about making the most of any window of opportunity)”.</i></p> <p><i>“I also think we could contribute to MDT in a consultative way as I often find the medical advice does not translate well into schools. I have seen them repeatedly advocate for an EHCP despite the need in school being met at SEN support which then puts SENDCo in a tricky position.”</i></p> <p><i>“Dependent on what input is already being provided by other members of the team. If the team is wide ranging, then EP role can be focused on advice to school, assessment of needs as they present in school, consultation, attendance at review meetings, etc. If the wider team is lacking then the EP may need to support more systemically, therapeutically, wherever he or she can!”</i></p>
	<p>Translating medical reports into implications for educational setting</p>	<p><i>“In an ideal world we would be referred to once a medical diagnosis has been received to support schools with interpretation of reports and how an ABI might present in the classroom.”</i></p> <p><i>“Helping to implement advice from health/specialists into a school context, remove barriers to the mainstream or specialist school context in order that these children have inclusive support and reach their potential.”</i></p>
	<p>Child voice</p>	<p><i>“Being an advocate for child/young person (or family) as appropriate - this could be at a variety of levels (statutory, individual and therapeutic)”</i></p> <p><i>“Not in every case, but individual work to explore a young person's self-perception following an injury could also be a very helpful role for the EP. I have done this in two pieces of casework, and the YP found it very helpful, and surprisingly had not been offered elsewhere. Of real importance was</i></p>

		<p><i>finding an agreed way with the YP to share this with a wider team including their family and teaching staff.”</i></p> <p><i>“I think we can help the young person to talk about and process their experiences and their personal constructs about themselves now.”</i></p>
--	--	--

Survey question: What do you feel are the barriers to supporting children with an acquired brain injury?

<b>Superordinate Theme</b>	<b>Subordinate theme</b>	<b>Excerpt</b>
Hidden Disability	Going under the radar	<i>“Perhaps a YP going ‘under the radar’ and not being referred for EP support”</i>
	Lack of identification	<p><i>“ Hidden cost of ABI to children and young people when not recognised”.</i></p> <p><i>“Not knowing if the ABI exists”.</i></p> <p><i>“Knowing if they have one in the first instance, several cases I have had have come to me due to concerns about behaviour, when I have tracked back I have found they have an ABI”</i></p>
	Hidden difficulties	<i>“The children’s difficulties can be hidden”.</i>
	Misinterpreting needs	<i>“That it is a hidden disability and needs can be misinterpreted”.</i>
Awareness of EP support	School staff not aware of how the EP could support	<p><i>“School staff not being aware of what the EP role could contribute here”.</i></p> <p><i>“Not being referred for EP support If the school does not understand the role an EP can have in supporting YP with an ABI”.</i></p> <p><i>“Understanding of the EP role or possibilities of our involvement”.</i></p>

	Not being prioritised for EP time	<i>"Identifying these children and prioritising EP time to work with them"</i>
	Believing clinical psychology or health professionals are more suited to help	<p><i>"Would schools raise CYP with an acquired brain injury with their link EP or go to a health professional or clinical psychologist for advice?"</i></p> <p><i>"Maybe schools not feeling it is our role to be involved for casework as part of their SLA and feel other professionals are better placed for this?"</i></p> <p><i>"School staff not prioritising traded EP time in this way when a number of professionals are likely to be involved already".</i></p> <p><i>"Some belief that only clinical psychologists can do this work".</i></p> <p><i>"Because there is a view that the children and their families are already receiving specialist support from other services".</i></p> <p><i>"Maybe school staff feeling that it is a medical condition and therefore not seek EP involvement"</i></p>
	ABI is medical in nature	<p><i>"Schools not raising these children to us as they feel it is 'medical' in nature".</i></p> <p><i>"Separating medical and educational factors".</i></p> <p><i>"I think because it is a very medical and neurological condition"</i></p>
ABI knowledge amongst school staff	Lack of recognition of the ABI	<p><i>"Staff seeing behaviour or learning difficulties and not making the link to ABI".</i></p> <p><i>"Recognition of brain injury"</i></p> <p><i>"May never be referred if the school do not link behaviour to ABI and resulting SEMH needs"</i></p>
	Lack of knowledge amongst school staff about ABI	<p><i>"Lack of knowledge in schools"</i></p> <p><i>"Settings not understanding the long-term impact".</i></p> <p><i>"School may feel that they lack knowledge and confidence".</i></p>

		<p><i>"For schools, lack of information and knowledge, being unsure about how it will affect behaviour and peer relationships".</i></p> <p><i>"I'm not sure that some school staff were aware of the potential extent of the impact of a brain injury or that there are possible strategies that could be tried to address difficulties".</i></p> <p><i>"Lack of understanding of the recovery process following ABI"</i></p>
	Limited awareness of ABI	<p><i>"People have a limited awareness".</i></p> <p><i>"Lack of awareness from schools as to the range and prevalence of ABI and the impacts"</i></p>
	Lack of identification	<p><i>"Lack of identification"</i></p> <p><i>"They may not be referred to an EP until they begin to struggle in school".</i></p> <p><i>"Challenges of identifying ABI".</i></p>
	Lack of training	<i>"Lack of training in schools"</i>
	Underestimation of need	<p><i>"Unless the ABI is very serious and traumatic, the child is often not recognised as having additional needs".</i></p> <p><i>"Lack of understanding of the significance of the injury".</i></p> <p><i>"Underestimation of the grief or PTSD the pupil and their family might be experiencing".</i></p>
Occurrence within EP practice	ABI cases are rare within EP practice	<p><i>"ABI in a generic role is relatively rare".</i></p> <p><i>"doesn't come up frequently".</i></p> <p><i>"Relatively uncommon difficulty"</i></p> <p><i>"Rarely coming across a child with an ABI"</i></p>
	No experience	<i>"I am not sure as I haven't experienced any casework for children with an ABI".</i>



EP capacity and time	Needing to use traded EP time as not in a services core offer	<p><i>“Funding- schools need to use traded time. Easier when part of statutory work”</i></p> <p><i>“Whether pupils with ABI would fall into our core work”.</i></p> <p><i>“Providing appropriate support within a traded model where schools may not always wish to purchase the additional services we can provide”.</i></p> <p><i>“Same as for all young people, a school needs to pay for our involvement”.</i></p> <p><i>“a lot of EP work is traded”.</i></p> <p><i>“The main barrier for me has been funding, specifically whether schools commission work from us or not. I've known of other CYP with ABIs through termly planning meetings but have not been involved as schools have limited funding and have prioritised other children, often with externalising SEMH needs at risk of PEX”</i></p>
	EPs having limited time for involvement	<p><i>“For an EP, it might be the ability to be involved in a timely enough way”.</i></p> <p><i>“Time is an obstacle for sustained work with any child at the moment due to statutory pressures squeezing all other work”.</i></p> <p><i>“Time- for the work unless statutory (and even then limited)”</i></p> <p><i>“Lack of time”</i></p> <p><i>“Our offer to schools is consultation or statutory work. This means it is unlikely we can offer support over time”.</i></p> <p><i>“Lack of EP time would most likely be the biggest barrier to be able to fully understand the child’s needs and provide ongoing support for the school and family”</i></p>
	EP capacity to pick these cases up	<p><i>“capacity”</i></p> <p><i>“workload”</i></p>

		<p><i>"Lack of capacity"</i></p> <p><i>"Usual constraints around capacity with focus on statutory work taking priority"</i></p>
	<p>High level of EHC needs assessments impacting on availability to pick up cases</p>	<p><i>"High levels of EHC needs assessments".</i></p> <p><i>"Other pressures on EPs, especially statutory load"</i></p>
<p>Lack of EP involvement within the MDT</p>	<p>Poor communication with health professionals</p>	<p><i>"Limited communication with health professionals"</i></p> <p><i>"Difficulties working in partnership with health colleagues".</i></p> <p><i>"Timely and detailed information from health professionals; in my experience when information from health professionals is limited, it's harder to plan work and come up with a working hypothesis on what is happening".</i></p> <p><i>"Medical professionals can be difficult to track down for a professional discussion or just to answer day to day queries parents may have."</i></p> <p><i>"Lack of communication/joint working with health teams"</i></p> <p><i>"Communication with medical professionals can be difficult".</i></p> <p><i>"Poor links between health and education to ensure early support is put in place to maximise outcomes for YP"</i></p>
	<p>Wider MDT not understanding the role of the EP and what they could offer</p>	<p><i>"Perhaps a multi-disciplinary understanding of what different services' contribution might be".</i></p> <p><i>"I also feel that lack of understanding of the EP role can impact on whether we are invited/included in supporting a child/YP with an ABI. The breadth of skills and support we can offer are not always understood by wider agencies and also by some</i></p>

		<p><i>schools, resulting in some seeing the EP role as quite narrow”.</i></p> <p><i>“The team were not clear on the role of the EP and what we could/could not provide”</i></p>
	Lack of multi-agency cooperation	<p><i>“Lack of multi-agency cooperation”</i></p> <p><i>“Minimal cooperation between us and NHS”</i></p> <p><i>“Usual difficulties with cross-discipline collaboration”</i></p> <p><i>“Systems not joining up- different perspectives and understanding not coming together with a shared approach, understanding or outcomes”</i></p>
	Minimal contact with the MDT	<p><i>“Minimal contact with the MDT once the child had been discharged from hospital”.</i></p> <p><i>“Difficulties in co-ordinating work with MDT- especially community/hospital as understandably they are all as stretched as we are”</i></p>
	Not enough time for co-operative working	<p><i>“Reduction in multidisciplinary working overtime”</i></p> <p><i>“Not enough time for co-operative working”</i></p>
	Prominent medical model within MDT	<p><i>“The medical model being predominant”.</i></p>
Grief, loss and trauma	Grief	<p><i>“Grief/acceptance issues”</i></p> <p><i>“fear”</i></p>
	Loss	<p><i>“Feelings of loss”</i></p>
	Trauma	<p><i>“There could be high levels of trauma attached to the cases depending on how the injury was acquired- considerations need to be given to losses experienced by the families and CYP in terms of alternative futures possibly?”</i></p>
Lack of knowledge and confidence amongst EPs	Lack of knowledge	<p><i>“Lack of information and understanding”.</i></p> <p><i>“Lack of knowledge and training”</i></p> <p><i>“Lack of understanding”</i></p> <p><i>“There is not a full understanding, even in the EP profession, about how ABI impact varies depending on the age of the child”.</i></p>

		<p><i>"knowledge and understanding of 1)what ABIs are 2) what are the signs 3) how to work with children and young people with ABIs 4) what the impact of ABIs are 5) ABIs and trauma context 6) SEND needs and provision for children with an ABI 7) educational and life outcomes for children and young people with ABIs 8) links to ABI and youth justice outcomes 9) ... EPs not seeing themselves as neuropsychologists and eschewing work in a medical context"</i></p> <p><i>"Lack of 'in the moment' knowledge as requires me to go away and research/find out more, use of medical terms within letters etc that are difficult for me to understand and take time to translate".</i></p> <p><i>"Lack of specialist knowledge"</i></p> <p><i>"I can feel limited in the standardised assessments I can do with children with an ABI, as often they are having in-depth neuropsychological assessment".</i></p> <p><i>"Limited knowledge of EPs"</i></p> <p><i>"EPs own knowledge and understanding of the topic".</i></p> <p><i>"Lack of knowledge, understanding and experience within the EP team"</i></p>
	Lack of confidence	<i>"Lack of confidence"</i>
	Lack of experience	<i>"Lack of experience"</i>
	Need for CPD	<p><i>"There is a need like most things to ensure we keep up to date with research so ensuring appropriate CPD is available is beneficial".</i></p> <p><i>"Lack of access to CPD"</i></p> <p><i>"Lack of training and awareness amongst EPs"</i></p>
	Need for specialist EP	<i>"It would be helpful to have an EP in the team who specialises in ABI, as a first point of support if involved in an ABI case."</i>

	Insufficient focus of topic in initial training	<i>"Insufficient focus in the training programmes for EPs, lack of trainers available to deliver input"</i>
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Survey question: Please explain why you gave this answer:

Preceding question: How confident would you feel in supporting a child who had an Acquired Brain Injury?

<b>Superordinate Theme</b>	<b>Subordinate theme</b>	<b>Excerpt</b>
Personal Experience	Participant has an ABI	<i>"I have an ABI and not that all ABI are the same, but I feel I have personal experience and knowledge which is useful."  "I have acquired brain injury myself - having developed meningitis as an adult - and I am aware that the long-term outcomes for me have been very different from what the medical staff, at the time, were expecting"</i>
	Personal awareness of ABI	<i>"I am also personally aware of the impact of ABI and understand that often people misunderstand the presentation"</i>
Self-directed learning	Own research	<i>"I would understand where further information and advice could be accessed to support the child/family/school and for my own professional development."  "I feel that I have good skills in self-directed exploration to further my knowledge through reading relevant articles and information"</i>
	Seeking advice from EP colleagues	<i>"I have the capacity to explore the area and seek support from colleagues to find out more should a case arise in my practice"</i>
	Seek advice from other professionals	<i>"I would work closely with health and other professionals and our service has the required expertise for consultation in (for e.g.) access"</i>

		<p><i>technology, SALT. Also, I would do my own research as needed”.</i></p> <p><i>“I know a little, meet with professionals who have more knowledge through CPD and case supervision”.</i></p> <p><i>“If there are areas I have less knowledge about I'm confident I have the means to find out more information through self-directed exploration and through liaison with other professionals involved in the cyp's care.”</i></p>
<p><b>Applications from general EP practice</b></p>	<p><b>Using existing EP skills in the absence of in-depth ABI knowledge</b></p>	<p><i>“Although I do not have detailed neuropsychological knowledge in this area, I feel that I am skilled in understanding the current presenting individual needs of CYP and supporting schools to plan support for CYP in collaboration with other professionals.”</i></p> <p><i>“I work with two special schools and a whole host of SEN children I am often having to read up about a special need, I don't need to know everything there is to know about everything...I can ask lots of questions and think about the young person holistically in the context they are in.”</i></p> <p><i>“I have had no experience in this area of EP practice and have very little knowledge. However, I do feel confident that if asked to support a child and family who are experiencing this my skills (e.g., consultation, exploring need, designing provision) would be transferable and provide a valuable contribution alongside medical professionals.”</i></p> <p><i>“While I have had no direct involvement in the past 10 years or so with a child who has had an ABI, I feel I am experienced enough to be able to research and be informed enough when a time comes where my involvement will be needed. This has always been the case in similar situations where a child with a</i></p>

		<p><i>rare condition (e.g., genetic) or need has required EP involvement.”</i></p> <p><i>“I think that EPs have a lot to offer within consultation that we do not always need to have specific knowledge about a condition/ diagnosis. We can support others who know the children/ family/ school best to problem solve collaboratively. For that reason, I would feel ok supporting a child with ABI in a consultative way, but I would not feel confident to deliver training/ answer specific questions. If I was writing an EHC advice, I would need time to do some research.”</i></p>
	<p>Considering the child holistically</p>	<p><i>“Educational Psychology practice involves supporting children and young people through evidencing and analysing the holistic picture of their strengths and areas for development; an ABI would be an element of this alongside the wider context historically, home wise and educationally which places Educational Psychologists in a unique position to support</i></p>
	<p>Advocating for and seeking young people’s voice</p>	<p><i>“I feel that many of the psychological principles that I use in my work can be applied to work with all children/young people, for example acting as an advocate, seeking and promoting young people's views. generating a problem-solving framework to support change etc. I feel confident in working in a multi-disciplinary way and through MDT supporting effective implementation of advice from other agencies via a consultation model with school/staff. I feel that often what has been missing is really 'hearing' and promoting the voice of the young person and I feel confident in being able to do this for young people including those with an acquired brain injury.”</i></p>

Accessed CPD	Less confident because of lack of training/CPD	<p><i>"I do not feel that I have received training on this. I would lean on medical advice to support my work."</i></p> <p><i>"I have accessed very little CPD on this area".</i></p> <p><i>"I have not had any training in my initial training or any CPD in this area"</i></p>
	Not taught in initial EP training	<p><i>"I have received no input as part of my doctoral training on supporting CYP with ABI."</i></p>
	Have accessed CPD so feel more confident	<p><i>"I feel that I can draw on sessions from my initial training as well as CPD pre- and post-training."</i></p> <p><i>"I attended a CPD event in a neighbouring LA delivered by EP specialists in Acquired Brain injury; I was there able to refer to this information."</i></p> <p><i>"I have attended training from CBIT which was excellent. I will be disseminating the key parts of this training to three EP services as part of a team CPD day in autumn 2022."</i></p> <p><i>"I attended a training session on the topic. This gave me some understanding of the kinds of difficulties commonly experienced by those with an acquired brain injury. I now feel more confident having this basic overview and having some understanding of the possible sources of relevant information should I need to carry out further research in relation to a specific case in the future."</i></p> <p><i>"I decided to put myself through a full day's training on it with a local ABI expert".</i></p> <p><i>"I do feel that more neuropsychological training is required for EPs though but as part of initial training and CPD across services (rather than as an optional interest for certain EPs as all EPs are likely to come across children with ABI)"</i></p>



Professional Experience	Limited experience supporting a child with an ABI	<p><i>“Due to very little experience of working with children with ABI in our service”.</i></p> <p><i>“My experience with ABI is limited and I therefore cannot provide advice regarding what a child's progress would look like, if the behaviour or needs we are seeing relate to the ABI or provide an evidence-based interventions”.</i></p>
	No experience supporting a child with an ABI	<p><i>“I have had no experience in this area of EP practice and have very little knowledge”.</i></p>
	Feeling underprepared	<p><i>“I felt extremely underprepared when I did it before, and that has not really changed.”</i></p>
	Confident as worked as part of a specialist MDT supporting child with ABI	<p><i>“I am part of a multi-disciplinary team (not local authority based) who specialist in providing support for children with ABI. To prepare for this role I undertook a lot of reading in this area. I now have my experiences with different cases to draw on and have also learned lots from other professionals on MDTs.”</i></p> <p><i>“I previously worked in ***** Children's Trust for children with brain injury. We also had a lecture while training from an EP who was currently working there. I am comfortable with how to work with parents, the children, and the staff.”</i></p> <p><i>“I have worked with children with acquired brain injury at a specialist neuro-rehab setting for the past six years.”</i></p> <p><i>“I work privately with a company involved in ABI rehabilitation”</i></p>
	Confident as worked as part of an MDT supporting child with ABI	<p><i>“I have usually found when a child has an acquired brain injury there is a team involved from Health who provide specific support and neuropsychological assessment, so I feel confident</i></p>

		<i>as part of that multidisciplinary team of professionals. However, were I to be the only professional involved, I would feel somewhat less confident as I feel expertise of neuropsychology is needed alongside Educational Psychologist involvement."</i>
	Supporting through EHCNA/casework	<i>"I have also had some experience in this area through EHCNA and casework, so I have that to draw on."</i>
	Organisational systemic work	<i>"I have researched the topic and worked alongside Hospital and Outreach to develop a system of working in this area. The system was successful but is no longer in place."</i>

Survey question: Please state why you have given this answer and include detail of what you would like to learn.

Preceding question: Do you believe further training on this topic would be beneficial to your practice?

Superordinate Theme	Subordinate theme	Excerpt
Didn't believe CPD would be beneficial	Due to infrequency of cases within practice	<i>"It's something I come across so infrequently that I'm not sure devoting time to additional training would be that much of a good use of public sector resources but if it was a short (1/2 day or 1 day) training I would be interested."</i> <i>"It seems that this does not come up very commonly in practice, although I would like to know more, I feel there are other areas of practice that I would prioritise seeking further training on before ABI".</i> <i>"In 16 years, I have not had to provide help. Any training would be helpful at the time of a case, but</i>

		<p><i>I would forget all information in between learning it and using it”.</i></p> <p><i>“The incidence is so low in my current role and capacity is such a big issue for our service that it might be hard to justify a significant time commitment”.</i></p> <p><i>“It doesn't seem to be very prevalent in my day-to-day practice so although training is always helpful unless I'm using it, I'm not sure I'll remember it”.</i></p> <p><i>“Because ABI has been so rarely encountered, it would not be good use of or a priority for CPD at this time. Sorry. The same goes for the myriad of very specific conditions that exist. I've found that it works for me to have CPD experiences on a need to know as and when basis with rarely encountered conditions/needs.”</i></p> <p><i>“In 6 years of practice, I have only worked with one pupil with ABI. Whilst my lack of knowledge is likely to have impacted the outcome of my psychological advice, I am unsure as to whether it would be a best use of time (as part of the doctorate) to further explore this issue.”</i></p>
	Existing specialist services for ABI in the local authority	<i>“Given the specialist services in my local authority which support children with ABI it is not very often that I come across these cases in my work. As such I think that the training I have had in this area is sufficient”</i>
	Other topics more of a priority for CPD	<i>“It would of course be beneficial but balancing that with training for issues which come up more frequently would make it difficult to prioritise”</i>
Training would be useful	Would like to learn about the common difficulties of ABI and	<i>“Would like to learn more about key factors e.g., the aforementioned 'common issues'.”</i>

	<p>the impact on the child and family</p>	<p><i>“As an EP it is likely that I may become involved again with a child with ABI. Further training would develop my knowledge and practice.”</i></p> <p><i>“It is something I am very interested in; particularly how specific areas of the brain affect different skills/lead to certain difficulties.”</i></p> <p><i>“Types of acquired brain injury, how to support young people with acquired brain injuries.”</i></p> <p><i>“Some indication as to what the long-term impact on the child is in terms of ability to acquire new skills and learning.”</i></p> <p><i>“It would be helpful to really consider all factors/possibilities in terms of presentation, barriers to learning and strategies to support”.</i></p> <p><i>“I think all EPs would benefit from basic training in understanding how ABIs can affect children and young people and how we might best help education professionals to understand and support children”?</i></p> <p><i>“Although I feel like I could contribute to supporting a child, more detailed knowledge of acquired brain injuries would support my practice and further develop how I might be able to support schools, CYP and their families in these circumstances.”</i></p>
	<p>Would like to learn about applications to EP practice</p>	<p><i>“Personally, I would like to increase some of my BASIC understanding, and how this may fit alongside our understanding of cognitive assessments (memory, concentration, simultaneous processing, language, speech etc)”</i></p> <p><i>“I think it is about the unique contribution that an EP could make: training, cognitive processes type assessment, bridging between cog psych/ neuro psych and schools, perhaps dealing more around</i></p>

		<p><i>supporting grief, loss of identity, or facilitating group processes using PATH etc.”</i></p> <p><i>“I’d like to know more about tailored curriculums and alternative ways of teaching children with ABIs. Also, how to help those who are grieving the person they were before and is refusing to accept support in school because they don’t want to be seen as someone who needs helps - identity I suppose. How do CYP make sense of their identity following an ABI? “</i></p> <p><i>“More about the EP role in identifying and supporting children with ABI”.</i></p> <p><i>“I know colleagues who have had casework particularly through EHC assessments for children and young people with ABI and it would be helpful to know some of the key information that is helpful when working with others who have experienced this. Things I would like to learn would be how ABI can impact on different areas of development, realistic outcomes and provisions that could support young people with ABI”.</i></p> <p><i>“What strategies have been helpful in supporting staff manage emotional regulation difficulties and overall, which are the key areas that should be considered when carrying out an assessment.”</i></p>
	<p>Would like to keep up to date with neuropsychological research</p>	<p><i>“Ongoing Neurological research to keep up to date.”</i></p> <p><i>“I feel that there is always more to learn, and it is important to keep up to date with advances in these areas.”</i></p> <p><i>“Because I think we quite often talk a lot about the 'brain' these days, in our practice, and schools</i></p>

		<p><i>expect it to a certain extent, but many assumptions can be made.”</i></p> <p><i>“I particularly would be interested in neurological implications of seizures as a few cases have had infantile seizures, which although stopped, seem to have difficulties with EF and this 'feels' like an ABI to some extent, but I would like to be more informed about this.”</i></p> <p><i>“I feel it would be beneficial to have training every so often (e.g., 2-3 years) to keep up to date with most recent research and relevant recommendations.”</i></p> <p><i>“The field of paediatric brain injury is always changing and emerging and so I feel that training needs to be an ongoing thing.”</i></p> <p><i>“More learning around neuropsychology and the implications of this for school contexts would be helpful.”</i></p> <p><i>“I worked with a child who had had a brain tumour...and another who experienced epileptic fits... info re ABI in these cases would have been helpful...More detail around the impact on memory and processing skills would be helpful.”</i></p>
	<p>Would like to learn about services they can signpost to</p>	<p><i>“Protocol/policies for supporting children with needs in this area. Services for signposting.”</i></p> <p><i>“I would like to know what additional support is available for families and where I could signpost them.”</i></p> <p><i>“Support that is out there for children/young people and their families in relation to ABI”.</i></p> <p><i>“Training and awareness raising is always helpful though, especially when it signposts to where to find more info and resources”.</i></p>

		<p><i>"I would like to know what support services are out there and what families have found most helpful in these situations".</i></p>
	<p><b>Should be covered in initial training</b></p>	<p><i>"I feel it should have been covered in initial training. I would like additional training on the impact ABI can have on specific cognitive processes, for example memory".</i></p> <p><i>"Hence, maybe. If it were to become as aspect of the doctorate training, I would like to learn more about models of injury, types of ABI, possible severity, impact, how to support/rehabilitate. I would hope that this opens up discussion around EP understanding of ABI and whether/what the role is to support CYP and how, if possible, we maintain the use of social, practical psychology without becoming overshadowed by health/medical models."</i></p>

Appendix 9: Details of the thematic analysis of the data from the focus groups.

**Focus group Question:** Thinking about your work with children with an Acquired Brain Injury, how has your role made a difference to the situation/support? (What did it involve? How did it help? What was the outcome?)

Superordinate Theme	Subordinate theme	Excerpt
Translating medical reports into implications for education	Helping school staff and parents understand the medical reports in application to education	<p><i>“The reason I was initially invited was because school was struggling to understand the implications for the ABI. And they'd had a huge wealth of medical reports and information as a result of the investigations and treatment. And really, we're not understanding basically the changes that are had occurred for the young person. And were looking to have advice from our service to be able to achieve that (...)They had been given a, like I said, a wealth of information. And within some of those reports, there were strategies. But those strategies were written from a medical perspective, not an educational perspective (...) In order to go from at that medical viewpoint to a school-based context. So, helping to understand okay, this is this is what the medical report is suggesting, and this is how it translates to a school context.”—</i></p>
	Translating complicated language from medical reports into simpler terms	<p><i>“It's very jargony. And we had that there. And what I think we managed to do, or I managed to do with the SENCo at that point was to sort of bring that into plain English for the families to understand what that was, and then what that would look like”.</i></p>



Providing emotional containment and support for school staff and families	Emotional containment for school staff	<i>"I think some of that was around emotional containment and holding for the staff about their loss of the student they used to know and how that student was then being interpreted"</i>
	Supporting the headteacher	<i>"I think people who are feeling a bit scared, quite scared is the head teacher was worried and anxious I think about whether they'd be able to cope with a child when she when she came back to school because the first meeting was before she was before she'd arrived back in school, and she was still in hospital."</i>
	Emotional containment around 'Window of opportunity'	<p><i>"The window of opportunity that was explained and it really emphasised in that first meeting, I think that really pressured people and so it became all about that what, what can we what can we do them? What do we need to do people wanted to help? What can we do? What do we need to do to support the maximise opportunities for development for the child? So, there was some containment around that as well and making that more tangible, because it felt like a big pressure and a big fear of what of what if we don't do it right. What if we don't? What if we can't? What if we do the wrong thing? What can we do so, that is a discourse of the window of opportunity became a big thing."</i></p> <p><i>"If you were a parent that's if you think there's a window of opportunity and you're working within that timescale, you've got that. That's your chance to get your child back. And that felt quite difficult thing for school staff to manage in their head. So, her role is supporting the staff as at the same code because SENCO approached me as well. And I've said supervision, obviously they didn't call it</i></p>

		<i>supervision, but they wanted to chat about some of these things, and to support the staff who were also managing their grief but also worried about whether they were going to do enough... So, I do think it was about being there as a partner with them through that process. Because it was a critical incident, wasn't it for that for the school. And so, holding some of that."</i>
	Emotional containment for parents	<i>"...includes the parents because the parent was very much still trying to move on from the loss of effectively one child to then getting another child almost because there was such a dramatic change."</i>
	Relational approach	<i>"I think it goes back to what you were saying earlier about the relational aspect and having a good connection with the people that we're working with, or if they're new people being able to invite that connection and foster that within that small space of time, we've got with them is one of the key aspects."</i>
Help change the narrative and bring about perspective shift towards hope in school staff and families	Help others to understand presentation in terms of unmet needs rather than behaviour	<i>"...supporting adults to view changes in personality and presentation as need and not behaviour". "And it might be about like, communication, you know, they're coming across as rude. Well, they're not actually meaning to be rude. This is actually another kind of impact of this brain injury. And so that's what kind I meant by kind of, you know, shining the light on the other areas and making them maybe go oh, actually reframing."</i>
	Encourage the system to reflect on their views in a sensitive way	<i>"...we have that ability to ask those curious questions to come in from a completely different angle, and explore further and further and further in the old Socratic method why? And asking an exploring in a real in-depth way, but from a</i>

		<i>completely different perspective, to help draw things together. So, when I'm talking about curious questions, we're also not afraid to challenge within that and to ask, have you thought about it in this way? Could it be this that's going on, and use those kinds of you know, I wonder phrases to introduce new narratives that might be going on?"</i>
	Shift focus to the. here and now	<i>"And what prompted me to write this, about that that perspective shift was that need to support people to look beyond the brain injury, and see the child or student for who they are now they know their what their character was like now, and yet kind of yes, acknowledging the changes that had occurred, but rather than dwelling on them as a negative, thinking more about what's the here and now for this young person, what do we now need to consider as their strengths and skill base?"</i>
	Recognise child strengths	<i>"...beginning to see not only her flourish, but also the other children in response to her really beginning to enjoy things within school once things have settled down a bit. And when I met with her the first time, I don't know what I'd expected, but here was this glorious little girl who was really engaging with the activities that we did together and so I was able to support and just encourage the talk around her. Both in the report that I wrote, but also just thinking in discussions dialogue, to enable and reinforce that sort of optimism around that, you know, here was a child who was going to succeed in her own way."</i>  <i>"having a conversation about strengths and positives, because a lot of the conversations have been about negatives and I think that ties in so well, because after one of these incidences, it's all</i>

		<p><i>about what they've lost or what they can't do anymore, or what went wrong and there's all that like, guilt and upset and anger and you know, all of that and then for someone to come in say, so what are their strengths and what what's been going well and what progress have they made and what do they enjoy?"</i></p>
<p>Working as part of an MDT and providing additional support from a unique perspective</p>	<p>EPs work within social model of disability compared to medical model of other professionals</p>	<p><i>"So, while I might talk about executive functioning and how it evolves and is a dynamic consideration to take on board within an educational context, the more clinical model would look at it in a completely different light about how it impacts on sort of more general functioning. So, I think we can bring a different perspective, which I think helps."</i></p> <p><i>"We are we work within a social model of disability, don't we? It's not the medical model. And I think when it's acquired brain injury, it is very much a medical model then all the people who were initially involved are medical or clinical professionals aren't they. Who give you the clinical psychologist give you their advice from their clinical setting where the child's been brought to them for and we're very much looking at them in their social environment, aren't we? We're looking at well, what's it like in the hospital school in the mainstream school back at home with parents as he still got his friendship groups? Is it still accessing his extracurricular stuff? We're very much looking at that, that that person with that very medical term acquired brain injury, but in that social model aren't we, and I think who else who else does that? Actually, who else does that?"</i></p>

	<p>EPs work systemically as well as individually</p>	<p><i>“But it also allows us to draw on the different levels at which we work. And within that space, we've got the individual level with our knowledge of the student or student functioning. We've also got our knowledge of working at the consultative level with drawing perspectives together knowledge of systemic level working, and also local authority system within system as it were, so we can pull all that together as part of that discussion to help move things on and help people feel supported, which I think is another key element of that supervisory role that we can take.”</i></p>
	<p>EP invited to MDT for EHC rather than to use other skills</p>	<p><i>“I was asked to be invited by the medical team. So, they'd asked if the educational psychologist could attend a multidisciplinary meeting, but the school would have asked me anyway, so that would have happened (...) So, I think the reason that they were asking is because they thought that the child would need any EHC(...) I'd love to think that they perceived educational psychologists our role to be doing all the things that we've just been describing, but I suspect it was about EHC (...) Yeah, I mean, I think they did. They still associate educate associated educational psychologists with the EHC process, the statutory role but no, we developed a good relationship. And I think partly that was because of the way the school functions as well and creating the space for that to happen. And we maintain dialogue for quite a long time in formal dialogue that was on another post it so there's quite a lot of communication. So yeah, I think they perceived a broader role for the educational psychologist following the collaborative work that we engaged in definitely.”</i></p>

Uncovering and emphasising importance of pupil voice and advocating for the young person	Pupil voice advocate	<p><i>"...taking our role as being pupil advocate, you know putting forward the things from the pupil view... enabling us to step into the shoes of that young person through the discourses that we create in our collaborative discussions. And bringing that view to the table I think is a really key part of our role in any situation."</i></p>
	Making adaptations to collect student voice	<p><i>"(...)this was a 19-year-old young person who was in a college, and I really can't remember the details of what the acquired brain injury was that he did have acquired brain injury. There was a progression of the impact, and he was losing skills quite rapidly, incredibly sad really. So, this was an but he it was amazing really is really impressive, but just the consultation needed to look very different. He needed to be given time to speak. And people who were supporting him weren't doing that not because they weren't kind but it's quite amazing, isn't it when we when we say what listening really is and how, you know, wait for somebody gives them time to give the answer(...) he was rarely having the opportunity to actually say what he wanted to say. And so, eliciting his views was the bit I went along to shadow and my colleagues do it. And it was incredible. Really, and we just sat in this actually created just a wonderful silence and acknowledge that it was there and that we all had to sit with it. And it was a really person centred session and he came through about what was important to him then an acknowledgment about what he was increasingly struggling with, you know, month by month, year on year(...) We are going to have silences and we are going to sit with them because he's absolutely capable and he</i></p>

		<p><i>has things to tell us and we did(...)was quite incredible for everybody in the room to hear that no one had heard his views before mum was really emotional because she'd been losing bits of her son as time has gone on. And but she knew he had his views and he had very strong views about what he wanted his future to look like(...) I don't think that would have happened without that EP doing that."</i></p>
<p>EPs can bring all the information together into a holistic understanding of needs through statutory EHC needs assessments.</p>	<p>Collate information from all professionals to create shared and holistic understanding</p>	<p><i>"So, for me that this the one statutory I'm thinking of it was a traumatic injury, and there were just so many professionals involved, you know, the whole gamut of the NHS, some physio, OT, hospital teacher, you know, vision, clinical psychologist, everybody, and there was all this information and letters flying around everywhere. So, I think it was really useful just to get all of that in one structured document, which I know is what we do anyway. But I just think, especially for a case like that, when there's so much medical input, to just kind of have a piece of paper to say, okay, this is where we're up to at this point in time and looking at everything."</i></p> <p><i>"When you realise that there is so much that needs doing it, no one else is doing this, this family probably had diagnosis and skills lost, like we said, and this is the sort of thing that is missed I think, is really our unique contribution that we use that term to always EPs but what we do bring that's unique, which is pulling everything together."</i></p>
<p>Supporting over time and help to</p>	<p>involvement over time through attending annual reviews</p>	<p><i>"...I think I wrote one about annual review, which again, is part of that statutory process, but it was I didn't do the original EHC for this young person.</i></p>

prepare for life after education.		<p><i>And there was a lot of change. Because the EHC advice had been written at the point of the illness for this young person. So, a very, very different picture. So, the school staff and family were confused, what's Why is it so different and why it why we're seeing what we're seeing. So, I was able to unpick the other piece of advice that was in there from the original assessment and sort of help everyone to understand that that was from a point in time and it's not that we're saying that that's not right, that was right for that situation. But now this presentation is really different."</i></p>
	Preparation for adulthood	<p><i>"...supporting key adults to think about factors such as PFA, just because obviously, and obviously I'm thinking more I'm going back to this particular case, because it was on such a very extreme end of the scale. I have had some of the more kinds of plan do review consultations as well but just with this one, thinking about how we have a role in because their adulthood is going to be very different to what they were anticipating it to be. So just using our knowledge of being able to ask those right questions, because we've done maybe lots of post 16 work or things like that, and, you know, just thinking about those different aspects of independence and what that can look like."</i></p>
Having knowledge to draw on from CPD	Have accessed CPD	<p><i>"Drew upon whole service and quite brain injury training that occurred a couple of years before and that information sharing to enhance your own CPD, and knowledge as well as that change for the young person".</i></p> <p><i>"What it did do was I knew that I'd got a resource that could look at which I did before I went to the first meeting. And it did. I did feel that this was</i></p>



		<p><i>something that so I might have probably felt less anxious than I would have done. had I been... or would I have been anxious?"</i></p> <p><i>"I did the training with the Child Brain Injury Trust, which was amazing(...) So, when I did that training. I realised I was like, gosh, I didn't know that. Brain injury can affect all these different areas and there are areas that often come through in consultation, and it's Oh, Child's naughty child's misbehaving. And actually, to be able to say, well, no, you know, memory and executive functioning and all these kinds of areas. It might not be that it might actually be this. So just being able to I think I put one about reframing as well, which is a similar thing."</i></p>
	<p>Sharing CPD with others</p>	<p><i>"So, I'm doing like a, an ABI input, basically distilling what I got to them. And one thing I've said with my group is can we just put this on the initial consultation framework, you know, when you're asking about the background and the context, just put in, has this child ever been in a hospital has this child ever had one of these injuries or meningitis or anything like that, because it can really change everything. So yeah, I think certainly at university, I don't think we've had a single session, not even referred to, and it's huge."</i></p>

## Appendix 10: Pilot feedback from participants

### Survey:

The following feedback was given from pilot survey participants:

- “Consider including a question to explain where EPs have gained any knowledge they have on the topic”.
- “When inviting EPs to participate in the focus group, maybe explain ‘examples of good practice’ better by stating that people can contribute if they have provided support at any level where they feel their role was beneficial.”
- “Maybe add examples of what the role of the EP could be”.
- “Consider changing the question around the prevalence of acquired brain injury within EP work to the prevalence amongst children accessing education.”
- “It took me 8 minutes to complete, and I found the questions were clear.”
- “It took me approximately 15 minutes to complete as I had work related distractions, but I felt that it was a good length and was interesting to complete.”

### Focus group:

The following feedback was given:

- “I think it would be useful to send out the main question to the participants before the focus group so that they can generate initial thoughts to save time during the focus group. However, I would stress that participants shouldn’t feel they have to prepare anything.”
- “As you are using Jamboard, it may be useful to notify participants of this so that if they are joining the focus group on a tablet, they can download the app in advance, so they are able to participate efficiently.”
- “It may be useful to send a test Jamboard to participants in advance of the focus group so they can have a look at it before the meeting if it is new to them.”
- “I would recommend recording the session on a Dictaphone in addition to using Otter AI software to help with transcription.”
- “I found it very useful when you asked clarification questions. These questions were broad and didn’t influence my answer”.
- “The process was clear throughout, and I feel it will work well for your focus group”

## Appendix 11: Literature Search

An initial literature review on the topic was conducted in November 2021 using the following search terms: child brain injury, educational psychologist, paediatric brain injury, acquired brain injury, traumatic brain injury, educational psychologist role in supporting children with acquired brain injury. A second, updated review was conducted in November 2022.

Evidence from a range of sources and databases were used, including academic literature, Google Scholar, StarPlus, and PsychINFO. By using the references and citations included in important articles, the "snowballing" technique (Creswell, 2009) allowed the discovery of more papers of relevance.

## Appendix 12: Samples from focus group transcription

### **Focus group 1**

#### Excerpt 1:

“Charlotte Kilroy 11:04

Yeah, please do. Super, brilliant. So now we've listed out ideas. I want us to take time to go back and briefly discuss each idea. So the purpose of this discussion is to clarify the meaning of each item on our jam board. It's also the opportunity to express our understanding of what the role involved and the level and the level of impact it had on situation. Please feel free to express varying viewpoints are to agree or disagree with each other. And I am going to sort of keep the pace so that we do have time to sort of discuss each of the items on the jam board and they have equal opportunity for attention. But saying that it's important to note that it isn't the responsibility of the creator of the idea to necessarily discuss or feel obliged to clarify or explain an item if you wish to do so that is great, but any member of the group can sort of contribute and play that role in explaining what they think are. What was it about that from both perspectives, so please feel free to chip in even if it wasn't necessarily your idea in the first place. As the discussion happens, I'm going to begin to move the post it notes into identifying the themes. So if some themes start arising between the different ideas, if you identify anything arising within the answers, please feel free to raise this and contribute to this process. Like I said before, we can add post it notes as we go through this process if more ideas generated. Equally, if anybody wants to make a comment by the Google meet chat, feel free to do so if you don't want to speak aloud. So we'll start with the first post it note which is casework. Does anybody want to maybe expand on that answer? And talk about sort of what their role involved in that case work?

Participant 1 13:36

That was me. Yeah. So I'm happy to kind of kick off discussion and I'd be really interested to hear if you have similar experiences. But the reason I was asked to complete the case work which then subsequently led later on, I did the EHCNA report as well, which I think often happens, but the reason I was initially invited was because school was struggling to understand the implications for the ABI. And they'd had a huge wealth of medical reports and information as a result of the investigations and treatment. And really, we're not understanding basically the changes that are had occurred for the young person. And were looking to have advice from our service to be able to

achieve that. So that's kind of that initial involvement came from people wanting to understand more but almost being overwhelmed with the information they had so almost acting as a mediation person or an interpreter, if you will, to information.

Charlotte Kilroy 14:41

Can I just clarify. So I'll be asking sort of clarification questions throughout. So when they sort of sought that advice from you, had they received any advice from any of that services or had had nothing been offered and they were kind of out on their own and thought we'll we'll ask some advice from the EP service.

Participant 1 15:00

They had been given a, like I said, a wealth of information. And within some of those reports, there were strategies. But those strategies were written from a medical perspective, not an educational perspective. So and I think on one of my other post-its I put about that interpretation of ideas. In order to go from at that Medical viewpoint to a school based context. So helping to understand okay, this is this is what the medical report is suggesting, and this is how it translates to a school context. Just to add in within to that, I think that they were floundering is the word I would use under the weight of information, and also the significant change in personality that had occurred as a result of the ABI.

Charlotte Kilroy 15:47

And how do you think, thinking about the impact of that support you were able to offer? What did you think that that meant for the school and what meant for the young person, thinking about the outcome from that?

Participant 1 16:01

I think that one of the main things was that broadening of understanding. So, drawing everything together, doing that interpretation and problem solving as to how that information can then be applied within the school context, in order to kind of affect change for the young person. And I think some of that was around emotional containment and holding for the staff about their loss of the student they used to know and how that student was then being interpreted. So a change of construction as well about how they were viewing them.

Charlotte Kilroy 16:42

That's really great.

Participant 1 16:43

Yeah, really interesting piece of work.

Charlotte Kilroy 16:45

Super, thank you for that. Would the other participant like to add anything in terms of the topic of casework.

Participant 2 16:51

So, I think this overlap with some of the other post-its, and the certainly looking at the post-its, I think there's a lot of there are a lot of similarities in terms of involvement. But so I was involved. Not prior to the incident, but as part of my role as a school EP, and it became a piece of casework if you like, but I was invited to, I was asked to be invited by the medical team. So they'd asked if the educational psychologist could attend a multidisciplinary meeting, but the school would have asked me anyway, so that would that would have happened. And it didn't feel as though the school was left with. They did have a lot of reports, medical reports and there were strategies and, and there was a lot of that, but the meeting was seen as the vehicle for some of that to be unpicked. And I think my role quite naturally became the sorts of looking at how how can some of this be implemented in practice, within the school setting? As well as lots of other discussion around other things that happened, but I think people who are feeling a bit scared, quite scared is the head teacher was worried and anxious I think about whether they'd be able to cope with a child when she when she came back to school because the first meeting was before she was before she'd arrived back in school and she was still in hospital. And then it became a journey over several months that ended with culminated in the involvement becoming a it became a piece of the EHC application as well.

Charlotte Kilroy 18:49

Yeah. I'm just typing up some of the themes that seem to be arising just already through that conversation of interpreting medical reports and thinking about real implications for the classroom.

Would you agree in sort of that that was a key part of the role was it is that translation into into a classroom environment.

Participant 2 19:18

But I think the thing that Participant 1 said about containment as well, I think that was a really important element to my involvement sounds very similar.

Charlotte Kilroy 19:30

Yeah. I think they were the two main ones from from that aspect that seemed to be a cropping up there. So I'm just going to just move some of these down so we can start grouping them better, and you're gonna copy I'm going to put casework on the both interpreting the medical reports but also containing sorting supporting the emotions of staff and the change that they've gone through. The next one we will look at is the perspective shift from information share to affect change. Does anybody want to sort of expand on that post it note?

Participant 1 20:13

I think that was me again. Yeah, I know. I think it links participant 2 with what you were saying about the anxiety that people can have around, you know, what do we do now for young people with an ABI? And also that, like I said, that that sense of loss that individuals can experience around this change of student functioning, personality, requirements, strengths. And what prompted me to write this, about that that perspective shift was that need to support people to look beyond the brain injury, and see the child or student for who they are now they know their what their character was like now, and yet kind of yes, acknowledging the changes that had occurred, but rather than dwelling on them as a negative, thinking more about what's the here and now for this young person, what do we now need to consider as their strengths and skill base? What do we now need to support them with? So really helping them to shift from the prior to the now following the brain injury, which was what I was talking about how to affect change, because though, as well as the the, you know, the student themselves was very much trying to move on. They didn't really remember themselves prior to the injury because of the nature of the injury. They were thinking about well, this is just you know, it's who I am. Why does everyone keep badgering on about the past. So trying to move everyone else on not the student but trying to move everyone else on from the past to the here and now. And when I say everyone else that includes the parents because the parent was was

very much still trying to move on from the loss of effectively one child to then getting another child almost because there was such a dramatic change.”

Excerpt 2:

Charlotte Kilroy 10:34

Thank you for that. So then, we've only got kind of four more to discuss. I think a lot of them have come up in in other points. But there's a post note around consultation and supervision with the head teacher what to do next, how to respond to parents who are now coping with a different child. Do we think that that falls it seems to fall under that contain in support emotions in staff?

Participant 2 12:06

Yeah, I wrote that. And that's where I'd put it. I think it was. Yeah, I think this is often a role for EPs. In relation to lots of different situations. And, again, it's not as containment it is moving things on as well. A little bit, it's the sort of consultation skills that we have supervision skills and problem solving. With the collaboration that's important so that is difficult head teacher aren't often on their own, aren't they? And that they might not go to other people within school. So being an external, somebody external that they can voice their anxieties to be able to do that, which you might not want to do with other members of staff within school. I think that's an important role for us. We are trusted so they entrusted us with that. And that's important

Participant 1 13:18

I think it goes back to what you were saying earlier about the relational aspect and having a good connection with the people that we're working with, or if they're new people being able to invite that connection and foster that within that small space of time we've got with them is one of the key aspects. And I think that what you're saying they're clear about, you know, supervision is such a key part of our job anyway. But it also allows us to draw on the different levels at which we work. And within that space, we've got the individual level with our knowledge of the student or student functioning. We've also got our knowledge of working at the consultative level with drawing perspectives together knowledge of systemic level working, and also local authority system within system as it were, so we can pull all that together as part of that discussion to help move things on and help people feel supported, which I think is another key element of that supervisory role that we can take.



Participant 2 14:16

Yeah, I would agree.

**Focus group 2:**

Excerpt 1:

“Charlotte Kilroy 1:18

So reading the question, then so thinking about your work with children with an acquired brain injury, how has your role made a difference to the situation? So thinking about what did it involve? How did it help? Now I want to I'd like each of you to take five minutes to list your ideas in response to this question. So using the little post it notes, describing each idea with a brief phrase or a few words, using the post it notes, and then later there'll be an opportunity to sort of expand on these. So when I know about the prompt questions of what you get involved, how did it help, what was the outcome, but that's just to kind of get you thinking, you don't need to write that full answer on one post it note and we'll use one post it note per idea, even if there's a bit of overlap. And so this is an opportunity to reflect on your practice and begin to generate ideas. At the end of the five minutes I'll call time and suggest how we proceed to share our ideas. So if you've not got any questions, you can get started using the post it notes to record your ideas. And I'll be here if anybody has any questions at any point.

Participant 2 1:20

So we do the sticky notes going on the board. One at a time. Yeah, sorry. Sorry.

Charlotte Kilroy 7:50

Two more minutes.

Just 30 more seconds just to finish any ideas off.

Super brilliant, I'm just gonna move us on there will be an opportunity to kind of put more ideas down as we discuss, but I just want to make sure that we've got enough time and I'm not keeping you for too long. So now that we've listed our ideas I want to take time to go back and briefly discuss each idea. So the purpose of the discussion is to clarify the meaning of each item on the jam board. It's also an opportunity to express further understanding of maybe what your role involved and the

level of impact it had on the situation. So feel free to express varying viewpoints as well if you want to voice that you disagree with something that's equally okay. And I'm just going to pace the discussion so that we've got enough time to cover every item on the jam board with equal attention and finally, it's important to note that the person who's wrote the idea doesn't necessarily have to be the one to clarify or expand on that point. Please feel free to both jump in and speak whenever you feel that you would like to contribute. And as the discussion happens, I'm going to begin to move the post it notes into identifying themes. So if either of you identify any themes along the way, please feel free to voice this or equally if you disagree with one of the themes that I've identified. That's also fine to share. So if we start with the one that was on the board, so created a shared understanding about what had happened for the child, does anybody want to kind of expand on that comment?

Participant 2 10:41

That was that was me I think was Yeah, already. Yeah,

Participant 1 10:47

it could apply for both. I think, though.

Participant 2 10:50

I think I think I'm thinking of a couple of cases not not an expert at all in this area. But couple of cases. I think I went in wondering what I could add because I didn't have I didn't think any expertise in this. But I think what what we do have as EPs is that ability to to gather everything that everyone else knew about the situation. And I think the cases I'm thinking of, there was a significant illness for this young person and then the recovery from the physical illness and the physical presentations changed. And there was possibly a presumption from everyone involved that we were expecting that recovery to be everywhere. And it clearly wasn't there was definitely a lot of skills lost. So it was it was about really unpicking what happened, you know, and how big that was, and, and supporting everyone to, to just to just sit with where we were at the moment and not just be waiting for that recovery. So that's what that one was. About using our EP skills that we use across lots of different situations rather than specific around ABI.

Charlotte Kilroy 11:47

Super. Do you want to add anything participant 1 or you do if you've got an experience related?

Participant 1 11:54

No, definitely. I think that is I agree with everything that's been said. Can I add another post it note where I might not allow you to?

Charlotte Kilroy 12:01

Yeah go ahead. As ideas come throughout the discussion. And as we go along, that's absolutely fine. And then sort of move on to talking to maybe with the statutory advice, so bringing the many professionals viewpoints together in one document, and maybe thinking about the benefit of this and what is it that kind of what can this add to the to the situation for the child if anybody wants to start that discussion?

Participant 1 12:33

Was that the statutory one sorry.

Charlotte Kilroy 12:34

Yes. Yeah.

Participant 1 12:36

So that was my one. Because, like participant 2, I've only had a couple of cases with ABI although I've got to say, knowing what I know now, I only know I've had a couple of cases with children with ABI. I'm sure I've actually had more and it hasn't actually been a discussion or hasn't been identified. So for me that this the one statutory I'm thinking of it was a traumatic injury, and there were just so many professionals involved, you know, the whole gamut of the NHS, some physio, OT, hospital teacher, you know, vision, clinical psychologist, everybody, and there was all this information and letters flying around everywhere. So I think it was really useful just to get all of that in one structured document, which I know is what we do anyway. But I just think, especially for a case like that, when there's so much medical input, to just kind of have a piece of paper to say, Okay, this is where we're up to at this point in time and looking at everything.

Charlotte Kilroy 13:41

Yeah, no, that's great. Is there anything you want to add to that participant 2?

Participant 2 13:45

Yeah, I think I wrote one about annual review, which again, is part of that statutory process, but it was I didn't do the original EHC for this young person. And there was a lot of change. Because the EHC advice had been written at the point of the illness for this young person. So a very, very different picture. So the school staff and family were confused, what's what's Why is it so different and why it why we're seeing what we're seeing. So I was able to unpick the other piece of advice that was in there from the original assessment and sort of help everyone to understand that that was from a point in time and it's not that we're saying that that's not right, that was right for that situation. But now this presentation is really different. So it just took took somebody to facilitate that. I think that's what was missing, possibly in in that statutory process because I know it's flexible the EHC process, but sometimes it can just stay where it is for a while. And these reviews just happened, don't they without without much getting updated and changed quite often.

Participant 1 14:47

And we're the people who kind of have that ability to go in and say, right, I can talk to everyone here. Yeah, and I have no qualms in doing so and getting it all together. And that was also another tension. I'm probably going off track here. But when you say about with that was at a moment in time. That was very much a challenge for me writing this advice because I knew even by the time it went to the panel, he was making progress, you know, small steps, but things were changing every day. So very much when you're writing it so that kind of audience thinking about how is this gonna progress over, you know, the next two years because you don't know Do you what that what the trajectory is so"

Excerpt 2:

Charlotte Kilroy 26:03

Thank you very much. So I'm going to take us on to the next one, which I'm going to pick as an EP bringing professionals together and facilitating the discussion using accessible language was helpful for the family to picture possibilities. Does anybody want to expand on that one?

Participant 2 26:20

Yeah, that was that I remember that. That was that was a young, a young one, a little one who was developing typically until about age four. And then there was an illness and, and, and then it was bringing dad into the meeting. We'd had input from the child brain injury trust and we had somebody from another profession, I can't think who it was, I think it was it was someone from

Health I can't think what her role was, but it was really, really helpful. And they thought they were speaking in quite, you know, lots of jargon really. The child brain injury trust person wasn't that that came in through email from the advice from them, but this person from health it was a lot. It's very jargony. And we had that there. And what what I think we managed to do, or I managed to do with the SENCo at that point was to sort of bring that into plain English for the families to understand what that was, and then what that would look like. So what that looked like in school, and then when we were eliciting dad's views about what the presentation was like at home is it as simple of what this person is saying. It was very deficit. You know, this is what this is what we've lost. These are skills that we've lost, and dad was saying how this child was presented at home. And we're able to, again, it's a bit like creating a shared understanding, I suppose, as well but it was accessible. In a world that's probably incredibly confusing really scary when you're just getting on with life with your typically developing children and then wham you know, there's no slowly let's get, let's get comfortable with with with where we are with our children. It's all of a sudden there's a big change and then it was a bit I think the bit where I said helpful for family to picture possibilities. It was a bit negative and deficit based was a conversation that was coming from the person who helped us to try and think what what role they have sorry, and and I think we were able to support reframing about not necessarily recovery, but there will have been recovery conversations in there but about adaptations and adjustments and, and things like that. And we were using that in the in the sense of reframing what we're seeing in school, and how progress is being made in school. So we will say Well, that's an example of what can already happen with just some minor adjustments so we can, we can look at hope for the future, I suppose.

Participant 1 28:33

Yeah, hugely. And then for me, you put that one out having a conversation about strengths and positives, because a lot of the conversations have been about negatives and I think that ties in so well, because after one of these incidences, it's all about what they've lost or what they can't do anymore, or what went wrong and there's all that like, guilt and upset and anger and you know, all of that and then for someone to come in say, so what are their strengths and what what's been going well and what progress have they made and what do they enjoy? I think sometimes we can be a bit blindsided by that because it's Oh, I thought we were gonna sit down here and list all the things. Were not so good. So I mean, I love that part of things. I love that. Like even today. I had a consultation. It wasn't about a brain injury one but again, that kind of thought, well, no one's ever asked me this before.

Participant 2 29:34

Yeah,

Participant 1 29:34

so I think it's really important isn't it with something as big and significant as as a brain injury and the many ways it affects the whole sphere of life at home and at school to actually be able to say, well, these are the things that are you know, these are things that are going well and there is hope and there is possibility there is a future and it's still your child underneath and I like that kind of thing.

Participant 2

I'm just thinking, you're making me think of yeah it's a different future though isn't it I think and when we have the whole expectations for young people around GCSE's, A-levels, university, work, you know there is kind of a way of doing things isn't there. And I think for, we again can do that can't we, because they don't get that message from schools. There is no right path is there like whatever you end up doing is your path, it might look different to what you expected and there is an amount of grieving that comes with that isn't there. For the parents, hearing all about their losses, what skills their child has lost, but also what their path is going to look like, and if we can reframe that like look at all the exciting opportunities they still have, or look at the possibilities that are also really good and will also get you safely into adulthood and enjoy a life, looking forward to something, being enthusiastic about something, if we're strengths based we can do that can't we. But if we just think about school and academic ability, it's not just about learning is it. But all those things we value in schools, you know it's not all about that is it. There is much more to life than narrow school life.

Participant 1

I think at the same time it's walking a delicate line isn't it because we're not trying to minimise or to dismiss or patronise and it's really hard. And again I mean this isn't about a brain injury one but I had a child who had been in school for one hour a day and now that's gone up to 2 and a half hours a day and I was asking this morning you know what's changed, what are we doing to help with that? And the family member said you're talking about that as though it's a good thing and I was like well it has its gone from one hour a day to two and a half hours. Yeah it's really tricky isn't it.

Charlotte Kilroy

It's really interesting to hear your ideas. I am going to move us on to the next one just because I am conscious of time. So I've sort of grouped together a couple here where it said, like what works and what had been tried, what support was still to explore, and then explored what had changed for the child and the family seems to be a bit of exploration and the consultation to ensure support was like the kind of the consultation and the explanation of kind of what's, what's going on before what's worked, and then maybe what's changed and what's going on in the white family to be able to identify what needs they have. Does anybody want to kind of expand on these points?

#### Participant 2

I think that yeah, a couple of those are mine and I think I'm trying to think about what I think I was thinking then about what we bring as EPs in the situation regardless of it. That that will you have that I'm not an expert, I don't know a great deal and I think the first time I came across a referral that said, ABI in it you know I went argh, I don't know what to do, you know, I don't know enough. I don't know anything. I've had a half a day at uni, or something like that. And then and then when, when you realise that there is so much that needs doing it, no one else is doing this, this family probably had diagnosis and skills lost, like we said, and this is the sort of thing that is missed I think, is really our unique contribution that we use that term to always EPs but what we do bring that's unique, which is pulling everything together. You know, when are the exceptions what works, what have you tried that's, that works and that that wider family support again in terms of it's a loss, isn't it quite often for the family of what they thought they had, where they thought they would go in and what their family unit looked like. So isn't this so much bigger than the thing that happened to that young person? And then and the skill set that we now have that we've been left with? So I think that is probably, it is those skills that I felt were much more valuable in myself than doing some research beforehand on brain injury and making sure that I knew and being able to say, I don't know a lot about this, however, let's find out what's going on for you as a family.

#### Excerpt 3

#### Participant 1

That's interesting. Well, no, I'm I think I'm the opposite I. in all areas of my practice, I'm really nervous about a family member asking me the question that I don't know the answer to, so I mean, that's why for me, I'm like, Yeah, I want to, you know, buy the books and read up on it. But also, like, I see my career going down that path. Anyway, you know, so it is, yeah. Yeah, that individual

contribution, it always comes down to bringing everything together and being holistic and it's almost like a cliché, we say, true, because no one else does. They don't do it.

Participant 2

I think I've practised than you in not knowing the answers and when somebody asks a question because I think I think I've gotten to the point where I think you can't possibly know it all can you and especially with this one child with an ABI is not gonna be the same as an extra with ABI and I think yeah, and it Yeah, obviously it's so interesting anyway that it's every time you have a case you do some reading and you go down that rabbit hole don't you read a little bit more and a little bit more? And clearly, quite passionate about it as well in terms of wanting to know more, but I do think I got quite comfortable with saying I absolutely don't know the answer quite a few years ago now so I am probably just don't know the answers. You know.

Participant 1

You could never know all of them in this field like it's it's new developments every week, isn't it? Yeah, definitely.

Charlotte Kilroy 0:04

Okay, so we're getting through them really well. And so we're gonna move on to contributing towards the child attending a different school, which was more appropriate to their needs, maybe helping the discussion around provision. Does anybody want to?

Participant 1 0:22

Yeah, I mean, for me that just comes under that statutory thing, but there's so much. I think a lot of people moan about statutory don't they? And you know, God knows I do when we have eight to do in a half term and all that malarkey, but one thing I really like out of it is that I feel like I'm really making a difference here. Like I really like that. So, so me being just a tiny wheel in that cog or is it the other way around a tiny cog in the wheel. All those many, many many people have had this input for this person. And yet it's kind of this big report that's going to panel and they're going to really look at it to be able to just be that little bit of the jigsaw is really fulfilling and yeah, I like it.

Participant 2 1:10

Yeah, I agree.



Participant 2 1:12

And it does a lot there. There is a lot of advices to do isn't there. However, I agree that you make them, you can get invested in every single one of them, can't you? And I think some people, a lot of them I absolutely agree with the failure there can be so interesting, and the fact that you can leave most of them feeling that you've had an impact is a really good thing, isn't it? I don't think many people can do that in their jobs and I do you know might moan about being busy and being tired and being overworked but I don't want to not do it. I I enjoy doing it every all of my work. I just would like to sometimes be on holiday. it's tricky, isn't it? I just want to be like maybe less busy would be nice, but I don't want to say no to any of you either. So which bits wouldn't you do? I think well, I don't know. But I think yeah, that upskilling and yeah, it's really important, isn't it?

Participant 1 2:23

There's a satisfaction there, isn't it? Yeah. Which is nice.

Participant 2 2:27

Especially with the ABI. It's complicated and it's scary. It acquired brain injury to anybody and it's such a scary three words. You concoct all sorts of things don't Yeah. So just to just just to just to bring it down and get everybody in the room to kind of think well, what does this mean to this young person who we've got here and and do what we do, I think is really important. And other people maybe don't do that. Maybe it's just as do that.

Participant 1 2:53

And maybe it ties back into what you were saying about when you were the people who kind of distil those scary professional reports into what does this mean and what does this look like? Yeah, so again, you know, thinking about your speech therapy reports and, or what have you to actually be able to have a conversation around the table with the parents and saying, Well, what this means is bla bla bla bla bla. Do you see this in class? Do you see this in school? Do you see this at home and they go, oh, yeah, we see that and it's like, Well, alright, then, you know, that's what we mean by working memory or this. Yeah, its nice to be able to do that as well.

Participant 2 3:31

And the big long words can be so scary and when you just like you describe that I could just picture when you're giving an example or what do you see and you're going oh, that's an example of that. And they go Oh, is that all that is that? I mean, not always obviously it's it's obviously that there are

other things that are just awful and devastating and, and huge, huge gaps in in what that child is able to do. But there are some things that may go Oh, that explains that. That's what that is. I know what that is now. I can handle that. I know what that means. So yeah, demystifying, isn't it, I suppose. Yeah. Yeah,

Participant 1 4:05

that's a good word. demystifying, demystifying.

Participant 2 4:07

Doctors don't try and do that. Do they? Just like do it using the really long words I think and then but we've got to haven't made because use the right word.

Participant 1 4:17

Can I just maybe, I don't know. I don't know where it goes. But something else. I really feel like there's a difference between EPs and clinical psychologists. When I read for children that have had input with the clinical psychologist and you know, of the SEMH ones as well, but also with these ones, where it's more of a, the impact of the physical injury. It is so I feel like they are trying to make it as impenetrable as possible to kind of show off I'm Dr. Blah, clinical psychologist and it's like, well, yeah, I'm a doctor too, but I don't write like so again, and also they don't have that kind of section on strengths and what's gone well, it's kind of like this child has, you know, this impact in this area of the brain is affected. And this is going to lead to that. And if you go and google that you're just going to be horrified and it's like where's the hope in these reports? And there you go. That's what you do Charlotte, we bring the hope in.