

Supporting the mental health and well-being of young people with learning difficulties

A thesis submitted to the University of Manchester for the degree of
Doctor of Educational and Child Psychology in the Faculty of
Humanities, and the School of Environment, Education and
Development.

2021

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**SCHOOL OF ENVIRONMENT, EDUCATION AND
DEVELOPMENT**

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List of acronyms

APA	American Psychological Association
BPS	British Psychological Society
CYP	Children and Young People
DfE	Department for Education
DoH	Department of Health
EBP	Evidence-based practice
EP	Educational Psychologist
EPS	Education Psychology Service
LA	Local Authority

NHS	National Health Service
PBE	Practice-based evidence
RCTs	Random Control Trials
SLR	Systematic Literature Review
TEPs	Trainee Educational Psychologist
UK	United Kingdom

Thesis Abstract

Background

Children and young people's (CYP's) mental health and well-being is an important issue within United Kingdom educational policy and practice. Research involving CYP with special educational needs, such as learning difficulties, is limited, even though they experience mental health difficulties more often than the general population. Schools and educational settings are ideally situated to identify and support CYP's mental health. This thesis explores how practitioners can promote the mental health and well-being for young people with learning difficulties.

Method

The first paper (Paper 1) describes a systematic literature review (SLR) into the views and experiences of people with learning difficulties who received therapeutic intervention. Due to the dearth of research with CYP in this area, the study incorporates participants across a wider range, whilst ensuring that the views of some adolescents and young adults aged 11-25 were represented. Paper 1 identified 12 studies examining the views of people with learning difficulties and used the critical appraisal skills programme (2018) to quality screen studies, and a thematic analysis to aggregate the findings.

The empirical study (Paper 2) explored how four practitioners from a specialist sixth form setting in the North West of England supported the mental health and well-being of students aged 16-19. This consisted of virtual semi-structured interviews, which were thematically analysed, and a follow-up focus group gathered more tangible strategies and provision to improve the practitioner utility of the findings.

Results

Analysis of the studies in Paper 1 yielded insight into strategies around the contracting of therapeutic work, importance of clear communication, the therapeutic alliance, and the ending of therapy to promote accessibility and participation in therapy.

Findings from Paper 2 illuminated tangible practice and strategies that are implemented by practitioners to promote mental health and well-being at both the universal and targeted levels. The study also identified facilitators and barriers to implementing such support, which included difficulties monitoring the effectiveness of interventions, access to skills-based training for staff, and difficulties for those with more complex needs and how they communicate their feelings.

Implications for practice

This thesis outlines good practice that can promote students' mental health and well-being, with a population where there is a limited research available. Papers 1 and 2 offer suggestions to practice that can promote universal and/or targeted avenues of support. Further research is needed to explore the implications for practice for younger pupils. Paper 3 defines a dissemination and impact strategy for the research undertaken in Papers 1 and 2.

Declaration

I declare that no portion of the work referred to in this thesis has been submitted in support of any application for another degree or qualification of this or any other university or other institute of learning.

Funding body

This project was funded through England's Department for Education (DfE) ITEP award 2018-2021

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Acknowledgments

I would like to thank my family and lovely friends for their unwavering encouragement and support over the past few years, even whilst we were all battling through the unpredictability of a global pandemic. I would not have been able to complete this journey without you all.

I would also like to express my sincere gratitude to Cathy. Thank you for keeping me calm, offering endless amount of support, and your patience throughout our regular zoom calls, which helped me so much with the journey.

Finally, thank you to all those who took part in this study and showed patience whilst redesigning the study. You made this research possible, thank you!

Introductory statement

Research aims

Within the United Kingdom (UK) there has been a growth in attention towards promoting the mental health of children and young people (CYP) (Department of Health [DoH] & Department for Education [DfE], 2017). Vizard et al. (2020) suggests one in six children (5-16 years) have a probable mental health disorder, a rise from one in nine in 2017 (Sadler et al., 2018). In addition, common mental health problems appear to be increasing amongst 16–24-year-olds (McManus et al., 2016), highlighting the importance of early intervention and prevention. As such, schools are suggested to be in an ideal position to support CYP's mental health and well-being (DoH & DfE, 2017). The overarching aim of this thesis was to contribute to the growing evidence-base around best practice for practitioners who support young people with learning difficulties, to promote their mental health and well-being.

Paper 1 of this thesis, the systematic literature review (SLR), aimed to answer the research question of how access and participation in therapy might be facilitated for young people with learning difficulties. This paper aimed to provide more detail about the experiences of young people with learning difficulties in receiving therapeutic intervention, to learn aspects of best practice for educational settings and practitioners. Due to the limited research available, the scope had to be widened, therefore papers with adults up to the age of 66 years are included, although it should be noted that all of the studies included in the review involved participants aged 25 or under, to reflect the age-range of CYP with whom educational psychologists are involved (DfE & DoH, 2015). Paper 2 of this thesis, the empirical study, aimed to advance knowledge about universal and targeted approaches practitioners use to support the mental health and well-being of post-16 students that attended sixth form in a special school. The research also identified facilitators and barriers to

implementing such provision. Paper 3 is a discussion paper that includes a review of the concepts of evidence-based practice (EBP) and practice-based evidence (PBE) within the field of educational psychology, subsequently followed by considerations as to how the current research will be disseminated.

Researcher's professional background and experiences

The researcher had a prior interest in developing research and knowledge which stemmed from their involvement and discussions with others around post-16 casework as an assistant educational psychologist. Amendments made to the Children's and Families Act (DfE, 2014) meant educational psychologists (EPs) worked with young people up to the age of 25 years. The researcher felt that the educational psychologist service (EPS) was still developing practice around this change, with reference to a limited amount of literature. The researcher was eager to develop their knowledge and practice of working with this age group, particularly as this differed from their primary teaching experiences, and such knowledge may benefit the EPS team, where they will be working upon qualifying.

In addition, the researcher has a younger brother who had an education, health, and care plan to support him to access education. He developed mental health difficulties and required additional support to help him to overcome this; however, he struggled to access therapy which may have been due to the mainstream approaches practitioners were utilising and not adapting them to meet his idiosyncratic needs. Therefore, the researcher was drawn to this research commission from a special school sixth form, located in the North West of England, who wanted to explore the targeted support offered to post-16 students around their mental health and well-being.

The original research design would have entailed the researcher working therapeutically with post-16 students. In anticipation, the researcher had attended additional training to facilitate their skills and knowledge of the Human Givens (Griffin & Tyrell, 2003)

approach. Unfortunately, as described in the sections below the research design had to be changed due to the implications of the COVID-19 pandemic.

Research commissioning and preliminary study

A preliminary study was conducted by the researcher which used a Human Givens (Griffin & Tyrrell, 2003) approach to support a post-16 student with learning difficulties, and was subsequently published in the journal *Educational and Child Psychology* (Attwood & Atkinson, 2020). The paper concluded that the Human Givens approach could be used to provide a template for EPs offering therapeutic support to such students. The article attracted attention of Human Given practitioners and was showcased in the Human Givens Journal (Attwood, 2020) as an example of contemporary practice. Hence, the original aim of the empirical study was to upscale the pilot study and include additional data collection methods. Ethical approval was granted, and participants recruited. However, this coincided with the start of the COVID-19 pandemic. The researcher initially postponed data collection, however the school could not confirm that such individual work would be possible at the start of the academic year. This led to the difficult decision to completely change the research design, with choices limited to those with virtual data collection methods. This led to a new focus on exploring practitioner practice and how school-based staff support mental health and well-being renegotiated with the commissioner. It was anticipated that findings could potentially facilitate the development of practice, policy, and school development action plans.

As a result of the changes made to the design of the empirical study, the SLR (Paper 1) was based on the original research design, therefore it is not as close a match to the empirical study (Paper 2) as had been intended. If Paper 1 had been designed around the completed research project, the researcher would have liked to have explored literature around post-16 provision that supported mental health and well-being.

Rationale for engagement

Alongside EPs now working with young people up to the age of 25 years, just before the researcher commenced their doctoral studies, *The Transforming Children and Young People's Mental Health Provision* (DfE & DoH 2017) was published. This positioned schools as being situated to facilitate early intervention and support for CYP's mental health and well-being. Such developments in practice led to a gap in the research literature, which was further highlighted to the researcher when exploring literature around supporting mental health for young people aged 16-25 years, an identified vulnerable group in the government paper (DoH & DfE, 2017). Thus, the researcher became aware this was an area with limited evidence-base. Alongside this, and the researcher's own interest in the area, this provided a rationale to engage in this research topic.

Paper 2 was commissioned by staff whose rationale for engagement was initially around developing the targeted support they offered to post-16 students to support mental health and well-being. Through further discussion, this developed into using aspects of the Human Givens (Griffin & Tyrrell, 2003) approach as a foundation of this support. The approach was used successfully within a pilot study involving a single student (Attwood & Atkinson, 2020) and a plan was made to use a similar approach with a larger sample and to capture a wider range of data. However, the implications of the global pandemic resulted in direct work not being an option. This led to the redevelopment of the research, and to an exploratory qualitative study exploring the universal and targeted approaches implemented by school staff in relation to mental health and well-being. The research commissioners felt findings would inform practice and highlight areas for possible improvement within their school development plan. The practitioner utility aspect to the design was important as staff wanted the findings to be accessible to other practitioners in similar settings.

The findings from the empirical study are perhaps particularly pertinent, in light of the COVID-19 pandemic, where the long-term effects are uncertain. Notably, the social distancing and isolation measures implemented to manage the pandemic can impair mental health (Brooks et al., 2020) and such impact is likely to be greater for people with learning difficulties because they have limited coping abilities (Countenay & Perera, 2020).

Ethical issues

The research followed the standards outlined in Manchester University's Ethical Practice Policy and Guidance. Informed consent was given by all of the participants, and their right to withdraw was made explicit. Notably, Paper 2 focused on staff, rather than student perceptions about support, because it was not possible to incorporate student views from this vulnerable population due to implications of the COVID-19 pandemic. Therefore, while Paper 1 highlights the importance of agency for young people, it was not possible to address this within the remit of this study.

In relation to research including young people with learning difficulties, studies included in Paper 1 demonstrate possible difficulties other researchers encountered when gaining informed consent.

Evaluation of ontological and epistemological stances

Ontology refers to considerations of the nature of reality and the perspective through which reality is considered. There is a continuum of positions, on the one hand, realism asserts there is one reality and the research inquiry would aim to objectively describe the world (Hathcoat et al., 2018). On the other hand, relativists would argue there is no absolute truth, where everything exists and is interdependent, hence one's beliefs, perceptions, and emotions are assumed to be relative (Hathcoat et al., 2018).

Epistemology is concerned with what constitutes knowledge, and how it is obtained (Scotland, 2012). In this continuum, positivism believes that the one true reality can be

measured using quantitative experimental designs. In contrast, constructivism believes that knowledge is constructed through a person's experiences and social interactions, with this favouring qualitative research designs. The researcher has a critical realist stance (Scott, 2005), which combines realist ontology with a constructivist epistemology. Therefore, reality exists independently of our knowledge of it, whilst accepting our understanding of it is socially constructed (Maxwell, 2012).

Paper 1

In the SLR paper, the researcher included 12 papers that were qualitative in design and provided subjective views about experiences of therapeutic intervention for people who had learning difficulties. Therefore, such views will be influenced by factors such as accessibility and the therapeutic alliance developed during the intervention. The aim of the review was not to study the effectiveness of the interventions, but rather what factors could facilitate such young people to access and participate in direct therapeutic intervention. Therefore, knowledge is not based on the world as it 'really' is, but rather how people construct knowledge through their daily interactions (Burr, 2018). Thus, a level of interpretation was required by the researcher, as it is not always clear what people's distinct view is.

Paper 2

Through the use of qualitative semi-structured interviews, the researcher invited participants to contribute their own experiences, views, and opinions. This derives from individuals' understanding and perspectives of their professional role, as a member of staff working with students with special educational needs and how they support mental health and well-being. Other influences may also exist, such as individual childhood experiences, previous work experiences, and self-efficacy in fulfilling their school-based role. As an individual's reality is constructed by trying to make sense of the world through their unique

concepts, interpretations, and knowledge, the researcher valued all views. The researcher endeavoured to encourage face validity through member-checking the thematic map derived from analysing the transcripts. Therefore, the researcher continues to adopt a critical realist approach; considering the social constructivist notion that a participants' understanding of the world is inevitably formed from their perspectives whilst acknowledging and searching for the existence of an objective explanation (Maxwell, 2012).

Axiology

Axiology relates to the values and beliefs that one holds (Cohen et al., 2011) and encourages researchers to reflect on their intrinsic values and beliefs, and acknowledge how these impact the research (Killam, 2013). Darlaston-Jones (2007) found that when conducting research, personal values can bring bias or prejudice, which could affect how data is collected and interpreted by researchers.

The researcher believes that young people benefit from early interventions and preventative approaches to promote mental health and well-being. This is particularly salient for young people with special educational needs, such as learning difficulties, who are identified as more vulnerable to developing mental health difficulties (Sadler et al., 2018). However, there is a dearth of research to support practitioners to implement evidence-based knowledge when supporting this population of students.

The researcher places high value upon the subjective experiences of the practitioners as the people implementing the universal and targeted approaches. Thus, their collective understanding of their realities will hold great value.

It is important to acknowledge the researcher's values, belief, and attitudes may have influenced the methodology and data analysis process. To help overcome researcher bias, the researcher took into consideration the four factors of trustworthiness for qualitative research: credibility, transferability, dependability, and confirmability (Shenton, 2004).

Credibility is concerned with ensuring the researcher's account is believable and measures what it is intended to. The researcher conducted a pilot study, although this was following the original research design. However, this meant the researcher developed relationships with some members of staff, had some familiarity with the routines and organisation of the sixth form department and had a positive view about how the school was run. This may have affected the objectivity of the analysis, as the researcher was not completely detached from the setting. Alternatively, it could have been facilitative in enabling the participants to give more open and honest answers, as trust and rapport had been developed. After the data had been analysed, participants were provided with an opportunity to member check the thematic map and contribute further tangible strategies to improve practitioner utility of findings.

Transferability refers to how confident one can be that the research is transferable to other contexts. Paper 2 provides an exploration into provision implemented by one sixth form in a special school, which could be compared to settings with similar characteristics as outlined in the methodology section. However, it is difficult to assume that if the research was replicated in another setting, it would arrive at the same conclusions. Instead, this site-specific research may help others to identify facilitators and barriers to the successful implementation of similar provision, as well as suggesting strategies for others to try; therefore, advancing knowledge in this field.

Dependability refers to the notion that if the research was to be repeated, using the same participants and context, the findings would be similar. To support this, the researcher has provided detailed evidence about the research design, data gathering, and analysis process in the methodology section.

Finally, confirmability refers to the idea that data must be informed by the participants' experiences and ideas. The researcher's own propositions are stated within the

methodology section, as suggested in Yin's (2018) case study design. The researcher also had regular supervision where they provided a rationale for decisions made concerning data collection and interpretation.

Links to Psychology

Humanistic psychology focuses on looking at the whole individual and stress concepts as opposed to concentrating on dysfunction; the paradigm strives to fulfil potential and maximise well-being. It is the orientation towards holistic understanding and relational processes (Todd & Bohart, 2006) which are apparent within the thesis and will be described in more detail below.

Within Paper 1 there are clear links to Carl Roger's, Person-Centred Theory (1959), which focuses on the person's subjective view of the world. Rogers proposed that it was the therapeutic relationship that was the critical variable to positive change. This is in line with the findings of Paper 1 which identifies the importance of the therapeutic relationship to supporting participation. Roger's (1957) emphasised the importance of utilising relational techniques such as listening and ensuring collaborative understanding, further supported by the findings in Paper 1 with regard to increasing participation for young people with learning difficulties during therapeutic intervention.

In addition, aspects of the Self-Determination Theory are relevant to Paper 1. This refers to a person's ability to manage themselves, make confident choices, and think on their own (Deci, 1971). This theory suggests that people are driven by innate needs: competence, relatedness, and autonomy; and one's well-being is a direct function of the satisfaction of these needs (Deci & Ryan, 1991; Ryan, 1995). For example, autonomy relates to a person's ability to feel in control of their behaviour, including involvement in decisions associated with feelings of independence. Autonomy can be enhanced when people are given choices (Lopez- Garrido, 2021). In Paper 1, suggested implications for practice includes the careful

contracting of therapy to ensure young people can make an informed decision and understand the upcoming process. Careful contracting by practitioners would promote access and participation which in turn fulfils one's innate need for autonomy.

In relation to Paper 2, there are links to Maslow's hierarchy of needs (1943) which comprises of a five-tier model of human needs (often depicted as hierarchical levels within a pyramid). At the bottom of the hierarchical pyramid is physiological needs (food and clothing), followed by safety (job security), love and belonging needs (friendship), esteem, and finally self-actualization at the top. Originally needs at the bottom of the pyramid needed to be satisfied before humans could attend the higher up needs, however Maslow (1987) later proposed this was too rigid and that the order of needs are flexible and based on individual differences. It is this needs-led approach that feels relatable to aspects within Paper 2, and the suggestion of practitioners implementing provision to support students with learning difficulties to meet these needs, so they are in a place of self-actualisation.

More recently, the Humans Givens theory (Griffen & Tyrell, 2003) was developed and introduced the concept that human beings have innate emotional needs (Humans Givens Institute 2006). This theory suggests that these needs should be met in a balanced way to ensure positive mental health and well-being. If this is not the case, it can lead to emotional distress and mental health difficulties. Therefore, part of the therapeutic process is to help a person to recognise and address any unmet emotional needs.

In relation to an education context, Human Givens has a growing evidence base. Yates and Atkinson (2011) explored using this approach therapeutically with three, 14-16 year olds and concluded that the approach reduced emotional arousal. Attwood and Atkinson (2020) proposed that the approach could provide a template for offering support to students with learning difficulties. Most recently, Waite et al. (2021) conducted a large-scale study amongst UK secondary school students indicated that when innate needs were unmet,

students were more likely to report depressive symptoms. The findings from Paper 2 tentatively suggest that the emotional needs (Humans Givens Institute, 2006) could be used as a framework for implementing a whole-school approach to supporting the mental health and well-being for post-16 students in a special school.

Rationale of terminology

For over a century, there has been an on-going debate amongst professions into the terminology and interpretation of learning difficulties. As a result, there is considerable diversity regarding the definition and classification of such terms. The main difference is across health and education sectors. Health professionals tend to favour the term learning disability, which is the official term used by the National Health Service. The educational sector uses the term learning difficulty as used in education policy (e.g. Special Educational Needs and Disability [SEND] Code of Practice [CoP], DfE & DoH, 2015). Learning difficulty is suited to education practice as it focuses on the learning processes rather than concepts relating to disability. As phrased in the SEND CoP (Dfe & DoH, 2015) learning difficulties is defined under the heading of ‘Cognition and Learning’ (page 97), which specifically refers working at a slower pace and needing differentiation. It also states:

Learning difficulties cover a wide range of needs, including moderate learning difficulties (MLD), severe learning difficulties (SLD), where children are likely to need support in all areas of the curriculum and associated difficulties with mobility and communication, through to profound and multiple learning difficulties (PMLD)...(DfE & DoH, 2015, p. 97)

Thus, as the thesis is written from an educational perspective, the term learning difficulty will be used.

There are a number of definitions, descriptions, and models that exist around mental health. A widely-used definition of mental health is supplied by the World Health Organisation (WHO) (2013):

A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to (their) community. (WHO, 2013, para. 2)

This highlights that mental health is a vital component of daily life and functioning; whilst also highlighting that it is not just the absence of impairments but also personal and social skills that promote optimal functions (Kazdin, 1993). Therefore, this thesis will use the term mental health in relation to this widely-used definition to support reader understanding. In addition, the Children and Young People's Mental Health and Well-being Taskforce (DoH, 2015) recognise a commitment to "encouraging schools to continue to develop whole school approaches to promoting mental health and well-being" (p.19). Thus, the term well-being refers to actions that can help alleviate the development of mental health difficulties (Public Health England, 2015).

Paper 1 refers to therapy, which in layman terms is a treatment which intends to relieve a disorder, such as mental health difficulties. Paper 1 is specifically interested in psychotherapy, which refers to a diverse array of techniques, delivery modalities, and goals, which aim to promote individual or group well-being and self-understanding (Buchanan & Haslam, 2019). There are many different psychotherapies, for example, Paper 1 makes references to cognitive behaviour therapy, psychodynamic therapies and systemic/family psychotherapy. Contradictory to most empirical research associated with psychotherapy, this

thesis is not investigating effectiveness, instead it focuses on how practitioners can facilitate access and participation of therapy for young people with learning difficulties.

For the purpose of Paper 2, the term special school is used. UK special schools are for pupils aged 11 years and older and specialise in one of the four areas of need¹, as outlined in the Code of Practice (DfE & DoH, 2015). For this thesis, special school refers to a setting that provides specialist support for those with cognition and learning difficulties, and may also include students with autism. There is recognition that some findings may be generalisable to all special school settings.

¹ Definition from: <https://www.gov.uk/types-of-school>

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**Paper 1: Therapeutic support for young people with learning difficulties:
what enables effective practice?**

Prepared in accordance with the author guidelines for Journal in Research in Special Education

Needs (Appendix 1)

Abstract

Supporting children and young people's mental health is a central aim of United Kingdom (UK) government policy, with those with learning difficulties a particularly vulnerable group. This systematic review of research uses published literature to explore how access and participation in therapy might be facilitated for young people with learning difficulties. Twelve studies published between 2000-2019 were identified, which described the experiences of access to, and participation in, therapy for people with learning difficulties, although notably most of these involved adults. Findings indicated eight themes: pre-therapy, careful contracting, therapy is hard, idiosyncratic needs, therapeutic relationship, experiences of group therapy, reviewing therapy and it changed my life. These were organised into three chronological stages: setting up of therapy; therapeutic processes and therapeutic outcomes. A number of strategies that can promote access and participation are suggested for professionals working therapeutically with young people with learning difficulties, including: careful contracting, clear communication, creating a therapeutic alliance, and the ending of therapy.

Key Words: Therapy, mental health, access, participation, learning difficulties, young people

Introduction

The mental health of children and young people with learning difficulties

It has been a long-standing political imperative to promote mental health and well-being for children and young people in the UK (Department of Health [DoH], 2011; DoH, 2014; DoH, 2015; DoH, & Department for Education [DfE], 2017). The value and importance of preventative and early intervention to support children's and young people's mental health has been consistently emphasised (DoH & DfE, 2017). A survey by Green, McGinnity, Meltzer et al. (2005) suggested the prevalence of mental health difficulties was one in 10 amongst 5-to-15 year-olds, although data from a smaller, more recent survey suggests the figure is now one in nine (Sadler et al., 2018).

The National Institute for Health and Care Excellence (NICE) (2016) estimated that 36% of children and young people with learning disabilities experience mental health problems at any point in time, rising to 40% for adults. The Children and Young People's Mental Health Coalition (2019) reported that 5-15 year-olds with recognised special education needs were more likely to have a mental health problem (36%) compared to their peers (6%); and that one in seven young people with a mental health problem in the UK also had a learning difficulty. While literature surrounding therapeutic provision for children and young people with learning difficulties is minimal, within the Feeling Down Report (Foundation for People with Learning Disabilities, 2014) families reported that psychological support received was invaluable. NICE (2016) identified psychological interventions as the most evidenced provision for promoting the mental health for people with learning difficulties, recommending these are adapted to meet the needs and preferences of the client. Structured therapies that work for the general population should be expected to work for people with learning difficulties, unless proven otherwise (Foundation for People with Learning Disabilities, 2015). Reasonable adjustments are a legal requirement for all service

providers to avoid putting a disabled person at a disadvantage, as outlined in the Equality Act (Her Majesty the Queen's Government, 2010).

There is minimal research conducted purely with children and young people with learning difficulties around their experience of therapeutic support. During the researcher's initial scoping, only Boyden et al. (2013) and Mishna (1996) studies included all participants below the age of 25. Mishna (1996) obtained the views of 13-17 year-old Canadian students, who had attended a psychodynamic group therapy using a qualitative approach. Participants reported benefits, such as enhanced self-esteem and a better understanding of themselves and their ability to relate to peers; findings suggested that they perceived the psychodynamic group therapy to be beneficial. Boyden et al's. (2013) paper will be discussed in more detail throughout Paper 1.

There is more research involving adults from this population and therefore it may be possible to use this to draw tentative conclusions about how best to support the therapeutic needs in relation to access and participation for young people up to 25 years (DfE & DoH, 2015). Despite this, Brown et al. (2011) reviewed 25 papers on the basis of their relevance to informing future policy, research, education and clinical practice concerning psychological interventions for people with learning difficulties. The paper acknowledges a focus on policy implementation is required to guide national and local developments of therapeutic practice, as well as developing educational pathways to ensure practitioners are skilled and can promote equality of access for clients. Brown et al's (2011) paper recognises that people with learning difficulties have distinct needs, which have to be met during therapeutic interventions. This paper does not specify in detail how these should be met, therefore Paper 1 will tentatively offer implications for practitioners around facilitating access and participation of therapy for young people with learning difficulties by analysing existing research that has captured their voices and experiences of therapy. Prout and Nowak-Drabik

(2003) found evidence of good outcomes and concluded that psychotherapy could be effective and valuable for people with learning difficulties; while a meta-analysis by Vereenooghe and Langdon (2013) found that psychological treatment had an overall moderate effect for treating mental health difficulties for this population.

While quantitative studies tend to focus on outcomes and a reduction in symptoms, qualitative research might illuminate how to facilitate access and participation of therapy. Evans and Randle-Phillips (2018) conducted a systematic review using a meta-ethnographic approach with 16 studies. This study identified five key themes which included: adapting therapy, the therapeutic environments, group dynamics, the therapeutic relationship and the impact of theory on life. This paper concluded that further research needs to be carried out to facilitate adaptations needed to promote the accessibility of therapy and to ensure sure clients feel empowered, fully included, and equal within the therapeutic process. Therefore, Paper 1 explores specifically how access and participation can be facilitated for young people with learning difficulties who access therapy. Paper 1 has a focus on implications of practice for practitioners with the hope of improving the experience for this population.

Therefore, by understanding how psychological therapies are experienced by people with learning difficulties, practitioners can be better equipped to develop appropriate and effective therapeutic services. This is in line with the Preparing for Adulthood (2013) framework, which is about giving disabled young people the right to choice and control over their lives, to achieve their potential and live the life they choose. Alongside this, the green paper *Transforming Children and Young People's Mental Health Provision* (DoH & DfE, 2017) seeks to improve the identification and provision of early help in education settings through proposals such as mental health support teams and a designated mental health lead in schools. Children and young people with learning difficulties will potentially benefit from

these initiatives, but there is a need to ensure that policy and practice is cognisant of their specific needs and experiences in order to be most effective.

Rationale and aims of the current study

The dearth of research relating to the therapeutic experiences of young people with learning difficulties makes it difficult to draw conclusions about effective practice. In an attempt to try to provide practitioners working therapeutically with young people with some tentative guidance, this literature review intends to explore how people with learning difficulties across a wider age range experience therapy, prioritising the voices of younger participants aged 25 and under (DfE & DoH, 2015).

The researcher is aware that the participant age range varies from 11-66 years, but due to the focus of Paper 1 exploring narratives around access and participation of therapy, the age of participants does not feel to be a barrier to exploring how access and participation can be facilitated. Therefore, it feels relevant to suggest implications for practice for practitioners working with 11-25 year olds, based on the wider age range of participants, as it will provide tentative conclusions to a clear gap in the existing literature, to which future research can build on. Therefore the aim of this research is to address the following question: *What does the literature tell us about how access and participation in therapy might be facilitated for young people with learning difficulties?*

Methodology

Search strategy

This study was focussed on a single country (UK), as it was envisaged that it would be difficult to draw conclusions from different countries, because of international variation of the conceptualisation of mental health and learning difficulties and the way in which treatment is offered and delivered. A systematic search of the following electronic databases

was conducted: PsychINFO, Education Research Information Centre, PubMed, SAGE, Web of Science, and a review of British Library of Electronic Theses Online Service. Key search terms were: learning disability or learning difficulty or intellectual disability or mentally handicapped; therapy or intervention or therapeutic intervention or counselling or programme; perspectives or opinions or views or experiences; service user or client or patient or young person or teenager or adolescents or children. Searches were conducted for published papers between 2000 and 2019. Inclusion parameters were developed which included:

- Qualitative paper which aimed to capture people with learning disabilities' experiences of therapy;
- Involved interviews with participants;
- Direct quotes from participants were included;
- Included at least one participant who was aged 11-25 years. Notably, only one located study (Boyden, Muniz & Laxton-Kane, 2013) included participants who were all in the 11-25 age range;
- Research conducted in the UK;
- Written in English.

Outcomes of systemic search

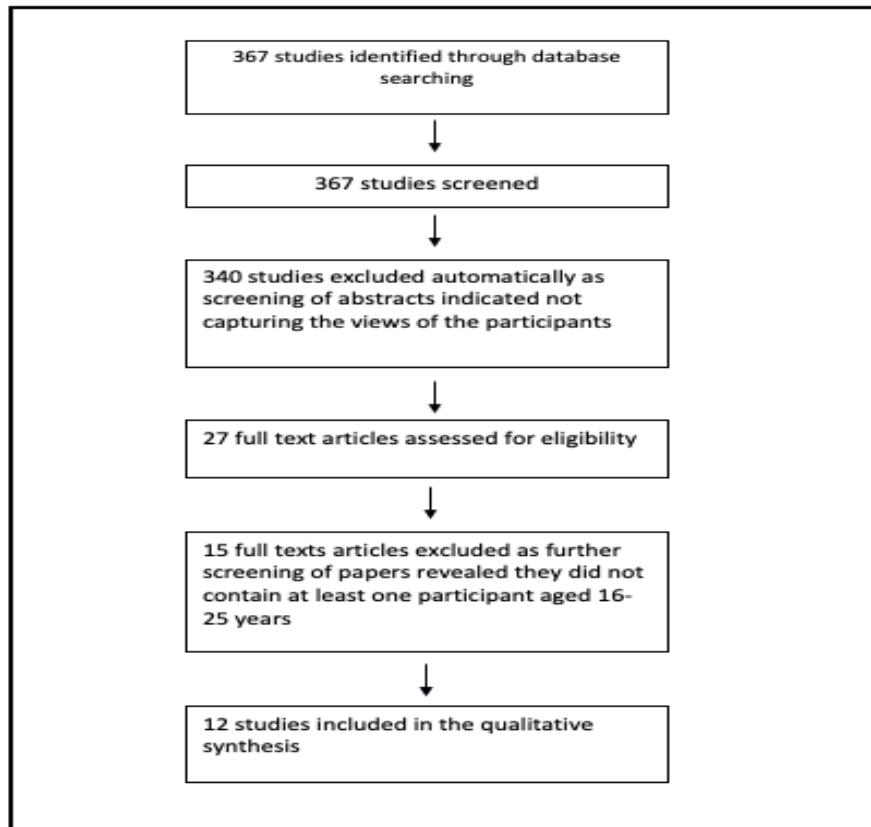
There was an initial screen of 365 articles; and from reading the abstracts 26 articles remained relevant. From the systematic search, 12 papers met the inclusionary criteria, of which three were theses. A descriptive overview of the studies can be found in Table 1.

Figure 1 shows the data screening process, documenting how the 12 studies were selected.

The current review adopted a systematic search strategy that was guided by Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff & Altman, 2009).

Figure 1

The PRISMA Guide (Moher et al., 2009)



Quality assurance

The quality of the studies was reviewed using the Critical Appraisal Skills Programme (CASP, 2018) Qualitative Checklist, to check for potential; therefore, not to include or exclude studies but to provide a guide as to the quality and methodological rigour of the studies for the reader. The researcher used the following judgements to indicate appropriate methodology: yes, partial, cannot tell and no (Appendix 3). The judgements were then assigned a score (yes=1; partial=0.5; cannot tell / no=0) (Appendix 2).

Study Information

This research was conducted from a critical realist perspective which focussed on the explicit meanings of the dataset. Sections of the papers labelled as ‘results’ or ‘findings’ were

analysed inductively, without a prior attempt to fit the data into a theory, using the six-step thematic analysis approach by Braun and Clarke (2006; 2019) using NVIVO software (QSR, 2020). One hundred and seven nodes were initially identified, these were refined to 63 nodes, which later equated to eight themes and 17 subthemes, as seen in Figure 2, through discussion and constant re-checking of the data. The stages of analysis can be located in Appendix 4.

Table 1*Overview of the included studies*

Author/Year	Paper	Sample (Number, age- range)	Research design	Therapy received (type, durations, format)	Data analysis	Main themes identified
1. Anslow, (2013)	Systemic family therapy using the reflecting team: the experiences of adults with learning disabilities	5 participants (4 female: 1 male) Aged: 18-44 years	Semi-structured Interviews	Attending regular systemic family therapy with one or more family members at the time of research.	IPA	Therapists' focus on strengths and difficulties Differences in metacognition Finding a voice in therapy Frustration with outcomes of therapy Managing an unusual experience
2. Arkless, (2004) *	Talking to People with Learning Disabilities and their Families about the Experience of Systemic Therapy	6 participants with learning difficulty. 3 female: 3 male. Aged: 19-47 years.	Semi-structured interviews	Attended systemic family therapy for a minimum of three sessions no more than 3 years ago.	IPA (only analysed result section for 'client views')	Relationship to help Value of therapy Having a voice vs being silenced
3. Bexley, (2017) *	Improving access to psychological therapy	7 participants	Semi-structured interviews	IAPT therapy based on CBT.	Thematic analysis	Helpful clinicians Inclusive service

Author/Year	Paper	Sample (Number, age- range)	Research design	Therapy received (type, durations, format)	Data analysis	Main themes identified
	(IAPT) for people with learning disabilities from service users' and clinicians' perspectives: An action research approach	(5 female: 2 male) (12 clinicians) Aged: 18-54 years.		Participants had received between 6-15, 50-minute sessions.	(only analysed qualitative data from phase 1: service user perspectives)	How clinicians could improve How the service could improve
4. Boyden, Muniz & Laxton-Kane (2013)	Listening to the views of children with learning disabilities: An evaluation of a learning disability CAMHS service	7 participants (2 female: 5 male) Aged: 11-17 years	Semi-structured interviews	All received input from service around mental health issues within the past 3 months	Thematic analysis	Experiences of the services Communication Impact of work carried out Difficulties encountered
5. Currie, McKenzie & Noone, (2019)	The Experiences of People with an Intellectual Disability of a Mindfulness-Based Program	6 participants (2 female: 4 males) Aged: 18-53 years	Semi-structured interviews	Voluntary participation in 11 sessions of a group Mindfulness Based Programme with adaptations. Interviews took place within 6 weeks of last session	IPA	Impact of mindfulness Mechanisms of the group
6. Knight et al., (2019)	"Getting into it": People with intellectual disabilities' experiences	25 participants (17 female: 8 male)	Semi-structured interviews.	Explored the experiences of individualised psychological interventions	Framework analysis	Before therapy Therapy process

Author/Year	Paper	Sample (Number, age- range)	Research design	Therapy received (type, durations, format)	Data analysis	Main themes identified
	and views of Behavioural Activation and Guided Self-Help for depression	Aged: 21 to 66 years.		for depression: Behavioural Activation or Guided Self-Help. Interviews took place within 8 weeks of last session		Relationships in therapy Ending and after therapy Impact of therapy Participants' views on the therapy overall
7. Lewis, Lewis & Davies, (2016)	'I don't feel trapped anymore. . . I feel like a bird': People with Learning Disabilities' Experience of Psychological Therapy	6 participants (5 female: 1 male) Aged: 20-43 years	Semi-structured interviews	Accessed direct psychological therapy from a clinical psychologist and had ended no longer than 6 months prior to the interview	IPA	Setting up of therapy Content and process of therapy Other positive aspects of therapy
8. MacMahon et al., (2015)	'It's made all of us bond since that course. . .' – a qualitative study of service users' experiences of a CBT anger management group intervention	11 participants. (3 female: 8 male) Aged: 22 to 44 years	Semi-structured interviews	Attended a 12-session Group CBT intervention for anger management. Interviews took place up to 2 weeks after the last session	IPA	The importance of relationships A new me New and improved relationships Presenting myself in a positive light What the group didn't change

Author/Year	Paper	Sample (Number, age- range)	Research design	Therapy received (type, durations, format)	Data analysis	Main themes identified
9. Merriman & Beail, (2009)	Service user views of long-term individual psychodynamic psychotherapy	6 males Aged: 22 and 45 years	Semi-structured interviews	In receipt of long-term individual psychotherapy for at least two years or more	IPA	Expectations Dependence alliance Therapy as private Reluctance to engage Positive change
10. Morgan, (2011)*	Reflections of individuals with learning disabilities and their experience of receiving psychotherapy services: An exploration using IPA	7 participants, (6 female: 1 male) Aged: 20-55 years	Semi-structured interviews	Accessing psychotherapeutic intervention with 2gether NHS Foundation Trust. They had undergone at least 10 sessions and currently engaged in the services	IPA	Relationship factors Therapeutic value of talking, Participants' understanding of reason for therapy
11. Ramsden et al., (2016)	Perceived barriers and facilitators to positive therapeutic change for people with intellectual disabilities: Client, carer and clinical psychologist perspectives	3 cases: 1 clin psych & 2 dyads of a client. 6 clients, all male Aged: 19 to 43 years	Semi-structured interviews	Completed individual therapy from specialist intellectual disability psychology service with length of therapy varying from 1 – 3 years	Thematic Analysis (verbatim from clients' perspectives only)	What the client brings Wider system Therapy factors Therapists 'Mental health General Practitioner' Systemic dependency
12. Roscoe et al., (2016)	Dialectical behaviour therapy (DBT)	10 female participants	Semi-structured interviews	Female inpatients of private mental hospitals and	IPA	Understanding DBT

Author/Year	Paper	Sample (Number, age- range)	Research design	Therapy received (type, durations, format)	Data analysis	Main themes identified
	in an inpatient unit for women with a learning disability: Service users' perspectives	Aged: 19 to 57 years		received adapted dialectical behaviour therapy		DBT as helpful and beneficial Engagement with the DBT process

*Note. *Theses*

Abbreviations defined: IPA - Interpretative phenomenological analysis; IAPT- Improving Access to Psychological Therapies; DBT- Dialectical Behaviour Therapy.

Results

Study designs

The 12 studies were all exploratory, qualitative research designs, involving semi-structured interviews. Nine of the studies used interpretative phenomenological analysis, while alternative methods were thematic analysis (Bexley, 2017; Boyden et al., 2013) and framework analysis (Knight et al., 2019).

Sample

Studies involved five to 25 participants aged 11-66 years, with precise ages specified in five studies (Arklees, 2014; Bexley et al., 2017; Currie et al., 2019; Morgan, 2011; Ramsden et al., 2016).

Focus

All papers involved the participants having engaged in a therapeutic intervention, including attending a set number of sessions, group or family intervention, or receiving intervention over a longer period of time. Only in Currie et al.'s (2019) paper did participants volunteer to participate in the therapeutic intervention.

Findings

Based on the analysis of the existing literature, Figure 2 identifies the themes and subthemes. The themes (highlighted in bold italics) and sub-themes (highlighted in italics) will be explored in relation to the chronological processes of setting-up therapy, therapeutic processes and therapeutic outcomes. Exemplar quotes are included, with those from participants aged 11-25 prioritised and indicated.

Figure 2

Thematic Map



Setting-up therapy

In relation to *pre-therapy*, the *referral process* was discussed, with only those in Currie et al's. (2019) paper working with volunteers. Elsewhere, participants were referred to services by other professionals and carers. Participants were not always sure who had referred them, but most were able to describe why they thought they had been referred (Merrimen & Beail, 2009). One of Morgan's (2011) participants preferred to seek familial support, perhaps linking to feelings about the *stigma of therapy*, centred around embarrassment at others knowing they were attending therapy (Morgan, 2011; Ramsden et al., 2016).

Aspects of *careful contracting* included *hope and expectations of therapy* for participants. These included expectations prior to therapy (Lewis et al., 2016); expectations

relating to end goals (Roscoe et al., 2016); and of desired outcomes such as improving mood (Morgan, 2011) and reducing worry (Merrimen & Beail, 2009). For some participants issues around length and frequency of sessions were expressed (Knight et al., 2019; Lewis et al., 2016) which might have been mitigated if addressed throughout the sessions. Morgan (2011) highlighted how previous experiences of therapeutic support could have a lasting impression.

Confidentiality was referred to by participants. Although there was recognition of the need for support (Boyden et al., 2013; Morgan, 2011), there were also concerns about sharing information with parents (Lewis et al., 2016). One of Morgan's (2011) participants was unsure whether the therapy was private or not:

I felt a bit nervous because again I thought if I say all the things I feel, they might say I'll repeat them to someone because every now and again, years ago when I was a lot younger I text saying about my feelings to someone and they repeated it and that is why I felt a bit nervous (p. 71)

Participants made reference to *nerves at the start* of therapy, linked to uncertainty (Knight et al., 2019), meeting the therapist (Boyden et al., 2013; Lewis et al., 2016) and talking about their fears (Morgan, 2011).

Therapeutic Processes

Some participants thought *therapy is hard* as it evoked difficult feelings, with some considering it a risk to disclose sensitive information to their therapist (Arkless, 2004; Morgan, 2011). Some participants had difficulty understanding the programme (Roscoe et al., 2016), with some suggestion that for some, understanding takes a little longer (MacMahon et al., 2015). It was suggested that complete understanding of the mindfulness-based programme was not essential for it to be beneficial (Currie et al., 2019).

Some participants reported that *communication difficulties* impacted on therapeutic work (Ramsden, 2016). Specifically, Anslow's (2013) participants reported a sense of

powerlessness in finding an effective way of communicating, with one recalling not understanding the “long words” (p. 42) used by the therapist in their initial session. Participants in Boyden et al.’s (2013) study valued creative and interactive tools such as books, pictures, Play-Doh and drawings to support communication, with one participant sharing that they preferred to talk and draw. In some studies, the presence of a family member appeared to facilitate communication: “My mum put it into sentence that I do understand” (Arkless, 2004, p. 105).

Practical activities in therapy were mentioned with one participant sharing “some of the things we haven’t really done, we’ve just talked about, they haven’t really been improved” (Anslow, 2013, p. 242); whilst others referred to examples of practical work completed with the psychologist (Lewis et al., 2016). One participant shared how the use of imagery helped with understanding feelings (Boyden et al., 2013). Participants recalled role play activities, which were a source of laughter, although the aim of such activities appeared unclear (MacMahon et al., 2015).

In terms of *support preferences*, Morgan’s (2011) participants were the only ones who spoke about having the option to have a supporter present, although only one participant opted to; linking to themes around confidentiality, as having another adult in the room was not always perceived as helpful (Arkless, 2004). By contrast, one 21-year-old participant (Arkless, 2004) made his own decision to have a parent present:

I was with [psychologist] and she was saying would you like to do one to one, or have someone come with you, and I thought, my mum... all on my own. I thought of that (p. 100).

In one study, participants commented on ensuring activities were age-appropriate was important, for example:

See the pictures, that is [*sic*] something like when I used to go to school. I don't like that I am not a child and I just mean that I don't need to draw daft pictures of wee people...Just because I have problems I don't need daft wee pictures with loads of colours to make me feel, I don't need that (Knight, et al., 2019, p. 827).

Participants reported difficulties developing friendships and support networks (Ramsden et al., 2016) which can influence overall psychological well-being.

Idiosyncratic needs related to difficulties encountered due to *clients' cognitive skills*, limiting their ability to reflect and appreciate different perspectives (Anslow, 2013), complete activities (Knight et al., 2019) or understand an in-session task (Roscoe et al., 2016). A *client's motivation to engage* appeared impacted on the therapeutic process (Roscoe et al., 2016).

An important factor in the *therapeutic relationship* was the *role of the therapist* with valued aspects including discussing things participants wanted to talk about (Morgan, 2011), adapting practice to meet their needs (Bexley, 2017), and identifying support to address their problems (Ramsden et al., 2016). Within family therapy, there was acknowledgement that participants valued the therapist speaking up for them (Anslow, 2013). By contrast another participant felt able to not respond to questions, demonstrating a sense of autonomy (Arkless, 2004). The *relationship with the therapist* was reflected upon by participants, with one 21-year-old stating “when you get along so well you can work on anything” (Bexley, 2017, p. 65). Helpful features included the therapist's ability to convey ease, understanding, and a sense of trust (Lewis et al., 2016; Morgan, 2011) with some participants feeling that the relationship was key to making life changes (Bexley, 2017; Morgan, 2011). In some instances, participants considered the therapist to be a ‘friend’, for example: “[therapist] just comes and is a friend. We talk to each other about all sorts of things, it's good” (Morgan, 2011, p. 92); although a participant in Knight et al.'s (2019) study acknowledged rules about

becoming friends with a therapist. The *function of talking* provided an opportunity to share and offload problems and worries (Boyden et al., 2013; Merrimen & Beail, 2009; Morgan, 2011). By contrast, some participants found talking difficult, with one finding it hard to think about the past (Lewis et al., 2016). Others felt talking was intrusive, especially questions about their family or difficult events (Morgan, 2011).

Three papers involved group therapy with notable differences in the *experiences of group therapy* for participants. A positive aspect noted was the relationships developed from the shared social experience: “I worked out that if you’re swapping stories, it helps each other out” (MacMahon et al., 2015, p. 347). Currie et al.’s (2019) mindfulness-based programme improved participants’ confidence, demonstrated by their increased participation in the sessions. However, some participants recalled negative aspects of group therapy, including feelings of anxiety about speaking in front of the group (Roscoe et al., 2016).

Therapeutic Outcomes

Upon *reviewing therapy*, some participants found the *ending of therapy difficult*, one referring to it as experiencing a sense of loss: “I said to mum, do you think [the therapist] will come to the house? Just do a wee visit to see how I’m getting on, not to stay... So she said, I don’t think she’ll come back” (Knight et al., 2019, p. 826). Others were worried about slipping back without support (Merrimen & Beail, 2009). Perceived benefits of *therapeutic outcomes* were mixed. In a study it was noted that all participants noticed positive outcomes (Roscoe et al., 2016), some refer to the experience as enjoyable (Lewis et al., 2016) and “fun and interesting” (MacMahon et al., 2015, p.346). Some participants talked positively about brighter futures (Currie et al., 2019; Lewis et al., 2016) and therapy helping to overcome the past: “I don’t feel trapped anymore because the past is out of my head. I feel like a bird” (Lewis et al., 2016, p. 451). Some participants felt no benefit from therapy (Merrimen & Beail, 2009) while others reported still experiencing anger post-intervention (MacMahon et al., 2015). In

Anslow's (2013) study, some participants acknowledged progress, while others it seemed felt a continued need for help. There was little criticism of their therapy experiences noted by participants in their evaluations (MacMahon et al., 2013), perhaps due to a reluctance to criticise therapy they felt dependent on, or a fear of losing access to a service (Merrimen and Beail, 2009).

In reference to outcomes from therapy; some participants reflect positively that *it changed my life* (Bexley, 2017; Knight et al., 2019; Lewis et al., 2016). *Practical and behavioural changes* were acknowledged, such as development of practical skills (Lewis et al., 2016), forming better relationships (Arkless, 2004), improved communication and negotiation skills (Roscoe et al., 2016), and changes to behaviour: "I'm a different person now, I used to be all boisterous but I'm not no more, I've calmed right down" (MacMahon et al., 2015, p. 347).

Some participants acknowledged they had to put strategies into practice to experience the benefits of therapy, including those attending Currie et al.'s (2019) mindfulness-based programme, who discussed incorporating the techniques into everyday life. Some of Knight et al.'s (2019) participants continued to use session booklets to remind them of helpful strategies.

Emotional benefits were reported including improved confidence and development of skills to help with heightened emotions: "I was really down at the beginning. I was bottling everything up and couldn't cope with it. It's different now... Everything was going wrong. That's all changed now." (Merriman & Beail, 2009, p. 45). Others reported improved self-identity and self-compassion and were less concerned about the judgement of others (Currie et al., 2019).

Discussion

Within this section, it is not possible to explore all the themes and sub-themes identified in the findings section. Instead the themes that are most relevant to practice with young people will be discussed in more detail.

Contracting

With regard to the referral process, apart from Currie et al.'s (2019) study where participants volunteered to participate, there was no mention of self-referral. While participants were all informed of the referral, there were only two examples of adults initiating and sharing this decision (Arkless, 2004; Morgan, 2011). Being involved promotes a sense of agency and is advocated within Preparing for Adulthood (2013) documentation, for young people with SEND. As stated in the United Nations Convention on the Rights of the Child [UNCRC] (1989), Article 12.1 states "Parties should assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the view of the child being given due within accordance with the age and maturity of the child" (p. 5). In addition, the Mental Capacity Act (The Stationery ([TSO], 2005), applies to those aged 16 and over, and aims to empower people to make decisions as well as protecting those who lack capacity by providing a flexible framework that places individuals at the centre of the process. In addition, Gillick competency is a way of working with those aged 13-16 years to assess whether they have the maturity to make their own decisions, and although it mainly applies to medical practice, it is beginning to be used by practitioners in other settings, such as enabling young people to access therapeutic support, without requiring parental consent. Dunsmuir and Hardy (2016) suggested a procedure for acceptance for therapy, which entails a self-referral or a request for help from a responsible adult, which may lead to signposting to alternative services, such as a specialist bereavement support; or access to activities that promote social inclusion, or acceptance for therapy. At

this point a contract is agreed. Notably, the views of the child or young person do not feature explicitly in this procedure (Dunsmuir and Hardy, 2016), but maybe should be taken into consideration as implied by the UNCRC (1989), adults work ‘with’, rather than ‘for’ children. Day (2007) felt children and young people should have access to developmentally appropriate, personally relevant, accurate information in useable format to assist involvement in their own mental health care, which should be the case and will increase access through increased agency.

Participants’ hopes from attending therapy were often centred around making a specific change in their lives, such as managing heightened emotions (Knight et al., 2019). However, participants often had unclear expectations about the therapeutic process, increasing their apprehension. Dunsmuir and Hardy (2016) suggested writing a letter as a way for professionals to introduce themselves, set a friendly tone and explain what the intervention will and will not entail. Such a strategy might help inform young people of what to expect and reduce nerves. Participants also voiced uncertainties about confidentiality, with some unaware of what information, if any, was being shared (Lewis et al., 2016; Morgan, 2011). Dunsmuir and Hardy (2016) referred to essential ethical considerations prior to carrying out therapeutic work. These include the professional asking themselves: “What has been discussed and agreed about the information shared through therapy? What knowledge and understanding does the child or young person have about the therapeutic approach offered?” (p.10). Considering such questions could promote careful contracting, ensuring issues such as confidentiality are explicitly addressed. This is particularly important given that the Children’s Commissioner (2017) concluded that insecurity about confidentiality was a barrier to young people overcoming mental health difficulties, therefore if achieved by practitioners, it may enhance access to therapy for such population.

Clear Communication

Although participants recognised benefits of attending therapy, there was a sense that for many, it was a challenging process. Areas of difficulty included answering questions (Lewis et al., 2016) and sharing sensitive information (Morgan, 2011) with issues exacerbated for participants with communication difficulties (Ramsden et al., 2016). Such issues could impact the therapeutic relationship, and therefore communication should be at a level appropriate to the child or young person (Boyden et al., 2013), if not they will not be able to participate in the sessions. This could be done through asking clients to summarise their understanding or asking simple questions to check that the level of language is accessible. In addition, research has indicated that young people can find the abstract nature of therapeutic conversations challenging (Dunsmuir & Hardy, 2016) therefore this needs to be considered, especially for those with learning difficulties. Wills et al. (2018) found that making adaptations to meet client's communication needs and ensuring they can express their emotions was a focus for therapists. NICE (2016) suggest recommendations including: explaining content of every session; use concrete, visual imagery and role play to explain concepts; and communicate at a pace that is comfortable for the person. These are relevant considerations when working with children and young people in an educational setting too.

Therapeutic Alliance

The limited research available suggests that, as with the general population (Asay & Lambert, 1999; Jones & Donati, 2009), the therapeutic relationship is key to the effectiveness of therapeutic work with individuals with learning difficulties. In the included studies participants praised therapists, some suggesting they were the key to making the change (Knight et al., 2016). Therefore, a successful alliance will promote participation for young people; beneficial factors included the development of a close relationship (Knight et al., 2016), creating a sense of ease (Morgan, 2011) and having the opportunity to talk about

themselves and their problems (Lewis et al., 2015). Wills et al. (2018) reported therapists working with people with learning difficulties alluded to being client-led, in a comparable way to person-centred approaches, therefore focussing on their client and how they perceive the world, to create a more successful alliance. This is in line with Dunsmuir and Hardy (2016) who proposed incorporating the young person's interests, as well as fun and engagement into sessions to help the alliance. In Boyden et al.'s (2013) paper, young people spoke of the smaller personal aspects as positives, including humour, smiles and talking about interests, which appear to help create a therapeutic alliance, which in turn promotes participation.

There was both confusion over, and recognition of, professional boundaries (Knight et al., 2019; Lewis et al., 2015) which may impact on one's participation within therapy. Participants' blurring of the professional role with friendship might be less problematic in an educational setting, where students are used to daily interactions with professionals. However clear contracting would help to ensure that participants with learning difficulties do not become dependent on professionals, thus reducing their sense of autonomy and probability of accessing future support.

Ending of Therapy

Participants acknowledged the benefits of therapeutic support, such as in Boyden et al.'s (2013) study where the young people felt their problems had been addressed and they had changed as a result. However, the ending of therapy appeared to be a significant part in the therapeutic process which may impact accessing future support. Some participants found this difficult, especially if they had created a 'dependent alliance' (Merrimen & Beail, 2009, p.44), although it is plausible that the adults in the studies may have been more socially isolated than young people, particularly those in educational settings. Wachtel (2002) highlighted that ending of therapy entails a separation, as well as other negative emotions,

such as those associated with loss and separation from someone with whom a person had formed an emotional attachment. Therefore, for a person with learning difficulties, these feelings could be exacerbated; making the ending of therapy particularly difficult. For children and young people, Dunsmuir and Hardy (2016) highlighted the importance of ensuring details about the ending of therapy are made clear from the start, whilst Evans and Randle-Philips (2018) suggested promoting choice with regard to the number of sessions offered to people with learning difficulties. In work with young people, this could potentially be extended to include the option of a follow-up session, which may help the ending of therapy to feel less abrupt, as well as gradually easing any sense of dependency. If the ending of therapy for a young person is considered by the practitioner, this may increase their likelihood to seek support in the future if needed.

Most participants spoke positively about the impact of therapy on their lives and were able to describe particular benefits they had identified, such as relief from nightmares (Lewis et al., 2016) and an emotional release from having someone to talk to (Morgan, 2011). Some participants explicitly acknowledged the importance of generalising what they had learnt beyond the sessions (Lewis et al., 2016) whereas others spoke about skills they had transferred from rehearsal in sessions to daily life, such as breathing exercises (Currie et al., 2019). Others reported continued use of resources beyond the sessions to help generalise skills (Knight et al., 2019). However, to accomplish this, there is a suggestion that young people with learning difficulties benefit from access to additional support and tangible resources that facilitate opportunities to practise and rehearse skills, therefore promoting more active participation in sessions (as opposed to just discussions). This appears to aid them to transfer those rehearsed skills into the real world (Attwood & Atkinson, 2020; Foundation for People with Learning Disabilities, 2015) and increasing the long-term impact of therapy.

Limitations and future directions

Limitations of the current review include the lack of published literature that met the inclusion criteria. Notably 25% were doctoral theses, although it has been reported that there is little difference in methodological quality of unpublished theses (Moyer, Schneider, Knapp-Oliver, & Sohl, 2010). Indeed, McLeod and Weisz (2004) suggested that theses might be stronger methodologically.

The inclusion criteria for this review were narrowed to include at least one participant who was aged 11-25 years, in line with the SEND Code of Practice (DfE & DoH, 2015), and limited to a UK context. Broadening the parameters may have yielded more research, thus illuminating other means of promoting effective therapeutic practice for young people with learning difficulties. Participants included in the papers ranged from 11-66 years, and it is therefore debateable to what extent some of the adult participants' experiences would be characteristic of those of young people, especially as the therapeutic focus might represent priorities at different lifecycle time points (e.g. health or housing concerns; financial or relationship worries). This review therefore advocates for further research eliciting the voices of young people with learning difficulties who have received therapeutic support, such as around mechanisms used to support generalisation of skills into the real world.

Implications for future practice

Based on the findings from this study, Table 2 below suggests implications for future practice with regard to promoting access and participation for young people with learning difficulties. Such implications could be relevant for those professionals who work with young people with learning difficulties and want to bring about a positive change.

Table 2*Summary of recommendations to promote access and participation*

Area to address	Suggestions
Careful contracting	<p>Ensure young person are involved (or at least aware) of the referral, reasons why and what the process will entail, this will allow the young person to make an informed decision to attend</p> <p>Do not assume the reason for referral correlates with the young person’s perception of the problem</p> <p>Pre-therapy considerations such as a letter to introduce the professional and provide accessible information around expectations and the process</p> <p>Ensure confidentiality is explicitly discussed with the young person in an accessible way, which includes what information may be shared and with whom, this may include reference to safeguarding</p>
Clear communication	<p>Professionals to explicitly ‘check -in’ with young people to ensure they are understanding the language used whilst encouraging them to speak up if they are unsure e.g. through use of questions or asking them to paraphrase information back</p> <p>Adapt language to the communication needs of the young person</p> <p>Refer to recommendations made in NICE (2016) guidelines (chapter 1.3.1 Communication)</p>
Therapeutic alliance	Where possible, allow sessions to be client-led

	Use of young person's interest to promote their engagement and make them feel at ease
Ending of therapy	<p>Consideration given to activities that promote the young person to implement skills beyond the sessions through practice and rehearsal of skills</p> <p>Number of sessions is made explicit and revisited each session</p> <p>Option of a follow-up session to 'check in' with the young person</p>

Conclusion

To date, there has been almost no research looking at how young people with learning difficulties perceive effective therapeutic support. To the best of the author's knowledge, this paper is the first to offer empirically-informed practical advice for professionals such as counsellors, therapists, mental health workers, clinical and educational psychologists, and pastoral leads, from the perspectives of a client, to support the mental health and well-being needs of young people with learning difficulties.

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**Paper 2: Supporting the mental health and well-being of post-16 students attending
special school**

Prepared in accordance with the author guidelines for British Journal of Special Education

(Appendix 5)

Abstract

Supporting children and young people's mental health and well-being is central to United Kingdom (UK) government policy, with statistics suggesting post-16 students and those with learning difficulties are vulnerable. This case study explored how practitioners at a special school's sixth form promote students' mental health and well-being. Data were drawn from four semi-structured interviews and a follow-up focus group. The thematic analysis identified a whole-team approach to supporting mental health and promoting student well-being. This was facilitated by staff knowledge and interpersonal skills which promoted effective communication and establishing trusting relationships. In addition, the provision promotes student experiences, whilst helping them to prepare for adulthood. Facilitators and barriers in relation to the current provision were also explored. A tentative conclusion suggests that the Human Givens Institute (2006) could provide a framework for practitioners in a special school's sixth form to plan provision to promote student's mental health and well-being, as well as offer practical and tangible strategies to facilitate this.

Keywords: mental health, well-being, learning difficulties, post-16 students, special school.

Introduction

Mental health and well-being

Mental health exists on a continuum and can fluctuate as a result of life and educational events (Atkinson et al., 2019). Mental health difficulties² refer to the wide range of emotional and social challenges that can impact individuals, leading them to feel stressed, anxious and depressed (Weare, 2015). Promoting well-being can help alleviate the development of mental health difficulties (Department of Health [DoH] & Department for Education [DfE], 2017; Public Health England, 2015).

Children's and young people's (CYP's) mental health has become a priority within UK government policy (DfE & DoH, 2017). Official statistics suggest that one in six 5-16 year-olds in England, have a mental disorder³ (Vizard et al., 2020), with the rate increasing with age. Amongst secondary aged pupils, it was suggested 17.6% had a probable mental disorder compared to 20% of 17-22 years-olds (Vizard, et al., 2020). Kessler et al. (2007) indicated that half of all mental health difficulties begin before the age of 14, and three-quarters of life-long difficulties commence before the age of 24 (Kessler et al., 2005). Therefore, adolescence is a critical life stage (Hagell et al., 2013) and can be a period of increased vulnerability (McLaughlin & King, 2015). Hence, improving support for 16-25 year-olds was a focus of the UK government's green paper (DoH & DfE, 2017).

Sadler et al. (2018) identified that CYP with special education needs and disabilities are at greater risk of developing mental health difficulties. For CYP with learning difficulties,

² The term 'mental health difficulties' will be used to refer to the wide range of mental health, emotional and social challenges, difficulties, conditions and illnesses that can develop such as stress, anxiety, depression and self-harming.

³ According to Vizard et al. (2020) they define mental disorders as identified in the International Classification of Diseases standardised diagnostic criteria using the Development and Well-being Assessment. To count as a disorder, symptoms had to cause significant distress to the child or impair their functioning.

the reasons for experiencing mental health difficulties are similar to the general population, such as: physical health, loss, change, bereavement, and transition to adulthood (Foundation for People with Learning Disabilities, 2005). However, mental health difficulties can be heightened, due to limited cognitive and communication skills which may hinder their ability to recognise and label emotions (CYP's Mental Health Coalition, 2019). There is also the tendency to misattribute problems to existing disabilities, as opposed to potential underlying mental health difficulties, known as diagnostic overshadowing (Jopp & Keys, 2001). Those with learning difficulties find it harder to form and maintain relationships, and therefore tend to have fewer friends (Solish et al., 2010) increasing feelings of loneliness and reducing support networks. A further barrier is their reduced capacity to find creative and adaptive solutions to challenges, which can negatively impact mental health (Better Outcomes New Deliver, 2014).

School as a source of support

Improving support for mental health and emotional well-being in schools is a key issue in the UK (British Psychological Society [BPS], 2019). The role of schools in supporting mental health was highlighted in the UK green paper (DoH & DfE, 2017), which aimed to create a joined-up approach between education and health. It recognised school as a non-stigmatising environment, able to facilitate a graduated response, making interventions more acceptable and accessible. Nearly one in five (19%) families reported that their child's school identified their mental health difficulty, with 21% first approaching teachers for advice and support, in comparison to 38% via their doctor (CYP's Mental Health Coalition, 2019). Due to the large percentage of time CYP spend in education settings, school staff need to be viewed as an important source of support (Doyle et al., 2017).

The National Institute for Health and Care Excellence ([NICE], 2008, 2009) and Public Health of England (2015) advocated for schools to adopt whole-school approaches to

supporting CYP's mental health and well-being. Whilst this idea seems logical, findings from studies into the effectiveness of whole-school mental health interventions have been equivocal. For example, the systemic review by McKenzie and William (2018) found neutral to small effects of universal UK mainstream school-based interventions. This study highlighted the difficulties of conducting research in schools and found issues related to fidelity of interventions, use of validated measures, and limited follow-up data.

Targeted approaches to support the well-being of students with learning difficulties

White et al. (2017) illustrated a range of activities used to support mental health provided in schools and colleges. Their case studies included 26 schools and colleges, of which five were special schools. However, the findings of special schools and pupil referral units (PRUs) were entwined, therefore specific data for special schools cannot be extracted. White et al. (2017) identified that special schools and PRUs viewed their approach to supporting mental health and promoting well-being as integral to their role as an educator. They were more flexible in their approaches and provided a more extensive range of provisions. Their approach to mental health was embedded across all staff, and referred to as a "whole staff approach" (p.24). In Robson's (2019) report into well-being supportive approaches, only one of the promising interventions identified was researched with children with special needs and there was no direct reference to students with learning difficulties' perspectives being sought.

Paper 1 of this thesis is a systematic literature review (SLR) exploring people with learning difficulties' perspectives on how access and participation in therapy might be facilitated. The only included study involving participants all below 25 years (Boyden et al., 2013) proposed communication pitched at an appropriate level and openness around approaches and aims of intervention as strategies to support young people's participation. In conclusion, Paper one called for: communication to be accessible; embedded opportunities to

practise and rehearse skills; the development of a therapeutic alliance; careful contracting of casework; and carefully considered endings, as important factors in promoting accessibility and participation.

Therapeutic support for students with learning difficulties

In what is, to the author's knowledge, the only published study detailing school-based post-16, therapeutic work in a special school, Attwood and Atkinson (2020) described an intervention with a 17-year-old male student, using the Human Givens (HG) approach, which offers a practical organising framework to facilitate positive mental health (Griffin & Tyrell, 2003). This proposes that for an individual to be emotionally healthy, the following emotional needs should be met: security, receiving and giving attention, control, feeling part of the wider community, privacy, emotional connection to others, sense of status, sense of competence, and meaning (Human Givens Institute [HGI], 2006). A large-scale study amongst UK secondary school students, indicated that where these needs went unmet, students were more likely to report depressive symptoms (Waite et al., 2021). Attwood and Atkinson (2020) proposed that the approach could provide a template for offering support to students with learning difficulties.

This research seeks to address the gap in examining whole-school mental health and well-being practice, through a single-case exploratory study that explores support offered to post-16 students attending a sixth form in a special school. At the outset it was hoped that this could provide potential structures of support for practitioners working in similar contexts.

Method

Design of the study

This study adopted a critical realist perspective (Maxwell, 2012), using an exploratory single-case-study design with an embedded unit of analysis informed by Yin (2018). The case was defined as 'mental health and well-being support within a special school's sixth

form'. The overall aim was to conduct an in-depth analysis from the perspective of the participants, to identify supportive provision and strategies for students with learning difficulties, as well as facilitators and barriers to effective delivery.

Drawing upon Yin's (2018) framework, the following components and stages of case study design were considered:

1. Research questions
2. Theoretical propositions
3. Units of analysis
4. Gathering data to link to the propositions
5. The criteria for interpreting the findings ensuring the validity of the data analysis

The first three components will be explained in Table 3 below, with the fourth and fifth embedded within the data gathering and analysis sections.

Table 3

Three components of research design (Yin, 2018)

Components	How components addressed within the research design
Research questions	<ol style="list-style-type: none"> 1. How do professionals in a special school's sixth form promote mental health and well-being? 2. What are the facilitators and barriers to promoting student mental health and well-being?
Theoretical propositions*	Although limited research has focused specifically on how mental health and well-being is promoted for students attending special schools, relevant literature, including research findings from Paper 1, suggests the following propositions could be made:

	<ul style="list-style-type: none"> • The relationship between staff and students will be key to providing appropriate and effective emotional health and well-being support; • There will be challenges when supporting students to promote and develop their emotional awareness and regulation, due to difficulties with cognition and learning, or conditions such as autism; • Staff will need to adapt strategies and techniques to meet students' bespoke needs; • There will be challenges for staff around the boundaries of confidentiality.
Units of analysis	An embedded unit of analysis was the most appropriate case study design, as shown in Figure 3.

Note. *Propositions helped to guide the interview schedule (Appendix 9).

Figure 3

The case study design

Case: School-based mental health and well-being provision
Context: Special school's sixth form provision
Unit of Analysis: Staff views about mental health and well-being provision

Participant recruitment and information

The setting involved in the study is an Ofsted⁴ outstanding-rated special school, which is part of an academy trust, in North West England. It caters for students aged 11-19 years old

⁴ Ofsted is the Office for Standards in Education, Children's Services and Skill, responsible for school inspections in the UK

with around 180 on roll, with 50-60 attending the sixth form⁵. The headteacher and sixth form staff commissioned research from the university, to explore good practice in relation to students' mental health and well-being.

Staff participants were recruited from the sixth form, which supports students with severe and profound learning difficulties, all of whom have education, health, and care plans (DfE & DoH, 2015). The researcher used purposive sampling to ensure a range of staff were recruited. Participants provided written, informed consent (Appendix 7 and 8) following university and Health and Care Professions Council's (HCPC, 2016) ethical procedures (Appendix 6). Participant information can be found in Table 4.

Table 4

Participant information

Participant	Brief description of role (provided by the participant) in relation to supporting mental health and well-being
A (female)	A tutor who holistically supports students through daily monitoring of well-being, which includes setting targets and implementing both universal and targeted interventions to achieve these
B (male)	A form tutor role
C (male)	An educational psychologist (EP) who provides individual, group, and systemic support to promote mental health and well-being for student
D (female)	Assistant principal and lead teacher for outreach support, who is involved with multi-agency working and supporting students and families in need of additional well-being intervention

⁵ The sixth form caters for students aged 16-19

Data gathering methods

Data gathering methods relative to the research questions are shown in Table 5.

Table 5

Overview of data gathering methods

Research Question	Data Gathering Methods
How do professionals in a special school's sixth form setting promote mental health and well-being?	Interviews Researcher's field notes from focus group
What are the facilitators and barriers to promoting students' mental health and well-being?	Interviews

The participants took part in individual semi-structured interviews, which, due to COVID-19 restrictions, were conducted virtually. The schedule was informed by the study propositions, research conducted within Paper 1, and professional knowledge from the author's role as a trainee EP, which included work in special schools (Appendix 9). All interviews were transcribed for analysis.

Following the thematic analysis (Appendix 11), the data generated themes linked to systemic support; however, there was limited detail of specific strategies employed to promote mental health and well-being. Because the aim of the research included a focus on highlighting supportive strategies, an additional virtual focus group was held with the four participants (Appendix 10). This provided an opportunity to present the thematic map to participants and ask for feedback through the process of member checking (Cote & Turgeon, 2005), as well as gather tangible strategies, techniques, and provision implemented by

participants in relation to the generated themes. The researcher recorded the focus group and listed strategies via fieldnotes (Appendix 12).

Data analysis methods

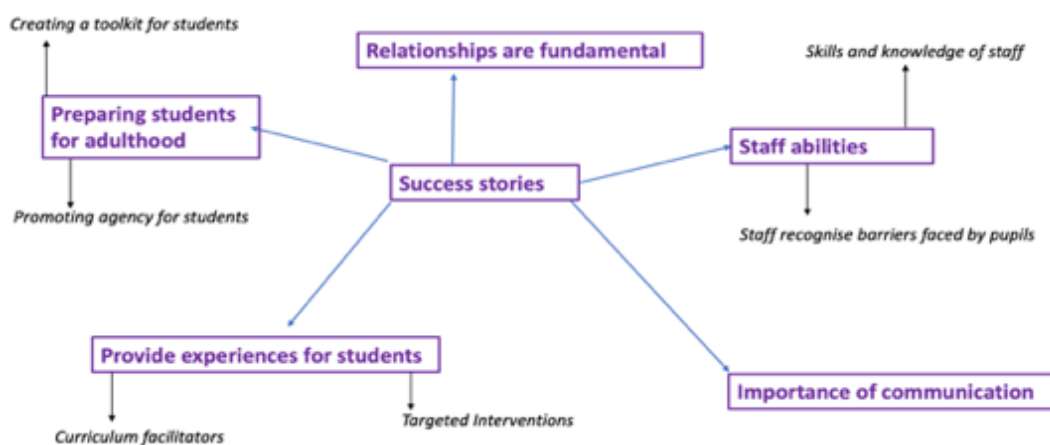
The transcribed interviews were analysed using a reflective thematic analysis approach outlined and revised by Braun and Clarke (2006; 2019). Semantic themes were generated inductively and derived from the words of the participants, with the research questions and interview questions also used deductively as a framework for analysis. Researcher fieldnotes from the focus group complemented the analysis. Inter-rater coding did not take place as this was not congruent with the aims of the qualitative research (Braun & Clarke, 2019) (Appendix 11).

Results

Figure 4 represents six themes and six subthemes identified from the analysis. In the following sections, the two research questions will be answered simultaneously, with quotations included where applicable. Themes will be identified in bold, and subthemes using italics.

Figure 4

A thematic map identifying themes and subthemes



Success stories emphasise good practice implemented to promote mental health and well-being, which were facilitated by intervening early and staff being proactive in their approaches to helping students overcome such difficulties. The participants reported working with students to help overcome barriers such as limited emotional literacy skills, demonstrating adaptability and confidence to try alternative strategies, and building their skills and knowledge.

One way to promote mental health and well-being was to **provide experiences for students**. *Curriculum facilitators* included adapting teaching to develop students' skills and abilities to promote their well-being. The "essential" (Participant 2 [P2]) morning tutor group session allows students to remain in the same group throughout sixth form to maintain relationships and routine.

It just starts with seeing those students at the same time...we're the first face they see every day and they get a little bit more...it's not just 10 minutes, quick register...it's when we'll recognise...if a student walks in the room and they're not OK or if they're just a little bit withdrawn today...and we will talk and listen to how we can help them [P1].

"Social community time" [P2] offers activities which promote social interaction, such as running a café. In addition, work experience placements provide novel experiences and the development of essential life skills but can cause "mass anxiety for some" [P2]. Staff work closely within the academy trust to provide opportunities to facilitate monitoring and liaison with providers, to maximise the chances of successful placements. Having access to such resources facilitates the participants ability to secure such opportunities for all students. Drama was recognised as a tool to promote student well-being through self-confidence and rehearsing of different emotions.

Targeted interventions included those focussed on promoting emotional literacy skills, managing anxiety around transition, and developing social skills, through impromptu individual work, planned individual sessions, and structured group interventions. Recently, a group intervention, co-delivered with the EP, focussed on worries about transition to college. As well as practical life skills strategies, the intervention also included psychological elements:

Then there was [sic] things about not knowing what to do...when you're worried or upset or anxious, so we kind of built-in self-regulation strategies, but we also built in...what anxiety is, what happens in your brain...at a relatively simple level, but in enough detail so they kind of understood it. And that actually...those feelings of anxiety are...helpful in some situations...for a range of reasons. We tried to give them that kind of psychoeducation...self-regulation strategies [P3].

Other self-regulation strategies were demonstrated and practised as part of the intervention. These included: exercise; listening to music; progressive muscle relaxation techniques; guided visualisation; and breathing techniques. A helping factor recognised by staff is student openness to trying strategies.

A self-referral system enables students to refer themselves for EP involvement. At the start of an academic year, the EP holds a student information presentation about the process, which is reinforced by tutors throughout the year. Completed paperwork is triaged by staff who will either complete the referral or offer pastoral support. Referrals to the EP typically involve access to 4-6 individual sessions.

A barrier appeared in relation to measuring the impact of interventions, which is typically measured by observation. P3 suggested more formal pre- and post- measures could be considered for future practice. Gaining informed consent was discussed; in instances

where there was uncertainty, parental consent was sought. It was observed that students had demonstrated their right to opt-out.

Relationships are fundamental, and supported by staff investing time to build trusting relationships with students, using techniques such as learning about their interests to promote engagement. Staff inform students if they are going to share information with others before doing so, which appears to facilitate the trusting relationships. The importance of promoting peer relationships was also emphasised, for example, P4 reflected on supporting a non-attendee:

We also did... messages from the students for her when we went and did the home visit. So her friends in school were saying, "When we see you...we'll be glad to see you back." So she...tried to sort of re-establish those relationships... You could tell that they [mum and student] were really pleased...that she felt wanted and part of something. Because I think she lost that. [P4].

A barrier acknowledged was the sense of powerlessness to promote students' networks outside school. For some, school offers students their only opportunity to meet and socialise, meaning non-term time can be isolating.

Staff abilities were important, including *skills and knowledge*, with a focus on building capacity through training, often facilitated by EP support. Upskilling staff was significant in providing students with the knowledge and skills to be proactive in supporting their mental health and well-being. Staff co-deliver interventions with other professionals and access regular training, such as implementing Zones of Regulation (Kuypers, 2011). Staff can access 'drop-ins' with the EP, which provide an opportunity to problem-solve, reframe thinking, and explore alternative strategies, and supervision is offered to staff with significant pastoral responsibilities, although currently only one individual accesses this support.

There was a sense of challenge around reducing feelings of distress for students with more complex needs. P3 noted a barrier around the limited information available to professionals working in similar contexts: “There’s not...a great deal out there in terms of, ‘This has got a really strong evidence base for this particular population’”.

Staff recognised barriers faced by students, including student difficulties with reflection, peer relationships, and understanding emotions. For this reason, explicit reflection activities are incorporated into the curriculum, such as sharing what went well in a lesson or over a day. Students have a one-page profile that references their strengths and is regularly reviewed to help promote understanding of personal skills, and those of peers. Praise is always specifically labelled to ensure that student virtues are made explicit.

Participants felt common requests from students for targeted support tended to be around transition (where issues can be exacerbated by family members openly voicing concerns); difficulties with relationships; and anxiety or low mood. Students are often offered support to facilitate with their transitioning to adulthood and potentially coming to terms with their difficulties, via individual conversations and personal development sessions. Staff recognise the importance of students understanding their identity and promoting a positive sense of self-efficacy to help drive motivation to develop skills.

The **importance of communication** includes sharing good practice which was referred to as a “strength of the school” [P4]. School systems ensure information is disseminated to all staff involved with the student. A facilitating factor included workplace partnerships demonstrated through informal chats over lunch, including the opportunity to exchange successful strategies, such as keeping dialogue as open as possible and joint problem solving with students. Students’ communication skills are promoted through social stories and focusing on skills such as sharing likes and dislikes. Over time, when trust is

developed, most students demonstrate help-seeking behaviours. However, there are concerns that some students' communication skills remain a barrier to promoting their mental health.

Communication with families happens via email, telephone, and in-person to share information or strategies; although this only tended to occur where staff had concerns about a student's well-being. Examples of direct work in the home were reported where there was non-attendance. It was reflected that more regular contact with all families could further facilitate supporting students' well-being.

Preparing students for adulthood included *promoting agency for students* by encouraging seeking help from a range of staff. Other strategies included assigning roles of responsibility to promote student self-efficacy, such as peer mentoring or demonstrating practical strategies during personal development sessions. A commitment from staff to prepare students for post-school life was demonstrated through valuing student voice and allowing independent decision-making, including informed consent. The boundaries of safeguarding appear to facilitate student awareness of what information would be shared.

Creating a toolkit for students entailed staff initiating and/or facilitating strategies to become embedded over time through role-play, rehearsal and repetition of key points. Promoting emotional literacy skills included emotion check-ins such as the use of Zones of Regulation (Kuypers, 2011) or a large pictorial thermometer to identify feelings, ensuring accessibility for students with limited verbal skills. Concerns were noted over students who always refer to themselves as 'okay', prompting thinking about how to develop their understanding.

Other techniques to promote students' well-being included: normalising and validating feelings; psychoeducation (exploring situations using a cognitive behavioural model); co-written social stories; joint problem solving; working to students' strengths (e.g. keeping a diary if they enjoy writing); use of visuals such as Talking Mats (Murphy 1998);

and providing a safe space for students to feel listened to, which was referred to as “really kind of powerful” [P3].

Discussion

Within this section, the research questions will be revisited, followed by considerations of the limitations of the study and implications for future practice.

Promoting mental health and well-being in a special school sixth form

Weare and Nind (2011) proposed a balance between universal and targeted approaches is beneficial to promoting mental health and well-being. While there is limited research specific to special schools, this study suggests that some mainstream universal approaches are appropriate; for example, personal development sessions where well-being strategies are used. This is in line with Marshall et al. (2017) who found that 73% of mainstream and special schools in England implemented similar approaches. The importance of a hands-on approach (e.g. use of drama) to help students generalise skills was explicitly indicated in this setting. Other approaches referred to included psychoeducation aimed at improving emotional literacy to help students identify issues and seek support (Crane et al., 2019). Students appeared to benefit from explicit teaching of emotional literacy skills as well as opportunities to regulate emotions within authentic situations (e.g. work experience) (Nguyen, 2018).

In this study, a whole-team approach provides a solid base for promoting well-being. Students are encouraged to be involved in decision-making, including about life beyond sixth form, an approach suggested within the Preparing for Adulthood (2013) framework which promotes a shared vision. As part of the framework, the use of one-page profiles is suggested, and staff in this study ensure students are involved in co-constructing profiles and make decisions about what they want to include.

Staff interpersonal skills were evident in promoting student mental health and well-being. These facilitated collaborative working with students and promoted positive, trusting relationships (Robson et al.2019), an identified key feature of effective support (see Paper 1). Staff develop skills through staff mentoring and promote emotional literacy through validating emotions and normalising feelings, which in turn encourages students' help-seeking behaviour (Weare, 2015). Although research highlights the importance of promoting staff well-being (Weare, 2015) only one member of staff accessed supervision offered by the EP. Whilst reasons for this are unclear, it could reflect time pressures (Bouchamma & Basque, 2012) which limit capacity for accessing personal support.

Research undertaken by Attwood and Atkinson (2020) with a post-16 special school student highlighted the benefit of using an emotional needs-focussed approach (Griffin & Tyrrell, 2003; HGI, 2006). In this study, participants described meeting emotional needs in a manner congruent with the HG approach. For example, in terms of *control*:

- Staff promoted student autonomy via the self-referral system;
- The aims and structure of the transition group intervention were co-developed with students, helping to create a sense of ownership and ensuring they were not passive recipients;
- Staff prepare students for adulthood by gradually promoting students' decision-making skills and sense of agency and control;
- Students with learning difficulties tend to have decisions made on their behalf, meaning they might not speak up or make decisions for themselves (Foundation for People with Learning Disabilities, 2005). Therefore, staff are trying to develop independence skills imperative for adulthood.

While the example of *control* is expanded, there is evidence that staff were undertaking activities that supported students to ensure all of their emotional needs are met,

as shown in Table 6. Therefore, the framework could provide a template for systemic support, as well as for individual support, as suggested by Attwood and Atkinson (2020).

Table 6

Description of participants meeting student's emotional needs (HGI, 2006).

Emotional Need
Description of provision
Security – access to an environment where we do not feel scared and we are able to develop, learn and be ourselves. Safe environment, build trusting relationships, openness about sharing information, personal development well-being sessions, remain in same tutor group for familiarity, students demonstrate help-seeking behaviour, well-being targets for students to achieve.
Autonomy and control – having some control over what happens to us and what we do. Having freedom to do what we want. Self-referral system, some element of choice within timetable, option to opt-out of interventions, gradually make more decisions (provided with slightly less structure and routine), staff recognise ‘done with not done to’ approach, students help develop aims of intervention sessions (shared ownership).
Attention – receiving good attention from others and giving it to other people. Promote peer interaction, sharing of one-page profiles with form group, staff initiate interactions about student's interests, participate in drama projects, video messages from peers, joint working between staff and students, promote social interaction through targeted intervention.
Emotional connection with other people – having good friends and people around us who we love and who love us back.

Promote relationships between staff and students, allocated social time, video messages from peers, same tutor group to promote emotional connections, promote social interaction through targeted intervention.

Connection to the wider community – being part of something bigger than ourselves, feeling part of a team or group.

Provide work experience opportunities, work as a team: ‘Social Community time’, participate in drama projects.

Privacy – having time and space to ourselves so that we can reflect and think about things.

Promote student’s reflection skills, students access time out when needed, well-being check-ins during tutor group.

Status – being accepted and valued by other people.

All treated like adults, joint working between staff and students, option to opt out of interventions, students given roles of responsibility, participate in drama projects.

Competence and achievement – feeling like we are good at things which make us feel positive about ourselves.

One-page profile (which explicitly acknowledges strengths), drama awards, staff give specific-labelled praise, personal development sessions around well-being, planned reflection activities to build confidence/self-efficacy, participate in interventions e.g. to relieve feelings of anxiety around transition

Being stretched – feeling challenged both mentally and physically to the point where we feel we can be our best.

Co-production of targets, work experience opportunities, regular emotional check-ins, use of psychoeducation to promote understanding of emotions, students experience range of emotions which are normalised/validated by staff, students supported to develop strategies to support well-being (e.g. breathing techniques).

Purpose and meaning – to have people who need us, to have challenge of our life, to believe in something spiritual.

Development of trusting relationships, work towards achieving goals, students given roles of responsibility (e.g. peer mentoring), personal development sessions around identity, work experience opportunities.

Facilitators and barriers to promoting student mental health and well-being

Staff are aware of their responsibility to support students' mental health through helping to identify problems and intervening with additional support. In White et al.'s, (2017) study, staff from special school and PRUs described their role around mental health as of equal or greater importance than producing academic outcomes. While staff received high-quality training (White et al., 2017) this appeared to focus on knowledge and practical strategies, rather than the interpersonal and relational. Short's (2013) research with students attending mainstream settings found a balance of attunement and relatedness between students and staff led to increased self-esteem, greater sense of competence and more opportunities for positive teacher recognition. Paper 1 also highlights the importance of communication skills and building a relationship, therefore staff may benefit from training related to developing relational skills, such as principles of attunement and unconditional positive regard (Rogers, 1959).

A further facilitating factor is workplace partnerships that facilitates staff to support student well-being. For example, the EP co-delivered an intervention with a member of staff before transferring responsibility to ensure sustainability and upskilling of staff knowledge; a model of delivery recommended by Weare (2015). Participants gave examples of targeted interventions which are typically assessed for effectiveness via observable effects; although scaling questions and written evaluation formed part of a group intervention around anxiety about transition to college. Whilst evaluation of student outcomes concerning well-being is encouraged (Dunsmuir & Hardy, 2016) the author is not aware of any research that looks at the use of pre- and post- measures with students attending special school, suggesting an area for future research.

Participants provided examples of working with families, but this appeared to occur when there were underlying mental health or well-being concerns. Perhaps more regular

contact with families may facilitate consistency of support/ strategies between home and school. White et al. (2017) found staff in special schools and PRUs believed engaging families was important to fully support the needs of CYP, which may in turn help support offered around well-being to be more preventative.

Difficulties were acknowledged for students with more complex needs who struggle to communicate emotions and feelings, even with the approaches and strategies in place, as also identified in Paper 1. There is the added challenge of ensuring problems are not mis-attributed to a disability as opposed to underlying mental health difficulties (Jopp & Keys, 2001).

Limitations/ rival explanations

There are limitations to this study, including the single-case-study design within a single context limiting generalisability, and the fact that the research only explored post-16 practice, as the school's priority focus. The participating school commissioned the project, and the research was co-constructed with school staff; additionally, the researcher knew some of the participants prior to data collection, potentially limiting objectivity.

The school was in an urban area with ready access to transport links and workplace providers. It is unknown how being in a different locality, for example, a rural area may impact a school's ability to make links with external organisations, that provide authentic community experiences. This could create further barriers around access to future college and employment services which help promote a sense of purpose and agency (Kaehne & Beyer, 2014).

Unfortunately, due to ethical and moral implications of the pandemic, the researcher was not able to include the voice of the students in this study. Ideally, the researcher would have liked to have included a student focus group. Within this session, the researcher would have shared the thematic map, in an appropriate and accessible manner, which would have

allowed a student-orientated discussion around the provision offered and an opportunity to capture their opinions. It would have identified what provision they perceived to be helpful as well offering the researcher the ability to compare and contrast the findings from students and practitioners.

Finally, data collection took place virtually during the COVID-19 pandemic. While research into the use of video conferencing for data collection is limited, its ability to replicate features of face-to-face interviews (e.g. transmit and respond to non-verbal cues) has been acknowledged (LoLacono et al., 2016). Moreover, Mathews et al. (2018) suggested that application for video-enabled online focus groups provides a useful mechanism for research.

Implications of practice and future research

This study begins to address the gap in research literature for professionals supporting students' mental health and well-being in a special school's sixth form and reveals numerous rich strategies which could support practice elsewhere. There is the potential for these to be organised using the HG emotional needs framework (Griffin & Tyrrell, 2003), which might offer a systemic approach to identifying and addressing students' emotional needs, which practitioners in other settings can populate with their own strategies and best practice. Such a framework could also facilitate the development of more targeted support, as demonstrated by Attwood and Atkinson (2020). Future research could explore the applicability of this framework more widely, and its usefulness in guiding both special school and mainstream practice in relation to student mental health and well-being.

Facilitators included staff understanding of the importance of supporting mental health and well-being, to which further training around relational skills may be beneficial. Barriers to improve practice included implementing methods to monitor effectiveness of interventions and having more consistent contact with families. The sense of challenge to

promote the well-being of those with more complex needs, was further exacerbated by the lack of evidence available to support participants was noted as a further barrier. Given the limited research in this area, there is much scope for larger scale research, building on this exploratory study, to examine practice in special schools more widely, including across the full school age-range.

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Paper 3: The dissemination of evidence to professional practice

Introduction

Developing effective interventions is just the starting point for providing support and improving the health and well-being of populations (Durlack & DuPre, 2008). However, the process of transferring these into a real-world context and then maintaining them is complex and influenced by other factors. This paper aims to review concepts of evidence-based practice (EBP) and practice-based evidence (PBE) within the discipline of educational psychology, followed by considerations around how findings from research can be effectively disseminated. Both areas will be discussed in relation to research described in Paper 1 and 2, conducted by the author, a trainee educational psychologist (TEP) within the area of supporting mental health and well-being for those with learning difficulties.

Evidence-based practice and practice-based evidence in the field of educational psychology

The Health Care and Professions Council (2015) outlined that psychologists are required to engage in EBP in a bid to reduce the wide variation of practice across medical and social services (Fox, 2003). Such a concept originated from the medical sector; Sackett et al. (1996) defined EBP as: “integrating individual clinical expertise with the best external evidence from systematic research” (p.76), to increase effectiveness and accountability. Later, the American Psychological Association (APA) (2006) defined EBP as: “the integration of the best available research with clinical expertise in the context of patient culture, characteristics and preference” (p.273), with this definition also taking factors such as culture, values and participants’ preferences into account. Therefore, in relation to psychologists, it is proposed that the central purpose of EBP is to ensure children and young people receive good quality evidence-based support grounded in scientific knowledge and expertise (APA Task Force on EBP with children and adolescents, 2005). This ensures

psychologists are demonstrating a link between professional practice and research evidence, to inform decision-making.

The APA (2006) proposed three components to EBP: best research available, clinical expertise, and patient characteristics, specifying that each component is necessary for competent effective practice (Roberts et al., 2017). However, Roberts et al. (2017), highlighted that there is a discrepancy between the amount of research attention clinical expertise and patient discrepancies are given, compared to research psychological measures and treatments. Furthermore, it suggests that professional practice should be based on the best available research; suggesting that EBP encompasses various research designs. However, a hierarchy has developed suggesting that some methodologies are considered better quality than others (Fredrickson. 2002; see Figure 5).

Figure 5

Hierarchy of Evidence (Fredrickson, 2002)

1.	Several systematic reviews of randomised controlled trials
2.	Systematic review of randomised controlled trials
3.	Randomised controlled trials
4.	Quasi-experimental trials
5.	Case control and cohort studies
6.	Expert consensus opinion
7.	Individual opinion

Fox (2003) defined: “the accepted ‘gold standard’ for research is a systematic review of randomised control trials” (p.93). However, there have been criticisms of the EBP evidence hierarchy as an accurate reflection of high-quality research. Robson (2011) argues that random control trials (RCTs) are a distortion of scientific activity which limit what

constitutes as evidence; and instead, research design should be dependent on the research question. For example, if exploring reasons for children dropping out of an intervention programme; a qualitative, interview approach would be more appropriate than an RCT (Ramchandani et al., 2001). RCTs may provide a useful starting point for identifying trends and efficacy of approaches, however difficulties in translating evidence based interventions into school settings has been extensively discussed in the literature (Kelly et al., 2008). RCTs are strong in relation to measures of internal validity, but they lack ecological validity.

Salkovskis (1995) outlined an hourglass model to represent a framework for considering the different research designs that contribute to the evidence-base in psychology. A primary phase consists of small-scale research, such as single case-study designs to test interventions, to develop the theory and practice of an approach. There is then a need for research to conform to the most rigorous standards of enquiry, which includes consideration of internal validity to establish effectiveness. Lastly, considerations around generalisability and applicability are addressed through research focussing on external validity.

Furthermore, Taylor and Burden (2000) question the appropriateness of experiential designs for evaluating real-world interventions. They recommend the use of series of small-scale case studies, which employ an ethical and grounded research design which needs to be replicable. However, Fredrickson (2002) argued that this type of research needs to be carried out in addition to experimental designs, to facilitate with the identification of the effectiveness of approaches/interventions, as outlined in Salkovskis' (1999) hourglass model. Therefore, quasi-experiments and case-studies designs, although lesser forms of evidence according to the hierarchy (Figure 1), may be regarded as appropriate within educational research (VanDaal, 2015) and in turn EP practice.

PBE focusses on integrating both clinical expertise and service-led parameters with the best available evidence drawn from rigorous research carried out in clinical setting (Barkham & Margison, 2007). PBE considers different interacting factors, characteristics and contexts which may influence the effectiveness of an intervention (Biesta, 2010). These include factors such as the environment, the setting which the intervention was designed for, and relationships. Hence applied psychologists should continue to adopt other methods of evaluation, including qualitative research, models of professional practice, and case-study designs (APA, 2006) to develop and inform theory and practice. EBP may serve as a starting point when considering effective practice; yet the use of PBE may help to ensure that approaches are appropriate for different contexts and meet the individual needs of children and young people.

Barkham et al. (2010) acknowledged that government bodies and practitioners need to invest and promote PBE alongside RCTs, in order to help address the diversity of real-life practice. For example, in response to the ‘Transforming Children and Young People’s Mental Health Provision’ green paper (Department of Health [DoH] & Department for Education [DfE], 2017), the All-Party Parliamentary Group on a Fit and Healthy Childhood (2019) advocated for a revision regarding what is meant by EBP, with an emphasis on the incorporation of PBE. They reported that listening to the real-life needs of children and families should be “the bedrock of service provision” (p. 43). This paper proposed that PBE is integral to the design of joined-up services in the delivery of mental health and well-being support to children, young people and families that belong to vulnerable groups (All-Party Parliamentary Group on a Fit and Health Childhood, 2019). The paper also recommended that a parallel PBE hierarchy be added to the existing EBP classifications, for those professionals concerned with the evaluation of the quality of research.

In summary, there is a recognition that EPs make an active contribution to knowledge base which lends itself to PBE (Miller et al., 2015). Therefore, EPs are in a position to trial novel techniques and build a practitioner-led evidence-base. By analysing data from single case studies, in complex settings, it may result in generalisable findings and further knowledge around effective interventions (Miller & Frederickson, 2006). However, it is acknowledged that the use of more experimental research to validate practices is also required, hence PBE could be considered a complementary paradigm for EBP (APA, 2006).

This thesis attempts to build on the evidence-base around supporting the mental health and well-being of students with learning difficulties. The aim was to expand the evidence-base relating to practitioners working in a special school's post-16 department, given that students with a special educational need and those 16-25-year-olds were identified as vulnerable groups (Sadler et al., 2018; DoH & DfE, 2017). By contributing to a practitioner-led evidence base, it was hoped the research would be of use to practitioners within the educational field who work with such individuals. This study explicitly contributes to EBP by examining practice within a special school's sixth form department.

The effective dissemination of research

The importance of EBP is widespread, however a research-practice gap continues to exist (Brownson et al., 2018) with only a small percentage of research conducted eventually integrated into policy and/or practice (Woolf, 2008). The transferring of findings into service settings has led to greater interest in the processes needed to more successfully embed research into practice (Fixsen et al., 2009). A reason for the gap is dissemination (Turale, 2011); therefore, an effective process for dissemination will be explored for Papers 1 and 2. This section will review the current literature concerning the effective dissemination of research and notions of research impact.

Harmsworth and Turpin (2000) describe dissemination as the delivering and receiving of a message, the engagement in the process, and the transfer of a process or product. Hence, it is not just transferring of knowledge, but the active uptake of research by consumers (Lawrence, 2006). Within the field of educational psychology, these consumers may be national and local policymakers, practitioners in the education sector, parents, carers and children, and young people (Sherrod, 1999).

Harmsworth and Turpin (2000) purposed three aspects to dissemination. Firstly, *dissemination for awareness*, which refers to target audiences being made aware of the research and its outcomes, without requiring prior knowledge although some recognition may be beneficial. Such type of dissemination may utilise a word-of-mouth approach. *Dissemination for understanding* provides specifically targeted audiences with a deeper comprehension of the findings, with the purpose that they will benefit from them. Finally, *dissemination for action* results in a change in practice as a direct result of the research; therefore, the target audience would need to have an aligned skill-set and knowledge base to access the research and effect change within organisations. These steps illuminate that dissemination is a conscious and proactive process (Harmsworth & Turpin, 2000), which is congruent with the Health and Care Professions Council's (2015) positioning of dissemination as part of the research activity.

Harmsworth and Turpin (2000) discussed methods of dissemination which included: scholarly journals; monographs, books and chapters; professional presentations; newsletters, and the internet. Tabak et al. (2014) found 75% of public health researchers' main method of dissemination was academic journals, closely followed by academic conferences. Although the peer-review process contributes rigour, dissemination through such routes restricts the target audiences to journal subscribers and publication bias may restrict the range of

published research (Kicinski, 2013). This links with Harmsworth and Turpin's (2000) suggestions around purpose and audience, and further highlights the need to go beyond more traditional forms of dissemination that serve academic communities and disseminate findings to those whom the research specifically concerns (Keen & Todres, 2007). In relation to qualitative research, Keen and Todres (2007) reviewed relevant literature and found the main features of successful dissemination were: tailoring the content material to the target audience, paying attention to the source of the message, and promoting active discussions of the findings. The researcher will be mindful of these features when planning the presentations to disseminate findings.

A summary of the policy, practice and research development implications

Paper 1

Paper 1 presents a systemic literature review (SLR) which aimed to explore how access and participation in therapy might be facilitated for young people with learning difficulties, as presented in existing literature. Twelve papers met the inclusion criteria, of which three were theses. The Critical Appraisal Skills Programme (2018) was used to provide a guide of the quality and methodological rigour of the studies, with all studies scoring over half marks. Analysis of the studies identified practical advice for professionals such as counsellors, therapists, mental health workers and clinical psychologists and EPs, who support the mental and well-being of young people with learning difficulties. Encouragingly, people with learning difficulties spoke positively about their experiences of therapy, with some noticing positive change and continued use of strategies beyond the therapy sessions. Implications for professionals emerged which included careful contracting of the therapy to ensure it is accessible to young people and they are aware of the aims and expectations before opting to participate or not. Participation was facilitated by accessible language, with abstract concepts (e.g. emotions) being made as concrete as possible, through

the use of visuals, role play and opportunities to rehearse scenarios. The development of a therapeutic alliance appeared to support the opening up of problems and participation in the sessions. In addition, consideration needs to be given to the end of therapeutic work, such as clear notice that an end is approaching, and the suggestion of a follow-up session. Such approaches will help ease the ending of therapy and in turn they may access such support again in the future, if needed.

Paper 2

Paper 2 reports the findings from an empirical study with staff who work in a special school's sixth form department, utilising Yin's (2018) single case-study design. The design of the semi-structured interview was guided by the findings from Paper 1, to see how the perspective of people with learning difficulties aligned with school's views. Four virtual semi-structured interviews were conducted and analysed using thematic analysis. This was then followed-up with a virtual focus group where participants were presented with the thematic map and asked to contribute tangible examples of how this looked in practice, in order to exemplify practitioner utility within the findings.

Data suggested that school staff employed a range of good practices that support the mental health and well-being of students, with examples on a whole-school and targeted level. Furthermore, support was offered on an individual, group, and systemic basis, with some strategies also appearing in the mainstream literature around supporting student mental health but with some adaptations (e.g. more focus on rehearsal). Staff members' interpersonal skills facilitated the development of trusting relationships, necessary for effective support, as identified in Paper 1. Staff were active in developing their skills to support students, including providing experiences and preparing them for adulthood by promoting agency. Facilitators and barriers were also analysed. Facilitators included staff understanding of the

importance of mental health and promoting well-being for students and workplace partnerships helping to build staff capacity. Staff had access to training, but this could be facilitated by including relational skill-based training. Barriers included monitoring the impact of interventions, contact with families tending to be more consistent where there were concerns, and difficulties ensuring students with complex needs are effectively supported. The analysis highlighted that school staff could utilise the Human Givens (Griffin & Tyrrell, 2003) emotional needs audit (Human Given Institute, 2006) as a practical and psychologically informed framework to facilitate a systemic approach to support meeting students' emotional needs.

Implications for research

An important stage of Harmsworth and Turpin's (2000) dissemination framework is to identify key stakeholders to whom the research should be disseminated. Implications of the current research for stakeholders at the research site, organisational level and professional level are outlined below.

Research implications at the research site

There are individual and group implications for the participants at the research site outlined in Paper 2. School staff who participated in the research were able to discuss their practice as well as reflect on perceived facilitators and barriers to supporting students' mental health and well-being. It will therefore be useful for the findings to be disseminated with all staff, as well as external staff who support student well-being, such as the counselling service. Disseminating findings might facilitate future action planning around school development plans, as well as have positive implications on individual practice.

In addition, the researcher became aware that the focus group appeared to provide a rare opportunity for the participants to reflect upon their practice together. The participants shared that having the space to reflect on the provision they offer and the range of strategies they draw on to support students was helpful. It felt to be an empowering session for the participants who were able to share as well as reflect on others practice. This opportunity may be an option for future continued professional development and an alternative method to offering on-going support to staff and contributing to development of good practice.

The findings from Paper 1 were not directly linked to the research site; however, the findings will be included within the dissemination session, as this will help to increase practitioners' understanding from an alternative perspective. In relation to EBP, this will widen practitioner awareness around how access and participation can be promoted when working therapeutically with young people with learning difficulties.

With regard to the implications for the researcher, the findings from Paper 1 have developed their awareness of methods and adaptations to practice that can facilitate access and participation for students with learning difficulties accessing targeted intervention. Such knowledge will be beneficial if delivering therapeutic work to young person and will also be referred to when working with practitioners around best practice, to ensure a young person gains the most from accessing such support. In relation to Paper 2, the researcher has a more developed awareness around strategies and provision practitioners have implemented to support post-16 students, who attend a special school, around their mental health and well-being. The researcher has developed their knowledge of strategies and provision at both the universal and targeted levels, which, when relevant, will be referred to in their practice for example during consultation, when delivering training, or participating in systemic work.

Implications at the organisational level

Paper 2 includes references to tangible strategies around how practitioners can support mental health and well-being, as well as identification of facilitators and barriers, which should be addressed in practice and policy, to promote further action at an organisational level.

The research site is part of a multi-academy trust, and although it has some distinct policies for the special school, the one relating to student mental health and well-being is for the whole trust. The findings from Paper 2 suggest that although some mainstream practices are appropriate, these do need to be adapted to ensure they are accessible and effective for students attending the special school's sixth form. It is well documented that to embed change the commitment of senior leaders is vital (Madanchian et al., 2017), which one of the participants in Paper 2 was. Therefore, with senior leadership involvement it is hoped the findings will lead to action such as improved practice and creating their own mental health policy. Such changes may include:

- Ensuring contact with families is more consistent and frequent (as opposed to when there is a well-being concern). This will help to build trusting relationships and facilitate implementation of strategies to be more proactive and consistent;
- For school staff to have an understanding of the emotional needs audit (Human Givens Institute, 2006) and how this can be utilised as a universal approach to promoting students' mental health and well-being;
- For staff to have means of monitoring the effectiveness of interventions. This could be strategies such as child-friendly goal attainment scale (Thomas & Atkinson, 2018), an adapted version of goal attainment scaling (Dunsmuir et al., 2009), or the use of

pre- and post-measures such as an adapted version of the Emotional Need Audit (Human Givens Institute, 2006);

- To consider training around relational skills. For example, training that develops awareness and/or understanding of skills such as active listening, attunement, and unconditional positive regard (Rogers, 1959).

A further barrier was ensuring students with complex needs, such as communication difficulties, can access support for their mental health and well-being. This is in line with findings from Paper 1 where clear communication was suggested to facilitate access and participation for young people. Wills et al. (2018) highlighted the importance of making adaptations to meet a client's communication needs and ensuring they can express their emotions as the focus for therapists, suggesting that should be a starting point for education settings to promote well-being for this population of students. Findings from Paper 2 acknowledged that school staff are attempting to develop students' emotional literacy skills, but perhaps this can be developed further through documenting and sharing of PBE for this population.

The case study in Paper 2 identifies the range of provision on a universal and targeted level that is implemented to support students' mental health and well-being. The role of schools as a central site for mental health support was acknowledged in the UK's green paper (DoH & DfE, 2017), with the findings from Paper 2 identifying what support and provision is currently in place within one special school's sixth form. The green paper aimed to promote a more joined up approach between health and education, which is reflected in Paper 1, where literature is drawn from both a health and educational perspective, with findings relevant for practitioners across settings. By including practitioner utility, the researcher hopes the findings will be of benefit to practitioners who work with such population of students,

through offering suggestions to improve individual practice and/or organisational changes such as school policies.

Finally, as scientist-practitioners, EPs understand the importance of promoting all students' mental health and well-being. As a local authority service with a traded service delivery, the findings and implications from both papers are useful with regard to EP practice. In addition, EPs are a central therapeutic resource (Sharpe et al. 2016), therefore the findings from Paper 1 may inform individual practice in relation to promoting access and participation when engaging in such work with young people with learning difficulties. Furthermore, Table 7 outlines further implications for the EP role based on the findings of Papers 1 and 2, in relation to the five functions (Scottish Executive, 2002).

Table 7

Implications for the EP role

Function:	Examples of EP role in supporting the mental health and well-being of young people with learning difficulties
Consultation	<ul style="list-style-type: none"> • Consider factors that affect students' mental health and well-being, including the emotional needs audit (Human Givens Institute, 2006) • If a young person is about to start or is accessing targeted support: share our understanding with practitioners of strategies that can promote access and/or participation
Assessment	<ul style="list-style-type: none"> • Use of observation to reflect on the whole school approaches e.g. are approaches meeting the emotional needs of student(s) (Humans Given Institute, 2006)
Intervention	<ul style="list-style-type: none"> • Support settings to audit and implement whole-school and targeted approaches to meet the mental health and well-being of students

	<ul style="list-style-type: none"> • Contracting and delivering therapeutic support ensuring access and participation is facilitated through implementing strategies from Paper 1
Research	<ul style="list-style-type: none"> • Engage special school settings in action research to promote mental health and well-being provision through identification of facilitators and barriers
Training	<ul style="list-style-type: none"> • Offer training to develop skills around relational approaches (e.g. attunement, active listening) and/or knowledge of the emotional needs audit (Human Givens Institute, 2006) • Offer training around strategies to facilitate access and participation when engaging young people with learning difficulties in targeted intervention, such as therapeutic support

Implications at the professional level

Paper 1 attempts to offer practical advice for professionals such as counsellors, therapists, mental health workers, clinical and EPs, and pastoral leads who support the mental health and well-being needs of young people with learning difficulties. Paper 1 has been accepted for publication in *Journal of Research in Special Educational Needs*, subject to minor amendments. The author also intends to disseminate the findings at their educational psychology services' continuing professional development day which will be attended by the Education Emotional Well-being Practitioner team. Their role is providing therapeutic support for children and young people who have developed social, emotional, and mental health difficulties as a result of the COVID-19 pandemic. Therefore, a summary of the findings of Paper 1, will offer practical advice to inform practice and policies.

Paper 2 findings were derived within a specific context, but they may provide insight for professionals working in a similar setting/ school. The dearth of research specific to special schools is limited, which does not reflect the findings that this population of students are vulnerable to mental health difficulties (DoH & DfE, 2017; Sadler et al., 2018). The

practitioner utility of this study may offer support to those who want to develop their provision and policies around supporting social, emotional, and mental health, an area of need as identified in the Code of Practice (DfE, 2015). Furthermore, EPs may facilitate this process for such special schools.

Papers 1 and 2 may be of interest to trainee EPs (TEPs) enrolled on doctorate training courses. Paper 2 provides examples of universal and targeted provision to support mental health that can facilitate post-16 students who attend a special school. This could also be appropriate for case work with a post-16 student, whose primary area of need is their social, emotional, and mental health, as referred to in the Code of Practice (DfE, 2015). Paper 1 offers suggestions around individual practice should they embark on therapeutic work (a requirement of the University of Manchester doctorate programme) with a young person with learning difficulties.

Papers 1 and 2 highlight useful directions for further research. The dearth of research including young people with learning difficulties resulted in the researcher having to use literature from a wider age range. Therefore, research exploring young people's perceptions and experiences of receiving target interventions in educational settings may help to develop future EBP for practitioners. The implications outlined in Paper 2 suggests the benefits of researchers conducting research into exploring the provision offered by other special schools, including secondary and primary settings, and see how findings compare.

Fallon et al. (2010) suggested that EPs are well placed to work within a range of contexts and roles, which may include organisational and systemic-led work. Paper 2 highlights the potential for EPs to support change within organisations, as the case-study design could be conceived as the initial stages of an action-research process to facilitate change and development within a setting. Action research entails principles of collaboration

with, and empowerment of, practitioners working within organisations by making them integral to change and development (Simm & Ingram, 2008). Therefore, directions for future research may also include involvement in organisational change and development, utilising frameworks such as Research and Development in Organisations (Knight & Timmins, 1995), or Appreciative Inquiry (Lewis et al., 2016) whereby if the outcomes were disseminated, it could contribute to PBE. This may occur as an extension of the current research, or within other special schools that want to develop their practice.

Strategy for promoting and evaluating the dissemination and impact of the current research

There are concerns that the full potential for research evidence to improve practice and inform decision-making is not yet fully established (Wilson et al., 2010). If the research community want to ensure evidence they generate informs professional practice in schools, educational psychology services and local authorities, then investment in the dissemination and implementation processes, as well as the research, is needed. For this reason, the researcher will consider strategies for implementation, as well as dissemination, within the strategy plan, as outlined in Table 8.

Through the dissemination strategy, the researcher aims to:

- Increase awareness and understanding for practitioners in pastoral roles, counsellors, EPs, TEPs and Education Emotional Well-being Practitioners to encourage action that improves practice relating to access and participation when working therapeutically (or delivering targeted support) with young people with learning difficulties;
- Increase awareness and understanding for practitioners, special education needs and disability coordinators, EPs, and TEPs, to encourage action that improves policy and

professional practice concerning universal and targeted provision that supports the mental health and well-being of post-16 students, who attend special schools.

Various dissemination methods, as specified in Table 8, have been selected to achieve the aims, with the focus on matching methods to target audiences to improve chances of success (Harmsworth & Turpin, 2000).

To disseminate findings amongst staff at the research site, a presentation will be given to outline the main findings of Papers 1 and 2 (as indicated in table 8). A similar presentation will also be presented to the educational psychology team that the researcher will be working with upon qualifying. Also, the researcher will host a workshop to disseminate findings from Paper 2 to the special school's network meeting. There is some hope these dissemination methods could lead to the commissioning of traded work.

Consideration was also given as to how to disseminate findings to the wider profession, including school-based staff, EPs, and counsellors. A pilot study for the originally planned research (see introductory statement) was published last year in *Educational and Child Psychology* (Attwood & Atkinson, 2020) providing insight into how EPs might work therapeutically with post-16 students with learning difficulties. Paper 1 has been accepted by *Journal of Research in Special Educational Needs*, subject to minor amendments, which publishes papers which are of interest to: teaching and learning support, advocacy, and educational psychology. Paper 2 will be submitted to the *British Journal of Special Needs*, which is a widely read journal that, unlike some others, covers learning difficulties relating to children in *both* mainstream and special schools and across all levels of education.

Evaluating the impact of dissemination

The purpose of research dissemination is to achieve impact; however, defining and measuring this is challenging (Brownson et al., 2018). Indicators of impact are used by practitioners, policy makers, and researchers, for example the use of journal metrics (e.g.

journal impact factor) or author metric (e.g., h-index). However, these have been criticised as poor measures of impact (Gasparyan et al., 2017; Kreiner, 2016). Consequently, the use of alternative metrics has presented an opportunity to measure dissemination to more diverse populations, to increase likelihood of the implementation of findings into policy and practice (Brownson et al., 2018). Alternative measures include Almetrics (almetric.com) and social networking sites are used such as Twitter and ResearchGate, which targets scholars. The researcher has included reference to evaluation strategies to monitor impact in Table 8.

Table 8

Outline of dissemination strategy

What is being disseminated?	Target audience	Purpose	Timing	Method	Disseminator	Costs	Success criteria
A wider understanding of the findings of the pilot study	EPs, TEPs, special education needs and disability coordinator, counsellors, and those with pastoral roles who work with students with learning difficulties Practitioners who are familiar with Human Givens	To raise awareness, develop understanding, and encourage action to improve practice	July 2020	Published manuscript in 'Educational and Child Psychology' Write article for Human Givens Journal	Researcher	None	Google Scholar profile to track author metrics. Use of ResearchGate (academic social network) to monitor citations and interest in journal Article in Human Givens journal will target specific audience with an interest in this approach, therefore influence practice for individuals
A wider understanding of the findings of Paper 1	EPs, TEPs, special education needs and disability coordinator, counsellors, and those with pastoral roles who work with students with learning difficulties	To raise awareness, develop understanding, and encourage action to improve practice	January 2021	Paper 1 manuscript provisionally accepted for publication in 'Journal of Research in Special Educational Needs'	Researcher	None	Google Scholar profile to track author metrics. Use of ResearchGate (academic social network) to also monitor citations and interest in journal Future research linked to the ideas identified in Paper 1 may be

							conducted with potential publication of results
The main findings from Papers 1 and 2.	Participants and staff at the research site	To raise awareness and encourage action to improve individual practice and inform school development plan	July 2021	PowerPoint presentation of main findings from Papers 1 and 2 to be shared with attendees	Researcher	Preparation time	Participants will discuss their reflections of the findings, and implications for future practice and policy (may write own policy for student mental health) as well as facilitate school development plan Evaluation forms with qualitative comments and goal attainment scaling (GAS) data to indicate what participants have gained from the presentation and how it may impact future practice May commission an extension of the research such as an Action Research project to promote school development

The main findings from Papers 1 and paper 2.	EP team and Education Emotional Well-being Practitioners	To raise awareness of the findings, develop understanding, and encourage action to improve practice	September 2021 (continued professional development slot)	Presentation followed by a discussion. Paper 1 and 2 distributed as pre-reading	Researcher	Preparation time	Discussion opportunities to reflect on new knowledge and results from the studies. Team members share ways in which the findings might influence their practice/ contribute to existing knowledge/ social media sharing (the team's Twitter page) Written evaluation forms, which includes qualitative feedback about how findings may inform future practice
The mains findings from Paper 2 Marketing of training or systemic work to support development of provision around mental health and well-being	Senior leadership members who attend special school's termly network meeting	To raise awareness, develop understanding, and encourage action to improve practice through attending a workshop	September 2021	Presentation which includes opportunities for staff to reflect on current provision and skills within this area.	Researcher	Preparation time	Use of goal attainment scaling pre- and post-workshop around provision, staff confidence/ abilities to support social, emotional and mental health needs of students. This will indicate what participants have gained from the training workshop and how it may impact future practice

							Uptake of training or support from researcher would be indicative of upcoming influence on policy, practice and behaviour
A wider understanding of the main findings of Paper 2	EPs, TEPs, special education needs and disability coordinator and teachers	To raise awareness, develop understanding, and encourage action to improve practice	August 2021	Submit manuscript for publication of paper in 'British Journal of Special Education'	Researcher	None	The use of Google Scholar profile to track author metrics. Use of ResearchGate (academic social network) to also monitor interest in journal Future research linked to the ideas identified in Paper 2 may be conducted with potential publication of results

Conclusion

The current paper outlined EBP and PBE in relation to EP practice. However, the links between research and practice can only be achieved through effective dissemination and active uptake of research findings to make an impact. The main findings of Papers 1 and 2 have been outlined with suggested strategies to support the dissemination at the research site and to the wider profession. The dissemination activities are currently on-going and will be monitored and evaluated over time, with impact measured as outlined in the dissemination plan.

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Appendices

Appendix 1: Journal submission guidelines for Journal of Research in Special

Educational Needs

The *Journal of Research in Special Educational Needs* publishes scholarly papers based on original research as well as critical reviews and theoretical essays. This includes submissions from a range of colleagues within the SEN field and across the disability community. Authors are asked to be sensitive to the diverse international audience of the *Journal* and explain the use of terms that might be meaningful or have a specific meaning in a particular national context. The use of jargon should be avoided, and technical terms defined. Standard stylistic conventions based on British spelling and form should be followed.

References should be listed in full at the end of the paper in alphabetical order of authors' names, set out as below:

Book:

Kornblum, W. & Smith, C. K. (eds) (2004) *Social Problems in Schools*. (5th edn). Milton Keynes: Open University Press.

Chapter in book:

Roof, C. (ed.) (2000) 'Behavioural difficulties in children.' In R. Davies & D. Galway (eds), *Listening to Children*, pp. 108–20. London: Fulton.

Journal:

Hadaway, C. (1981) 'The English school environment: proposed changes.' *Cambridge Journal of Education*, 20 (1), pp. 77–89.

Electronic resources:

Belson, K. C. (2005) 'Auditory training for autistic children.' *Paediatrics*, 102, pp. 41–3. <http://www.aap.org/policy.html<> (accessed 18 January 2005).

Others:

Firth, G. (2004) *Developmental Process in Mental Handicap: A Generative Structure Approach*. Unpublished PhD dissertation, Department of Education, Brunel University.

Clark, G. N. (1983) *Intensive Interaction: Changing Views and Relationships* (draft final report). Leeds Mental health NHS Trust: Learning Disability Psychology Services.

Illustrations, tables and figures should be numbered consecutively (e.g. Figure 1, Table 1, Table 2, etc.) and submitted on separate sheets. The approximate position of tables and figures should be indicated in the manuscript.

An electronic copy of manuscripts (Word files preferred) of 6,000–8,000 words including references and appendices should be sent to the Editor at the address provided at the end of these Guidelines. If electronic submission is not possible, three hard copies should be sent by regular mail. Each article should be accompanied by a 150–250 word abstract and a list of keywords on a separate sheet.

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Endfield, G.H., Veale, L., Royer, M., Bowen, J.P., Davies, S., Macdonald, N., Naylor, S., Jones, C., & Tyler-Jones, R. (2017) Extreme weather in the UK: past, present and future - event details from the TEMPEST database. Centre for Environmental Data Analysis [doi:10.5285/d2afd2af036b4d788d8eddf8ddf86707](https://doi.org/10.5285/d2afd2af036b4d788d8eddf8ddf86707).

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Appendix 2: Inter-rater quality assurance using CASP (CASP, 2018)

The use of quality assessment scales in systematic reviews has been both recommended and discouraged. The current review identified and assigned a score to help identify any possible sources of bias in each study, thus facilitating the interpretation of the evidence in light of the critical appraisal. The quality of the studies was reviewed using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2018), to check for potential bias in relation to three areas: were the results of the study valid? what are the results? and are the results helpful? The CASP tool was not used to include or exclude studies but to provide a guide as to the quality of the studies for the reader. The checklist recommends using the following judgements for each question: yes, no or cannot tell (indicates lack of sufficient detail to make a judgement). In discussion with their supervisor, the author added one more judgement, 'partial', to indicate that appropriate methodology had been used but maybe not as effectively, appropriately or sufficiently as other papers this felt to add clarity to the 'cannot tell' judgement which both the researcher and supervisor felt was hard to judge. A further criterion was added which identified those papers who had included quote from participants linked to their age, therefore verbatim from 16-25 years could be specifically identified. The author and supervisor quality assured 2 papers, initially there was 85% agreement, and after discussion around the criteria and scoring, there was 100% agreement. Therefore, the author quality assured the remaining papers independently.

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	<input checked="" type="checkbox"/>	<p>HINT: Consider</p> <ul style="list-style-type: none"> • what was the goal of the research • why it was thought important • its relevance
Can't Tell	<input type="checkbox"/>	
No	<input type="checkbox"/>	

Can't tell

Comments: Explore exp of adults with ID either via BA or guided self-help. Questioned approaches, but wanted to meet needs of Ps. follow on from RCT.

2. Is a qualitative methodology appropriate?

Yes	<input checked="" type="checkbox"/>	<p>HINT: Consider</p> <ul style="list-style-type: none"> • if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • is qualitative research the right methodology for addressing the research goal
Can't Tell	<input type="checkbox"/>	
No	<input type="checkbox"/>	

Yes

Comments: Use of framework analysis - rigid interpretation but large no of Ps. Initial framework created was linked to topic guide.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes	<input checked="" type="checkbox"/>	<p>HINT: Consider</p> <ul style="list-style-type: none"> • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)
Can't Tell	<input type="checkbox"/>	
No	<input type="checkbox"/>	

partial

2 expanded to 'yes' based on comments.

Comments: follow on from RCT. Used framework analysis. Modified framework to ensure captured new categories.

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	<input checked="" type="checkbox"/>	<p>HINT: Consider</p> <ul style="list-style-type: none"> • what was the goal of the research • why it was thought important • its relevance
Can't Tell	<input type="checkbox"/>	
No	<input type="checkbox"/>	

Comments: To explore the experiences of adults with ID either using Behavioural Activation or Guided Self Help using psycho-educational approach. Both were adapted to meet needs of Ps. This was a follow on from a RCT.

2. Is a qualitative methodology appropriate?

Yes	<input checked="" type="checkbox"/>	<p>HINT: Consider</p> <ul style="list-style-type: none"> • if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • is qualitative research the right methodology for addressing the research goal
Can't Tell	<input type="checkbox"/>	
No	<input type="checkbox"/>	

Comments: Framework analysis, so rigid interpretation of their views. Structured approach to analysis (large interview number). Initial framework was created related to topic guide. Framework was modified, ad quotes used in results section.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes	<input checked="" type="checkbox"/>	<p>HINT: Consider</p> <ul style="list-style-type: none"> • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)
Can't Tell	<input type="checkbox"/>	
No	<input type="checkbox"/>	

Comments: Justified based on follow on from RCT, and due to 25 transcripts to analyse, Framework Analysis was justified in the paper. It was modified to encompass new categories that were found.

Appendix 3 Quality assurance overview using Critical Appraisal Skills Programme (CASP, 2018)

Paper	Was there a clear statement of the aims of research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address aims of the research?	Was the recruitment strategy appropriate?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings	Is the research valuable?	Score (max score = 10)	Includes quotes from 11-25 year-olds
1	1	1	1	1	1	1	1	1	1	1	10	Yes
2	1	1	1	0.5	0.5	0	0.5	0.5	1	0.5	6.5	No
3	1	1	1	0.5	1	0.5	1	0.5	0.5	0.5	7.5	No
4	1	1	1	1	1	1	1	1	1	0.5	9.5	No
5	1	1	1	1	1	1	1	1	1	1	10	Yes
6	1	1	1	1	1	0.5	1	0.5	1	0.5	8.5	No
7	1	1	1	0.5	1	0	0.5	1	0.5	0.5	7	No
8	1	1	1	1	1	0.5	1	1	1	1	9.5	Yes
9	1	0.5	0.5	0.5	0.5	0	0.5	1	1	0.5	7	No
10	1	1	1	1	1	1	1	1	1	1	10	Yes
11	1	1	1	0.5	1	1	1	0.5	1	0.5	8.5	Yes
12	1	1	1	1	1	0.5	1	0.5	1	1	9	No

Note. Score 1 = Yes, 0.5 = Partially, 0 = No or Cannot tell

1. Arkless, L. (2004) 'Talking to people with learning disabilities and their families about the experience of systemic therapy.' Unpublished doctoral dissertation, University College London. Clinical Psych Doctorate
2. Merriman, C., & Beail, N. (2009) 'Service user views of long-term individual psychodynamic psychotherapy.' *Advances in Mental Health and Learning Disabilities*, 3 (2), pp. 42–47.

3. Morgan, T. (2011) 'Reflections of individuals with learning disabilities on their experiences of receiving psychotherapeutic services: An exploration using interpretative phenomenology analysis.' Unpublished Doctoral thesis, University of Bristol, Bristol. Doctorate in counselling psychology.
4. Boyden, P., Muniz, M., Laxton-Kane, M. (2013) 'Listening to the views of children with learning disabilities: an evaluation of a learning disability CAMHS service.' *Journal of Intellectual Disabilities*, 17 (1), pp. 51-63.
5. Anslow, K. (2014) 'Systemic family therapy using the reflecting team: The experiences of adults with learning disabilities.' *British Journal of Learning Disabilities*, 42 (3), pp. 236-243.
6. Macmahon, P., Stenfert Kroese, B., Jahoda, A., Stimpson, A., Rose, N., Rose, J., & Willner, P. (2015). '“It's made all of us bond since that course...” - a qualitative study of service users' experiences of a CBT anger management group intervention.' *Journal of Intellectual Disability Research*, 59 (4), pp. 342-352.
7. Lewis, N., Lewis, K., & Davies, B. (2016) '“I don't feel trapped anymore...I feel like a bird”: People with Learning Disabilities' Experience of Psychological Therapy.' *Journal of Applied Research in Intellectual Disabilities*, 29 (5), pp. 445-454.
8. Ramsden, S., Tickle, A., Dawson, D. L., & Harris, S. (2016) 'Perceived barriers and facilitators to positive therapeutic change for people with intellectual disabilities.' *Journal of Intellectual Disabilities*. 20 (3), 241-262.
9. Roscoe, P., Petalas, M., Hastings, R., & Thomas, C. (2016) 'Dialectical behaviour therapy in an inpatient unit for women with a learning disability: Service users' perspectives.' *Journal of Intellectual Disabilities*, 20 (3), pp. 263-280.
10. Bexley, K. (2017) 'Improving access to psychological therapy for people with learning disabilities from services users' and clinicians' perspectives: An action research approach.' Unpublished Doctoral thesis. University of London, London. Professional doctorate in psychology.
11. Currie, T. L., McKenzie, K., & Noone, S. (2019) 'The Experiences of People with an Intellectual Disability of a Mindfulness-Based Program.' *Mindfulness*, 10 (7), pp. 1304-1314.
12. Knight, R., Jahoda, A., Scott, K., Sanger, K., Knowles, D., Dagnan, D., Hasting, R.P., Appleton, K., Cooper, S.A., Melville, C., Jones, R., Williams, C. & Hatton, C. (2019) '“Getting into it”: People with intellectual disabilities' experiences and views of Behavioural Activation and Guided Self-Help for depression.' *Journal of Applied Research in Intellectual Disabilities*, 32 (4), pp. 819-830.

Appendix 4: Data analysis

The data were analysed using a reflective thematic analysis (Braun and Clarke, 2006; 2019). The steps are detailed below which were undertaken by the researcher to complete the analysis:

Research question: What does the literature tell us about how access and participation in therapy can be facilitated for young people with learning difficulties?

Stage 1: Become familiar with the data

The 'results/finding' section of each paper was uploaded to NVIVO (a computer software program). The researcher then read and re-read the papers to immerse themselves in the literature, this was an active process which involved a deep engagement with the data. This involved the researcher being observant as they began to notice patterns.

Early observations included the researcher thinking about how agency was promoted from the perspective of the participants (people with learning difficulties) and how at times professionals had not appeared to adapt practice to meet their needs, such as those struggling to understand language used.

E.g. Familiarisation notes from Boyden et al., (2013) paper:

- *All young people aged 11-17 years*
- *Participants were able to articulate what aspects of therapy helped*
- *Communication is an important– but not always through discussion e.g. use of interactive tools.*
- *Participants had the ability to acknowledge 'change' based on support received (e.g. behavioural and/ or emotional)*

E.g. Familiarisation Notes from Entire Dataset:

- *Some P's did not speak up when feeling marginalised, some felt able to. Is this due to therapeutic alliance / confidence of individuals/ presence of a supporter/ past experiences of being listened to?*

- *Therapeutic alliance feels important to participant's – is this due to their lack of experience of being genuinely listened to in their lives?*
- *Examples of communication issues not addressed by professionals from the participant's perspectives*
- *Positive outcomes were identified from therapy – suggesting it helps promote change.*
- *Lack of criticism about therapy*

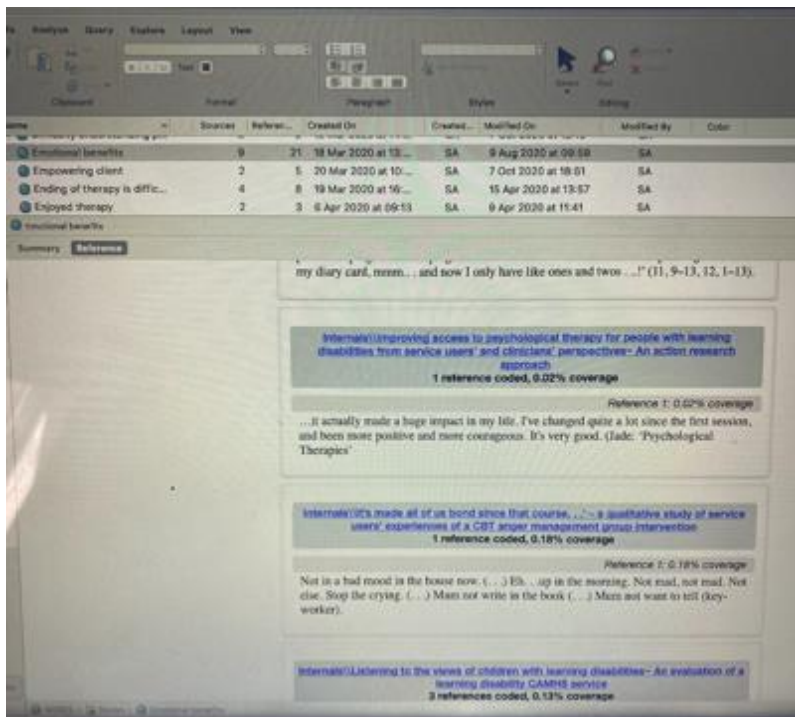
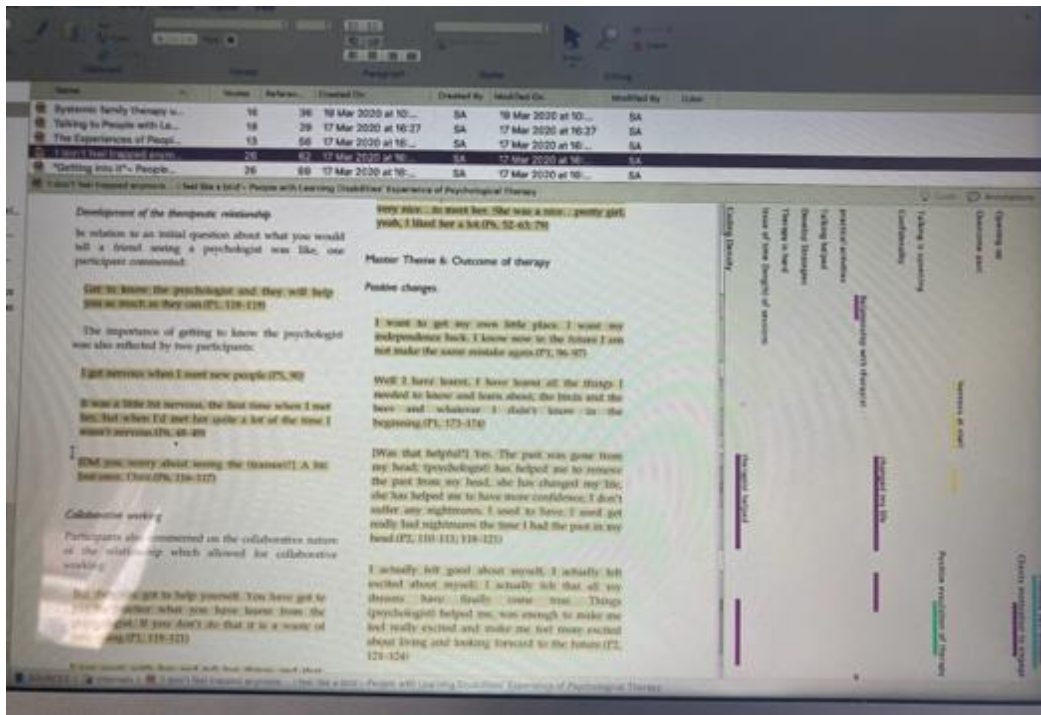
Researcher's reflective perspective

The researcher was aware that one's own experiences and values may influence an interpretation of data. The researcher was aware of their personal experience of her younger brother's experiences of therapy which had not been as successful as anticipated. Upon reflection, there were several reasons for this including their brother's lack of motivation to want to change, as well as the therapist's skills to deliver the programme at an accessible level. However, when reading the papers, it was pleasing to hear participants referring to success from their therapeutic experiences. It felt to highlight how important the therapeutic alliance was in therapy, something which the researcher related too. The researcher was surprised at the lack of participant involvement during the referral stage, and how this could not necessarily be the case for adults accessing therapy. The researcher had regular supervision during the analysis of the data, which helped to ensure the researcher was emerged in the data and open to the findings that would be generated.

Stage 2: Generate initial codes

This phase involved the production of initial codes (referred to as nodes in Nvivo) from the data. The data was coded inductively, therefore the process was data driven. Coding was systemic and involved creating meaningful labels attached to specific segments of the data that were of interest in relation to the research question. TA does not require line by line

coding. Below is an example of coding completed by the researcher. This process is iterative and flexible, by revisiting codes it helped to modify and ensure coding consistency.



Pictures of coding on NVIVO

The researcher then reviewed the codes with the research questions acting as a guide to ensure all codes were relevant. Some were deleted, merged with others if they were similar, or renamed to improve the descriptive label. At the end of this phase the researcher had a compiled list of 63 codes that felt to represent the data set.

Code	Sources	References
1. Achieve goal	2	2
2. Acknowledged negative aspects to group	1	2
3. Adapting communication	4	9
4. Agree/ negotiate sharing of information	1	7
5. Aim of therapy	5	9
6. Autonomy	3	4
7. Awareness of referral process	2	5
8. Beyond therapy	1	8
9. Bonding as a group	3	15
10. Carer vs Client agenda	1	3

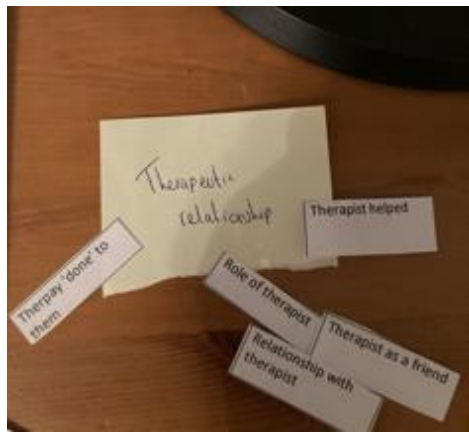
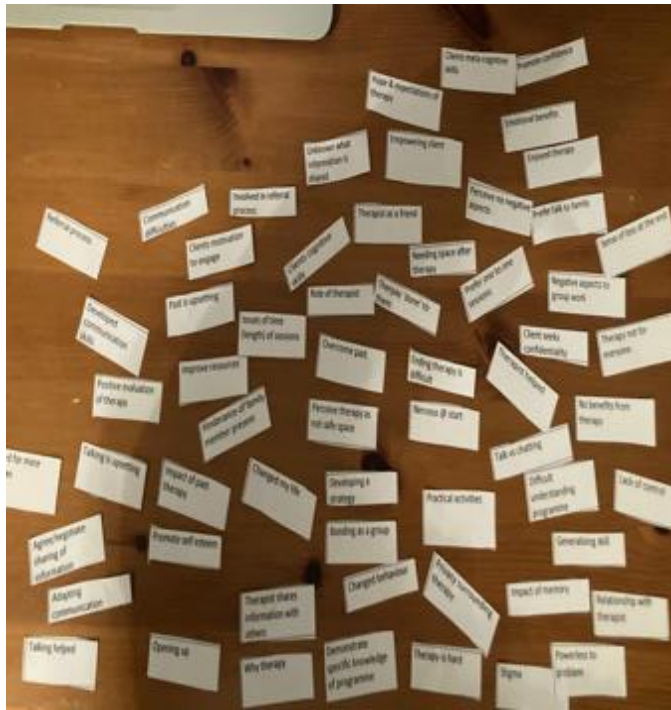
Exert of table with list of initial codes

23. Develop a strategy	4	13
24. develop communication skills	2	2
25. Develop Skills merge into 22 and 23	4	11
26. Generalising Skill	3	12
27. Differing opinion merge into 82	1	3
28. Difficulty understanding programme	2	2
29. Emotional benefits	7	14
30. Empowering client	1	2
31. Ending therapy is difficult	4	6
32. Enjoyed therapy	2	3
33. everyone finds things hard merged into 100	1	3
34. Expectation to talk to carers merged into 18	1	2
35. Feeling at ease merged into 85	1	2

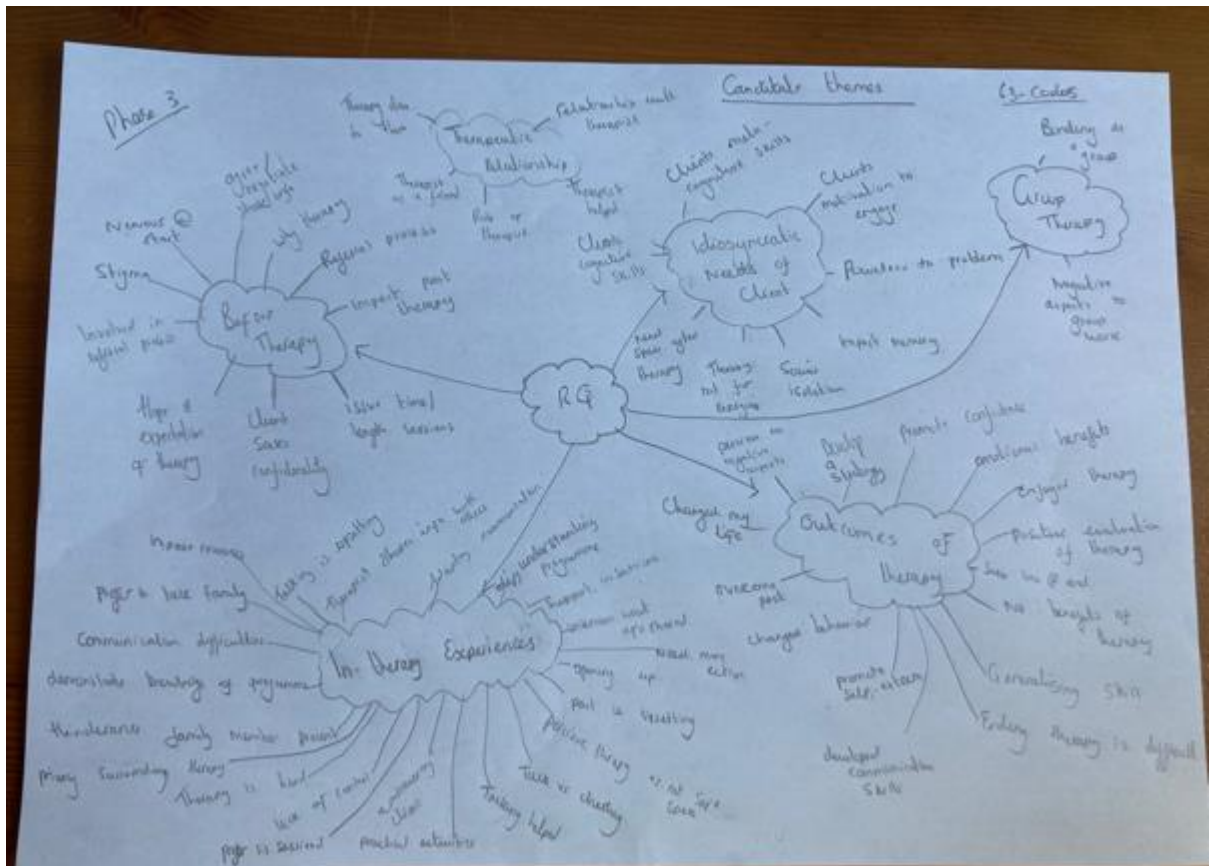
Exert of refined codes table

Stage 3: Generate initial themes

The research question helped organise the codes to generate ‘candidate’ themes. The researcher recognised the importance of the process being iterative and reflective of the data set. The researcher took time to develop these themes, revisiting them and moving the codes arounds until they felt to answer the research question. The researcher then compiled a map showing the candidate themes and corresponding codes and shared this with their supervisors. As inter-rater checking is not congruent with the aims of TA, the researcher talked through the map clarifying patterns behind the candidate themes.



Researcher organising codes into candidate themes



Representation of candidate themes with codes

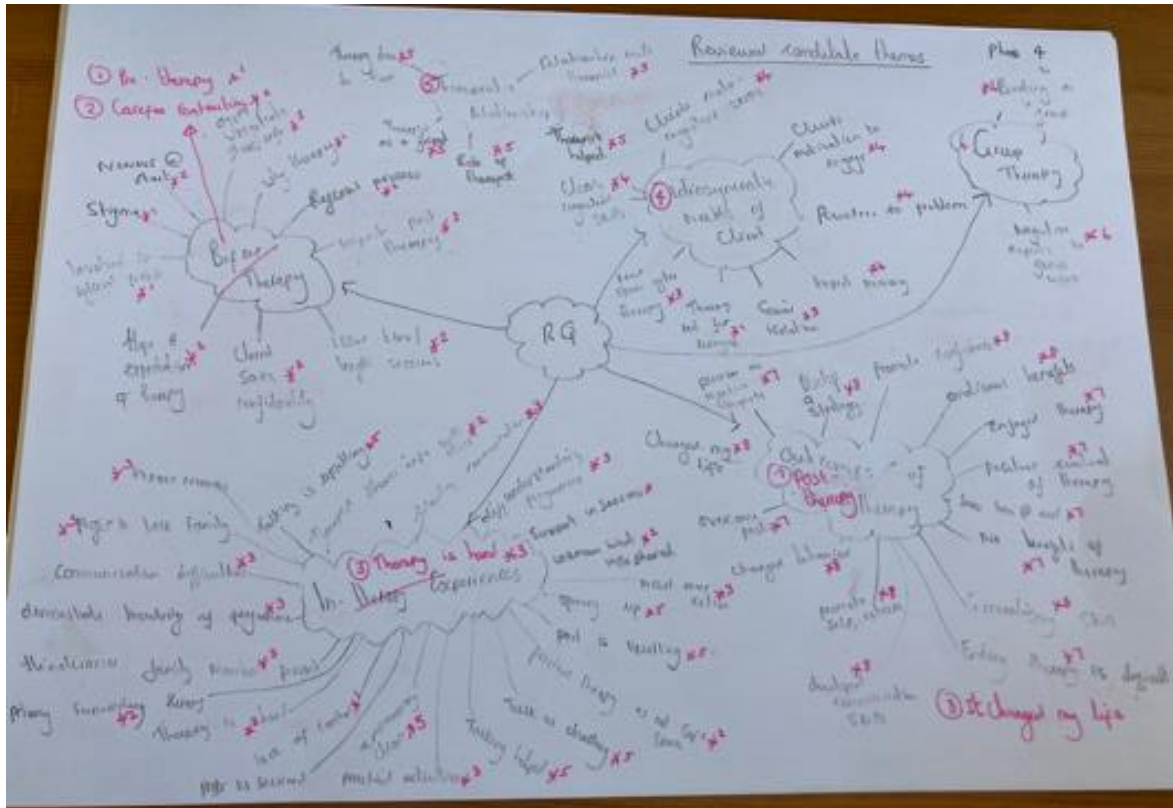
Stage 4: Review themes

Candidate themes (with corresponding codes) were re-looked at in order to ensure the analysis had clear links to the data and the research question. The researcher looked at each candidate theme, codes and data extracts to ensure each theme accounted and reflected the codes they represented. Once this was complete the researcher re-read all the data to ensure nothing had been missed and that the analysis had not moved away from the key points of the data.

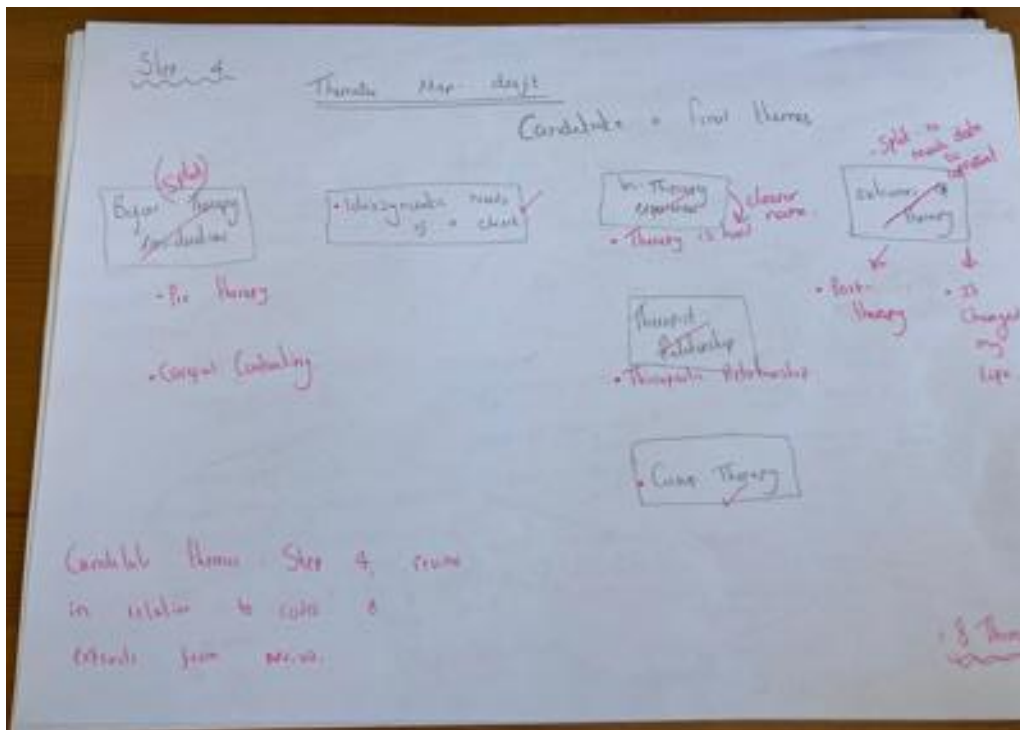
At this stage, the researcher felt that 2 of the candidate themes were too diverse in relation to the data they were representing, therefore these were amended, leading to 8 themes. The researcher felt this helped to provide a more accurate story of the data in relation to the research question. It was during this part of the analysis the researcher also created subthemes as this felt to provide a more coherent story of the data patterns. The researcher developed links to codes within each theme e.g. within 'therapeutic relationship', three subthemes were developed: role of the therapist, function of talking, and relationship with therapist.

Code	Paper	Quote
Positive evaluation of therapy	Not trapped anymore... Lewis et al., 2016	[So what would you tell your friend then, one of your class mates maybe, what would you tell them it is like seeing a psychologist?] I think it was good. [You think it was good] Yes. [In what way was it good do you think?] All of it. (P5, 76-82) It was good because I like to have help sometimes. (P5, 109) But then you got to help yourself. You have got to put in practice what you have learnt from the psychologist. If you don't do that it is a waste of time going.(P1, 119-121)
	DBT- Roscoe et al., 2016:	Participants showed evidence of having reached personal understandings and perspectives of the programme All of the participants spoke of how helpful and beneficial DBT had been for them I have learnt how to talk to staff better, and how to get out of a situation, and if there is a problem where to go. Where before I didn't understand ... cause before when I first come [to the hospital] I couldn't speak to anyone, I didn't know how to talk properly, but now since I have been doing DBT, and I get my sessions, I manage to talk to people more better. (Jenny: 4, 14-15; 7, 11-13)
	Made is all bond... MacMahon et al., 2015	Their comments suggest that they had noticed a positive personal change.
	Mindfulness... Currie et al., 2019	feeling good, it's not just about me it's about everyone^ (Sharon). Mostly just talk to someone instead of getting myself worked up. Did you do that before the course or not? (Interviewer) Hm not really. (Sharon)
Nervous at the start	Not trapped anymore... Lewis et al., 2016	.. I told her I was a bit nervous. [Did you, what did she say?] She said keep calm and that. [Did that help?] Yes; If you want to keep calm and that just go on the laptop or watch telly.(P5, 56-60; 95) It was a little bit nervous, the first time when I met her, but when I'd met her quite a lot of the time I wasn't nervous.(P6, 48-49)
	Made is all bond... MacMahon et al., 2015	One recalled that 'I was nervous, cause it was a new thing for me',
	DBT- Roscoe et al., 2016:	Kelly also talked about the intense feelings of anxiety and panic that she experienced before group skills teaching.
	Reflections of experiences....Morgan 2011	'I was a bit nervous at first because I thought me telling [therapist] everything, my fears and things, might be about with mum or anyone else...(P5:1).
	Getting into it...Knight et al., 2019	Perhaps unsurprisingly, a number of participants felt nervous or uncertain about starting therapy. I don't (sic) know what to expect, I was surprised in a way. ...It was scary first time meeting the therapist and then, yea, getting to know each other. (Beall; Female; Participant 96)
	Service user views...Merriman & Beall, 2009	This created a feeling of nervousness and uncertainty at the start of therapy. 'I was a bit nervous. I didn't know what to say. I got a bit tight, scared of what he might do to me...' (Interview 3)
	Talking to people...Arkless, 2004	Interviewer: "So you expected that there was going to be" ... [participant interrupts] Participant: "One. I didn't think there was going to be two. " Interviewer: "So what was that like when you walked in and there and saw two of them sitting in there?" Participant: "I was nervous. " F11 (5: 1-7)

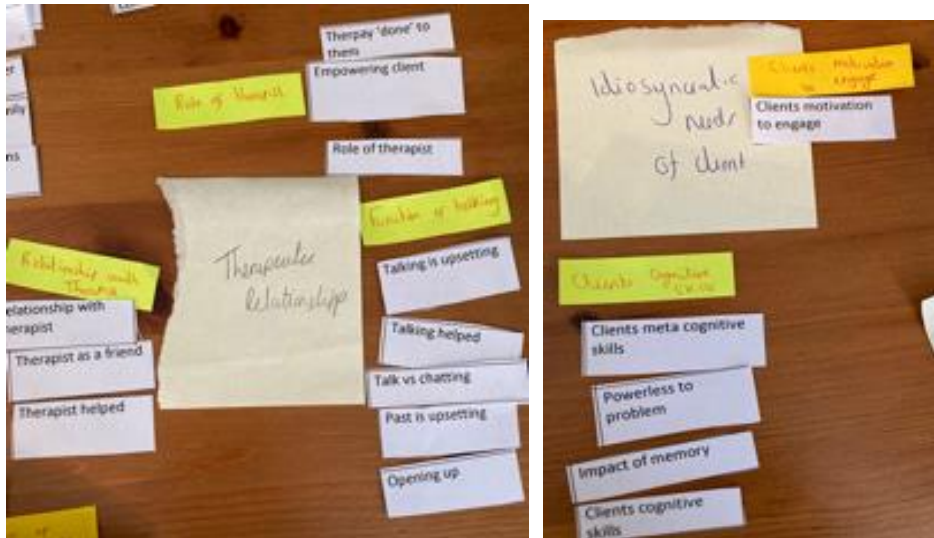
Exert of table representing codes and extracts.



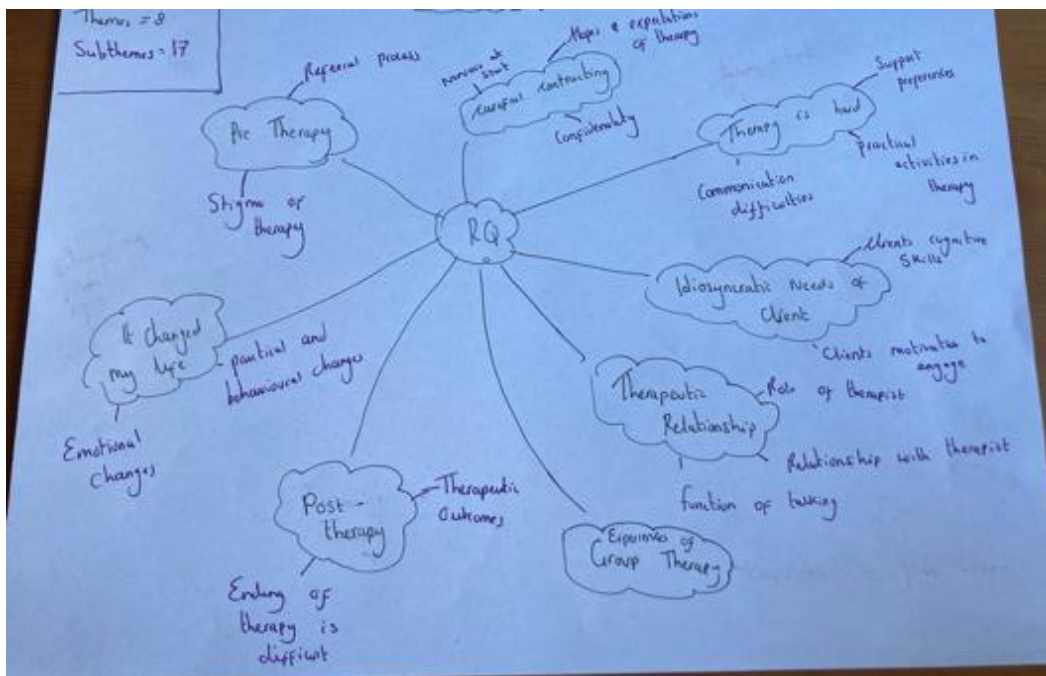
Review of candidate themes



Review of candidate themes to themes



Researcher creating subthemes from themes

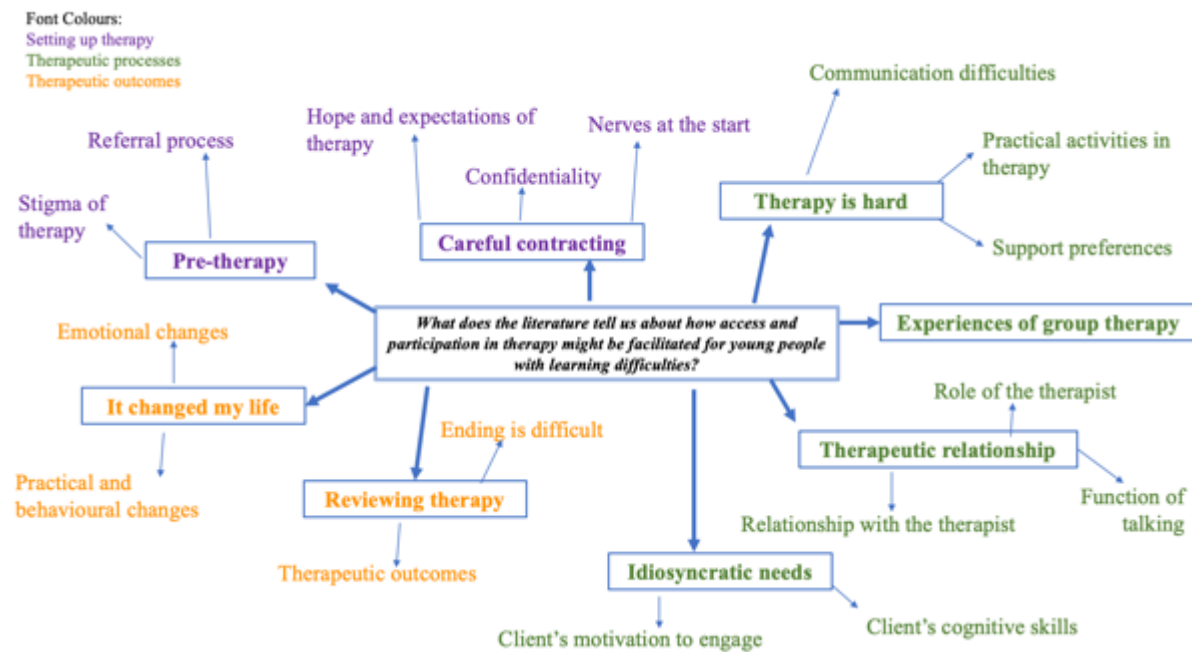


Thematic map end of phase 4

Stage 5: Define themes

The final review stage involved the researcher checking that the themes and subthemes told the story in relation to the research question. There was some refinement in relation to themes e.g. ‘post-therapy’ was amended to ‘reviewing of therapy’ as this felt to better represent the coded data and distinguish this from ‘it changed my life’ which was also referring to aspects of post-therapy. In discussion with their supervisor, the themes were then

gathered in relation to: setting-up therapy, therapeutic process and therapeutic outcomes, as the researcher felt this made the themes easier to interpret for the reader.



Final thematic map to be included in the report

Stage 6: Writing the report

The researcher weaved together data, analysis and connection to literature (in the discussion section). Data extracts were included where possible, as they evidenced key elements of the data, with priority given to quotes from participants aged 25 years and under. The results section was written up under the headings: setting-up therapy, therapeutic process and therapeutic outcomes.

Appendix 5: Journal submission guidelines for British Journal of Special Education

The *British Journal of Special Education (BJSE)* is the quarterly journal of Nasen. Nasen draws its membership from the entire range of professionals who are responsible for educating and supporting children and adults with special educational needs. *BJSE's* Editor therefore welcomes contributions focusing on any aspect of policy, provision or practice that relates to the pre-school, school or post-school experiences of those with special educational needs, whatever the degree of learning difficulty or disability. *BJSE* also welcomes articles relating to inclusion, inclusive education and international practice in relation to inclusive education and/or the experiences of individuals with Special Educational Needs.

An article can only be considered for publication in *BJSE* on the understanding that it has not yet been published and that it is not being considered for publication elsewhere. Authors are expected to confirm the originality of their work when submitting articles for consideration and to ensure that all necessary permissions to publish have been obtained. Successful authors will be expected to sign a copyright assignment agreement and to provide brief biographical notes. All articles considered for publication in *BJSE* are subjected to peer review.

Articles based upon empirical research should contain a clear indication of the rationale for the research; the methods used; the findings; and the implications of the findings for future practice. Authors must ensure that their work has been carried out within an ethical framework such as that provided by the British Educational Research Association.

Free Format Submission

The *British Journal of Special Education* now offers Free Format submission for a simplified and streamlined submission process. Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or

separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.

- An ORCID ID, freely available at <https://orcid.org>. (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)

- The title page of the manuscript, including:

- o Your co-author details, including affiliation and email address. (Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)

- o Statements relating to our ethics and integrity policies, which may include any of the following (Why are these important? We need to uphold rigorous ethical standards for the research we consider for publication):

- o data availability statement

- o funding statement

- o conflict of interest disclosure

- o ethics approval statement

- o patient consent statement

- o permission to reproduce material from other sources

- o clinical trial registration

To submit, login at <https://mc.manuscriptcentral.com/bjse> and create a new submission.

Follow the submission steps as required and submit the manuscript.

Presentation

Manuscripts should be submitted following the guidelines on ScholarOne Manuscripts.

All articles should be between 4000 and 6000 words including references. *BJSE* does not use footnotes or appendices. Materials such as tables, graphs, diagrams, flow charts and examples of pro formas, schedules or recording formats can be included in articles as Figures or Tables.

Illustrative materials should be selected carefully to support points made in the text of an article. Articles should be lively and engaging, clearly argued and concisely written in plain English in order to be accessible to a diverse readership. When technical terms prove essential, the writer should provide brief explanations supported by contextual descriptions or examples. Prospective authors should avoid language that can be seen as discriminating against people on account of disability, race or gender.

References

References should be selective and easily accessible. Sources should be indicated in the manuscript by giving the author's surname with the year of publication in brackets; *BJSE* does not use footnotes. Page numbers should be given for direct quotations. Full details for all references should be listed in alphabetical order of authors' names in a section at the end of the article. The following examples cover the kinds of references most frequently used in *BJSE* and can be used as a style guide:

DfES (Department for Education and Skills) (2001) *Special Educational Needs Code of Practice*. London: DfES.

Dyson, A (2001) 'Special needs in the twenty-first century: where we've been and where we're going', *British Journal of Special Education*, 28 (1), 24-29.

Goldbart, J. & Rigby, J. (1989) 'Establishing relationships with people with PMLDs.' Paper presented to the University of Manchester Department of Child and Adolescent Psychiatry Regional Study Day, 10 April 1989.

Lewis, A. & Norwich, B. (2001) 'A critical review of systematic evidence concerning distinctive pedagogies for pupils with difficulties in learning', *Journal of Research in Special Educational Needs*, 1 (1) [online at <http://www.blackwell-synergy.com/>].

Mittler, P. (2001) 'Preparing for self-advocacy', in B. Carpenter, R. Ashdown & K. Bovair (eds) *Enabling Access - effective teaching and learning for pupils with learning difficulties* (second addition). London: David Fulton Publishers.

Tilstone, C., Florian, L. & Rose, R. (eds) (1998) *Promoting Inclusive Practice*. London: Routledge

Guidelines for Submission to the *British Journal of Special Education*

BJSE has adopted ScholarOne Manuscripts, for online manuscript submission and peer review. The new system brings with it a whole host of benefits including:

- Quick and easy submission
- Administration centralised and reduced
- Significant decrease in peer review times

From now on all submissions to the journal must be submitted online

at <http://mc.manuscriptcentral.com/bjse>. Full instructions and support are available on the site and a user ID and password can be obtained on the first visit. If you require assistance, then click the Get Help Now link which appears at the top right of every ScholarOne Manuscripts page. If you cannot submit online, please contact Graham Hallett in the Editorial Office (editorsbjse@gmail.com).

By submitting a manuscript to or reviewing for this publication, your name, email address,

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Fiona Hallett & Graham Hallett

Editors

Email: editorsbjse@gmail.com

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Appendix 6: Ethical approval



The University of Manchester

****Please ensure you read the contents of this message. This email has been sent via the Ethical Review Manager (ERM) system on behalf of the University of Manchester.****

Dear Miss Samantha Attwood , Dr Cathy Atkinson

Thank you for submitting your low risk ethics application for your project entitled: What strategies, techniques and approaches do practitioners use to support the mental health and well-being of post-16 students attending specialist provision? ; Ref: 2020-9885-15500 which has now been approved by your supervisor and logged by the Ethics Administrator.

For those undertaking research requiring a DBS Certificate: As you have now completed your ethical application if required a colleague at the University of Manchester will be in touch for you to undertake a DBS check. Please note that you do not have DBS approval until you have received a DBS Certificate completed by the University of Manchester, or you are an MA Teach First student who holds a DBS certificate for your current teaching role.

If anything untoward happens during your research or any changes take place then please inform your supervisor immediately.

This approval is confirmation only for the low risk Ethical Approval application.

Please let us know if you have any additional queries by emailing: PGR.ethics.seed@manchester.ac.uk .

Best wishes,

Mr Liam ~~Grindell~~

Environment, Education and Development School Panel PGR

Appendix 7: Participant information sheet

Research Participant Information Sheets

What strategies, techniques and approaches do practitioners use to support the mental health and well-being of post-16 students attending a specialist provision?

Participant Information Sheet (PIS)

You are being invited to take part in a research study to explore what strategies, techniques and approaches practitioners use to support the mental health and well-being of post-16 students attending specialist provision, as required for the Doctorate in Educational and Child Psychology at the University of Manchester. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

About the research

➤ **Who will conduct the research?**

Samantha Attwood

Manchester Institute of Education
Ellen Wilkinson Building
The University of Manchester
Oxford Road
Manchester

➤ **What is the purpose of the research?**

The aim of the research is to consider how practitioners support the well-being of young people who attend a sixth form in special school. This will involve recruiting up to five participants and carry out up to four virtual one to one semi-structured interviews, where we will discuss their experiences of supporting young people's mental health well-being. This information will be analysed and developed

into a model/framework that can provide insight into practices to promote the well-being of post 16 students.

➤ **Will the outcomes of the research be published?**

As part of the commissioning project, the findings of the research will be presented to the staff at the sixth form setting at a mutually convenient time. The findings will be collated and used to write up a thesis research project, as required on the Doctorate in Educational and Child Psychology programme at University of Manchester. There is a possibility that this data may be used as basis for further research and an academic paper drafted by the researcher and colleagues for publication in a psychology journal

➤ **Who has reviewed the research project?**

Ethical approval has been obtained from the University of Manchester, School of Environment, Education and Development, Ethics Committee.

➤ **Who is funding the research project?**

This research is funded by the Department of Education as part of the Doctorate in Education and Child Psychology programme.

What would my involvement be?

➤ **What would I be asked to do if I took part?**

Written consent will be requested before participation. Participation would involve a one to one virtual semi-structured interview using Zoom at a mutually convenient time. The discussion will focus on exploring what strategies, techniques and approaches you use to support the mental health and well-being of post-16 students. A copy of the interview schedule will be sent to you two days before the interview takes place, so you know in advance what the questions will be and gives you the opportunity to think about your answers. The duration of the interview will be around one hour and will be audio recorded so the interviews can be transcribed and analysed for themes. If you are interested in the findings I can arrange a phone call to inform you of these.

➤ **Will I be compensated for taking part?**

No financial reward is offered for participating in the research.

➤ **What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. Please let me or [teacher] (teacher at the sixth form setting) know whether you would like to participate. If you decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form. You are free to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised as I will not be able to identify your specific data. This does not affect your data protection rights. If you decide not to take part, you do not need to do anything further.

The audio recording of the sessions is an essential part of the study; they will be transcribed as soon as possible, anonymised and stored securely. You are free to stop the audio recording at any time and the recording will be destroyed.

Data Protection and Confidentiality

➤ **What information will you collect about me?**

In order to participate in this research project, we will need to collect information that could identify you, called “personal identifiable information”. Specifically, we will need to collect:

- Your role in school e.g. teacher, educational psychologist;
- Signed consent form;
- An email to send video call link to.

With your consent, the interview will be audio recorded using a dictaphone and will be transcribed by an external transcriber. The data will be analysed for themes and written up as part of a doctorate thesis. Only the research team will have access to this information.

➤ **Under what legal basis are you collecting this information?**

We are collecting and storing this personal identifiable information in accordance with data protection law which protect your rights. These state that we must have a legal basis (specific reason) for collecting your data. For this study, the specific reason is that it is “a public interest task” and “a process necessary for research purposes”.

➤ **What are my rights in relation to the information you will collect about me?**

You have a number of rights under data protection law regarding your personal information. For example, you can request a copy of the information we hold about you, including audio recordings.

If you would like to know more about your different rights or the way we use your personal information to ensure we follow the law, please consult our Privacy Notice for Research (<http://documents.manchester.ac.uk/display.aspx?DocID=37095>).

➤ **Will my participation in the study be confidential and my personal identifiable information be protected?**

In accordance with data protection law, The University of Manchester is the Data Controller for this project. This means that we are responsible for making sure your personal information is kept secure, confidential and used only in the way you have been told it will be used. All researchers are trained with this in mind, and your data will be looked after in the following way:

Only the study team at The University of Manchester will have access to your personal information, but they will anonymise it as soon as possible. Your name and any other identifying information will be removed and replaced with a random ID number. Only the research team will have access to the key that links this ID number to your personal information. Your consent form and contact details will be retained for 5 years as an encrypted file on a secure server.

With reference to the audio recordings, they will be transcribed as soon as possible by an external professional transcriber, after which the original recordings will be destroyed. The transcripts will be anonymised and stored securely as an encrypted file.

Please also note that individuals from The University of Manchester or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data. All individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

Your participation in this research will be recorded in Zoom and your personal data will be processed by Zoom. This may mean that your personal data is transferred to a country outside

of the European Economic Area, some of which have not yet been determined by the European Commission to have an adequate level of data protection. Appropriate legal mechanisms to ensure these transfers are compliant with the UK General Data Protection Regulation are in place. The recordings will be removed from the above third-party platform and stored on University of Manchester managed file storage as soon as possible following the completion of data collection.

Further privacy information: Zoom privacy policy (<https://zoom.us/privacy>)

What if I have a complaint?

➤ Contact details for complaints

Dr Cathy Atkinson,
Room, A6.5,
Ellen Wilkinson Building,
Oxford Road,
University of Manchester.
Tel: 0161 275 3511
Email: cathy.atkinson@manchester.ac.uk

If you wish to make a formal complaint to someone independent of the research team or if you are not satisfied with the response you have gained from the researchers in the first instance, then please contact:

The Research Ethics Manager, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester, M13 9PL
Email: research.complaints@manchester.ac.uk
Telephone: 0161 275 2674.

If you wish to contact us about your data protection rights:

Email dataprotection@manchester.ac.uk
Write to The Information Governance Office, Christie Building, The University of Manchester, Oxford Road, M13 9PL

You also have a right to complain to the Information Commissioner's Office about complaints relating to your personal identifiable information Tel 0303 123 1113

Full URL: <https://ico.org.uk/make-a-complaint/>

Contact Details

If you have any queries about the study or if you are interested in taking part, then please contact the researcher:

Samantha Attwood (Trainee Educational Psychologist)

School of Environment, Education and Development,

Ellen Wilkinson Building,

Oxford Road,

University of Manchester.

Email: Samantha.attwood@postgrad.manchester.ac.uk

Tel: 0161 275 3511

Appendix 8: Consent form for participants

Participant Consent Forms

What strategies, techniques and approaches do practitioners use to support the mental health and well-being of post-16 students attending specialist provision?

Consent Form

If you are happy to participate, please complete and sign the consent form below

	Activities	Initials
1	I confirm that I have read the attached information sheet (Version 01, Date 15/05/2020) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part on this basis.	
3	I agree to the interviews being audio recorded.	
4	I agree that any data collected may be published in anonymous form in academic books or journals.	
5	I understand that data collected during the study may be looked at by individuals from The University of Manchester or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
6	I agree that the researchers may retain my contact details in order to provide me with a summary of the findings for this study.	

7	I agree to take part in this study.	
<p>Can you please write your email address, this will be used to arrange a convenient time to conduct the interview and how the Zoom link will be sent to you. You will also be emailed the interview schedule in advance: _____</p>		

Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of the person taking consent	Signature	Date

[one copy for the participant, one copy for the research team)

Appendix 9: Semi-structured interview schedule sent to participants

Dear Participant,

Firstly, thank you for agreeing to take part in this research project.

Below is a list of questions that we will work through during our virtual zoom discussion. The questions are given in advance, so you have time to think about your responses, if you wish. I anticipate the interview lasting up to an hour.

The aim of the interview is to explore the strategies, techniques and approaches you use to support the mental health and well-being of your post-16 students.

If you have any questions, please do not hesitate to get in touch using the email provided. I look forward to meeting and working our way through the questions.

1. What is your role in school?
2. Do you feel that within your role, you support the mental health and well-being of the young people?
3. Thinking about your work in school, can you tell me about strategies/ techniques you use to support the mental health and well-being of young people? (e.g. work around transition, emotional literacy skills etc)?
4. Has a pupil ever approached you directly for support around their mental health or well-being? Can you tell me a little detail about the circumstances surrounding the young person(s) asking for support?
5. Are there particularly times within school which appear to be a 'trigger' and causes young people in your setting to require more support around their well-being?
6. Do you feel that pupils possess the skills to promote student well-being?

7. Within your role in school, how would you recognise if a pupil needed support regarding their mental health? What signs do you look for?
8. Can you think of a time when you have supported a young person / or group of young people and what you did to support them through this? (e.g. transition worries, worried about upcoming work experience).
9. (*May have already been answered*) With regard to promoting well-being, do the needs of the young person impact on the support you offer? Can you give examples of you may have adapted your practice and why?
10. Do you complete any planned interventions with pupils to promote their mental health or well-being?
11. In relation to information sharing, do you share what a young person may say with others or parents/carers? Would the young person be aware of this?
12. Are there any areas of additional skills or knowledge that may help you to further support young people around their mental health and well-being? If so, what are these and why do you think that?
13. How have you found this interview? Were any aspects particular useful or helpful?

Thank you for your participation. The interview will be transcribed and analysed in order to identify strategies, techniques and approaches used to support the mental health and well-being of post-16 pupils, who attend a specialist setting. The findings will be disseminated to those it is of interest to at the school, I shall inform you of this nearer the time.

Thanks again for your participation in this research project,

Sam

Email: Samantha.attwood@postgrad.manchester.ac.uk

Appendix 10: Focus group outline

Focus Group Outline

The aim of the focus group is to member check findings and to stimulate discussions around tangible ideas, strategies and approaches used by participants in relation to promoting students' mental health and well-being.

Introduction to aim of session

- Presentation of findings- screen share of thematic map and talk them briefly through the findings so far and suggest that themes can be changes/altered if this does not feel reflective of their practice
- Reflection of findings within the group:
 - Can you suggest examples that further highlights how you support students in relation to the findings so far?
 - If needed, direct them to a particular section of map to stimulate discussion

Appendix 11: Six Stages of thematic analysis (Braun and Clarke, 2006; 2019)

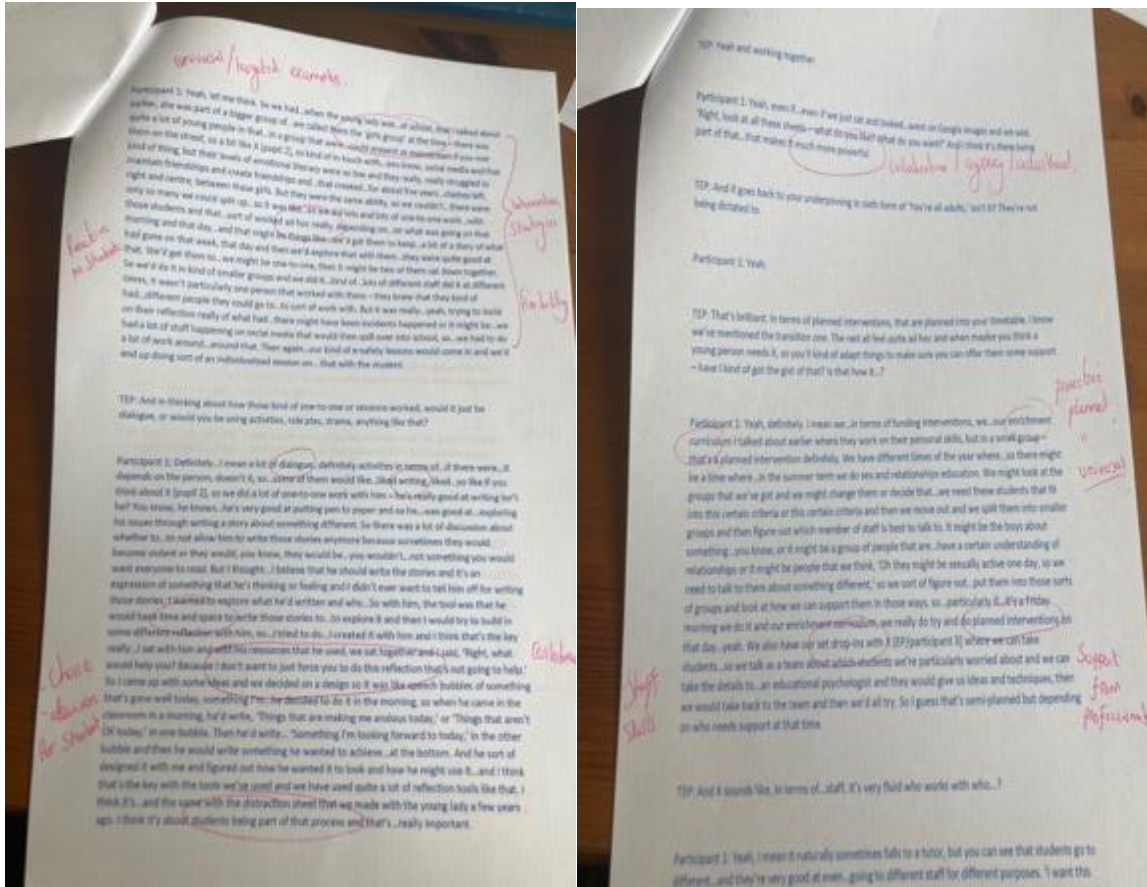
Braun and Clarke's reflective thematic analysis guidelines directed the analysis of the qualitative data gathered through the semi-structured interviews. The analysis is discussed in detail below.

Research questions:

- 1) How do professionals in a special school's sixth form promote mental health and well-being?
- 2) What are the facilitators and barriers to promoting student mental health and well-being?

Stage 1: Become familiar with the data

The researcher organised transcription of the data from the four interviews before checking against the original audio files to ensure their accuracy. Transcriptions were then read and re-read, noting down initial ideas such as: provision was evident at the individual, group, and whole-school level; staff strive to help students with regard to their well-being; staff have skills and knowledge etc.



Exerts of the first reading of transcripts

Researcher's reflective perspective

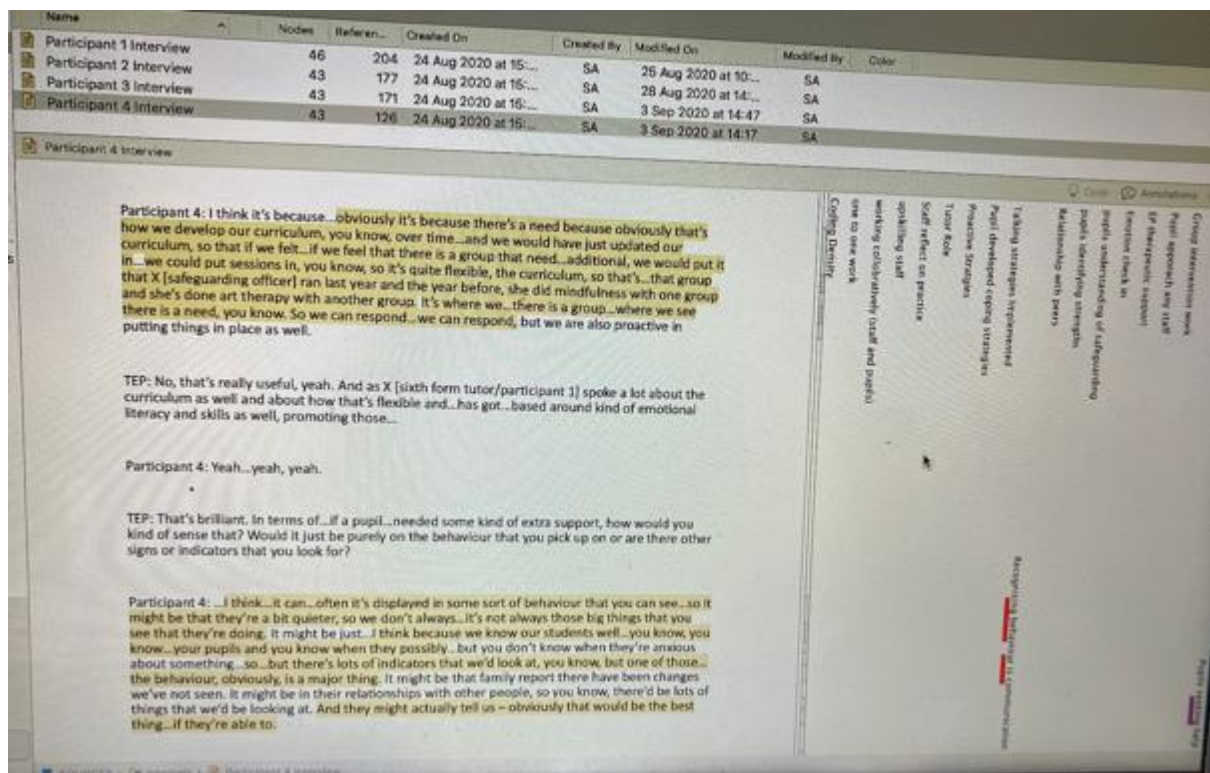
The researcher had a keen interest in the post-16 population since their role as an assistant educational psychologist whereby the team felt to be developing we're skills within this area concerning knowledge, practice, and relevant resources to use. Also, during the researchers' time as a teacher and special education needs and disability coordinator, they were keen for others to understand behaviour as a form of communication. This was reinforced within the Code of Practice (Department for Education & Department of Health, 2015) and the introduction of social, emotional and mental health as an area of need, which felt like an attempt to encourage adults to focus on the needs of children and young people. Therefore, although this was not the original empirical study design, the researcher felt this was an important area to explore, particularly within a special school, which feel to be

overshadowed within policies and research in comparison to mainstream. The researcher was familiar with the post-16 department from previous research and had met some of the participants. Therefore, the researcher had awareness of the setting and routines. As a result, this familiarity may have influenced the researcher's subjectivity but they felt it did help to have some established rapport with some of the participants, especially when all communication became virtual. The researcher was also aware of their practice concerning social, emotional, and mental health and therefore tried to ensure the interviews and focus groups were led by the participants. The researcher had regular supervision with their supervisor to discuss aspects of the analysis and talk through emerging findings.

Stage 2: Generate initial codes

The researcher systematically coded the entire data set by uploading the transcripts to NVIVO. The coding was conducted at a semantic level. Some sections were tagged with more than one code, whereas some segments were not tagged at all as they had no relevance to the research questions. Coding is a data reduction activity and a way of starting to organise the data and identify possible patterns. This process was iterative and flexible, with constant revision of codes, such as revising names to try and reduce duplicated codes.

This resulted in a compiled list of codes that adequately identified patterns and meaning from the dataset. The researcher then examined the codes in relation to research questions which led to subsuming (if codes were similar), deleting or renaming of codes (to improve the descriptive label).



Exerts of NVIVO Coding

Tutor Group	<p>P1: Our tutor groups are mixed ability so in my tutor group I'll have a complete mix.</p> <p>Well normally...they're a bit bigger this year! They're sort of creeping up...about...average 12.</p> <p>And depending on the need of your tutor group, they'll always be at least three staff in that room.</p> <p>We really try hard not to move anyone once they're in a tutor group – it doesn't always work, but we try and keep them with that same tutor, like someone who's in my tutor group hopefully will stay in mine for three years.</p> <p>That really is the key to most of the support that the students get, it really starts with the tutors.</p> <p>As a form tutor...seeing those students, 40 minutes every morning and then we get a Friday afternoon where we get a longer session with our tutor group. And I think it just starts with seeing those students at the same time...we're the first face they see every day and they get a little bit more than...it's not just 10 minutes, quick register.</p> <p>If a student walks in in the morning and they're not OK and we know them that well that we pretty much know straight away when someone isn't OK or if they're just a little bit withdrawn today or a little bit quiet today – that's the time when we're looking out for that sort of stuff, so that's where it begins.</p>
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Exert of the table created from NVIVO: codes and corresponding data extracts

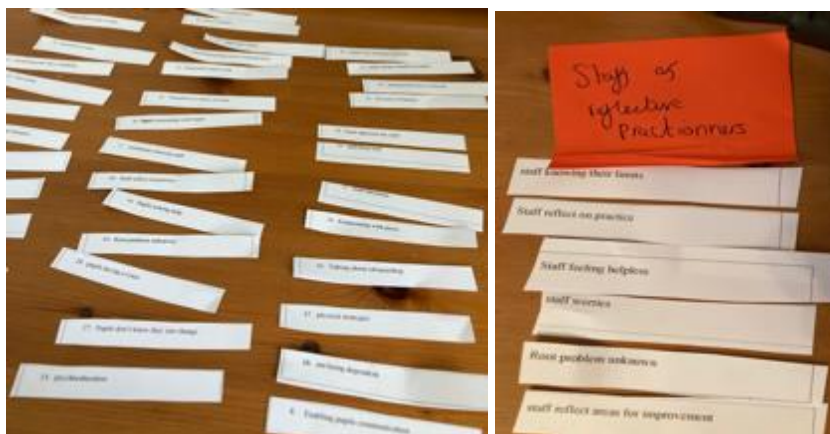
Type of code change	Code affected	Notes
Discarded as weak codes or duplicates	1, 2, 21, 22, 23, 26, 36, 47, 51, 59, 63, 79,	Codes were duplicates, supported by only one extract, or did not map easily into the research questions
Collapsed into existing codes	5, 92, 66 14	Code 5, 66 & 92 collapsed into 14
	10, 11, 80	Code 10 & 11 collapsed into 80
	12, 74	Code 12 collapsed into 74
	13, 57	Code 13 collapsed into 57
	52, 43	Code 52 collapsed into 43
	17, 72	Code 17 collapsed into 72
	28, 78	Code 28 collapsed into 78
	32, 92	Code 32 collapsed into 92
	29, 3	Code 29 collapsed into 3
	37, 80	Code 37 collapsed into 80
	39, 33, 19	Code 39 collapsed into 33 & 19
	40, 83, 94	Code 40 collapsed into 83 & 94
	35, 87	Code 35 collapsed into 87
	43, 85, 48	Code 43 collapsed into 85 & 48
	46, 14, 96	Code 46 collapsed into 14 & 96
	52, 56	Code 52 collapsed into 56
34, 72, 94	Code 34 collapsed into 72 & 94	
42, 74, 78	Code 42 collapsed into 74 & 78	

79. Promote confidence	5	9
80. Promote self-esteem	3	6
81. reduce anxiety merged into 28	1	2
82. Referral by whom merged into 82	4	9
83. Referral process	1	1
84. Relationship with therapist	8	23
85. Relaxation Skills merged into 28	4	8
86. Role of Therapist	5	18
87. Seek directiveness from therapist merged into 85	1	2
88. sense of loss at end	5	10
89. Share private information merge into 4 & 103	2	2
90. Social Isolation	2	6

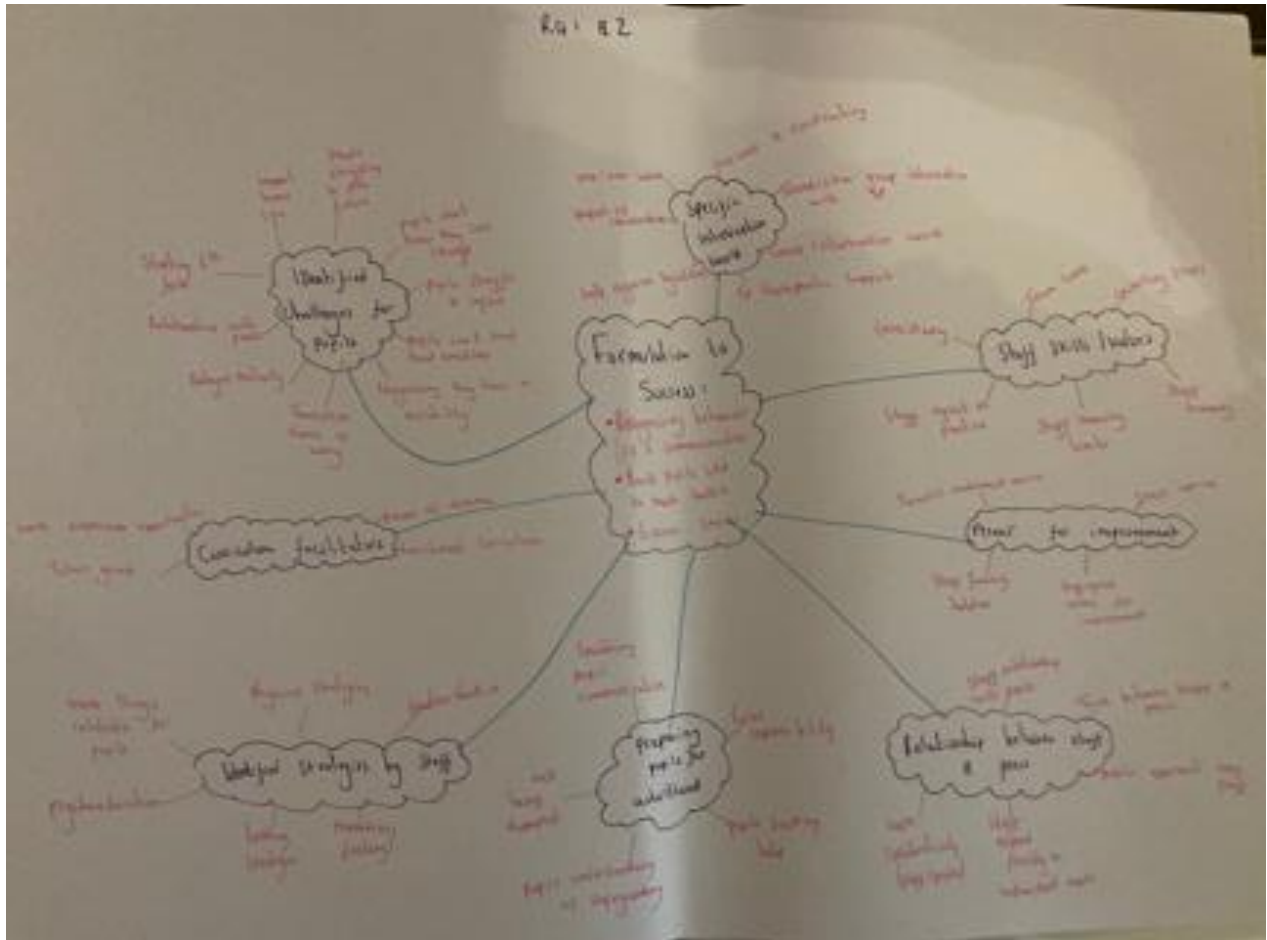
Exerts of refining code tables

Stage 3: Generate initial themes

The researcher then began to generate candidate themes based on the remaining codes. This involved a lot of thinking about the codes and identifying similarities and relationships across the codes. The researcher developed clusters of codes that were beginning to tell a story about that particular data set.

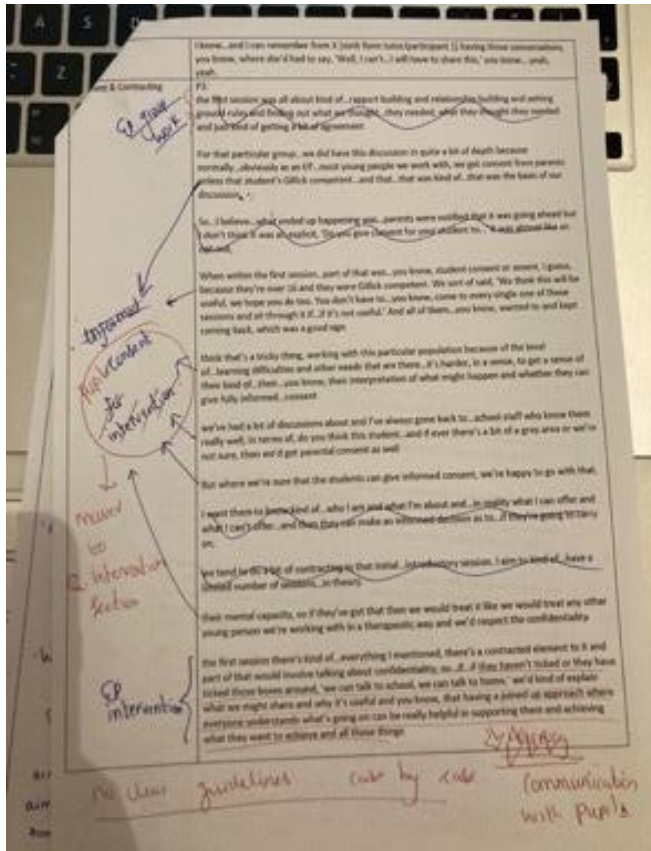


Pictures of researcher initially sorting codes



Researcher beginning to develop candidate themes

However, the researcher was not satisfied with the codes and revisited the list of codes for a third time. The researcher relooked at the codes and corresponding data extracts to ensure it was representative. This involved further renaming and subsuming of codes that were too similar to warrant a separate code. The codes and corresponding data extracts were then compiled into a table.

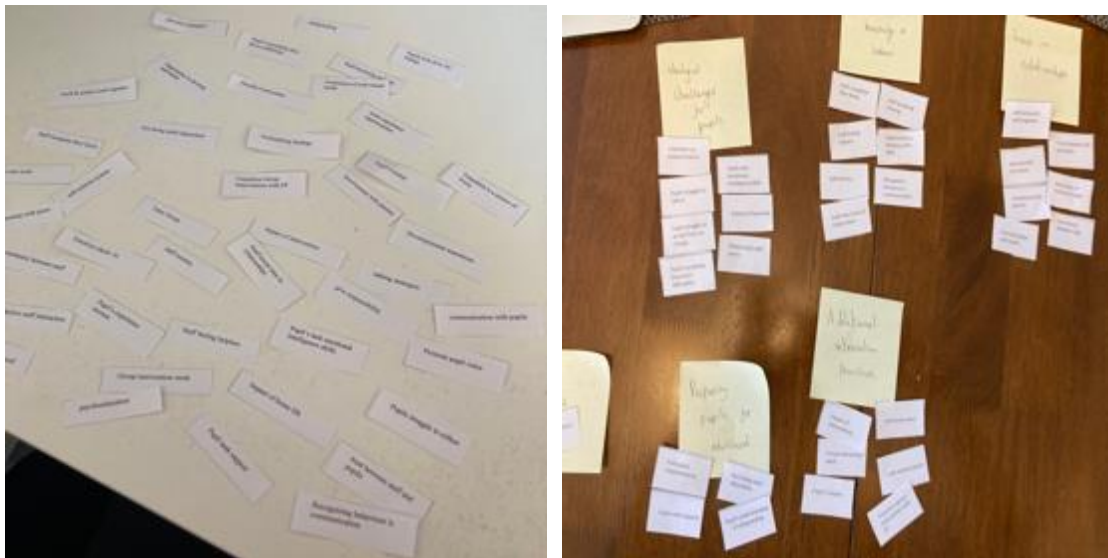


Researcher re-looking at codes and corresponding data extracts

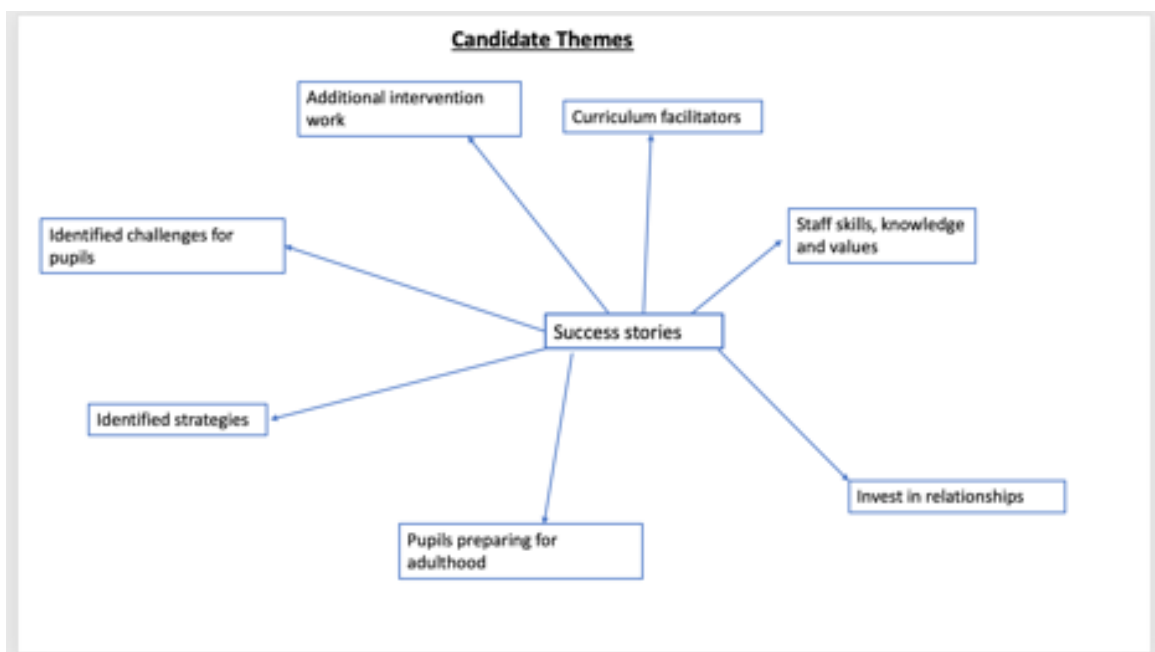
Type of code change	Code affected	Notes
Discarded as weak codes or duplicates		Codes were duplicates, supported by only one extract, or did not map easily into the research questions
Collapsed into existing codes	2, 39, 36, 41, 21	Code 2 collapsed into 21, 36, 39 & 41
	43, 33	Code 43 collapsed into 33
	21, 24	Some codes 21 moved into 24
	3, 44	Some Codes 3 moved into 44
	35, 31, 48, 6	Code 35 collapsed into 31, 48 & 6
	38, 45	Code 38 collapsed into 45
	8, 29	Code 8 collapsed into 29
	12, 20, 6	Code 12 collapsed into 6 & 20
Grouping/ separating codes	26, 5, 23	Code 26 collapsed into 5 & 23
	33, staff knowing their limits	Renamed to Staff recognise their limits
	33, Staff reflect on practice	Renamed to 'Effective staff interaction'
	48, upskilling staff	Renamed to 'Opportunity to develop staff's skills'
	37, Staff training	Renamed to 'Staff accessing training'
	21, Pupil approach any staff	Renamed to 'Promote pupil voice'
	24 Pupils seeking help	Renamed to 'Pupil seek support'
34, Staff relationship with Pupils	Renamed to 'Staff invest time in relationships'	

Exert of further refinement of codes table (2)

The new list of codes was printed off and cut up into individual strips and manually grouped and re-grouped to explore candidate themes in relation to research questions. The researcher was looking to capture meaningful patterns across the data set. A candidate thematic map was created.



Researcher sorting codes and generating new candidate themes



Candidate theme map

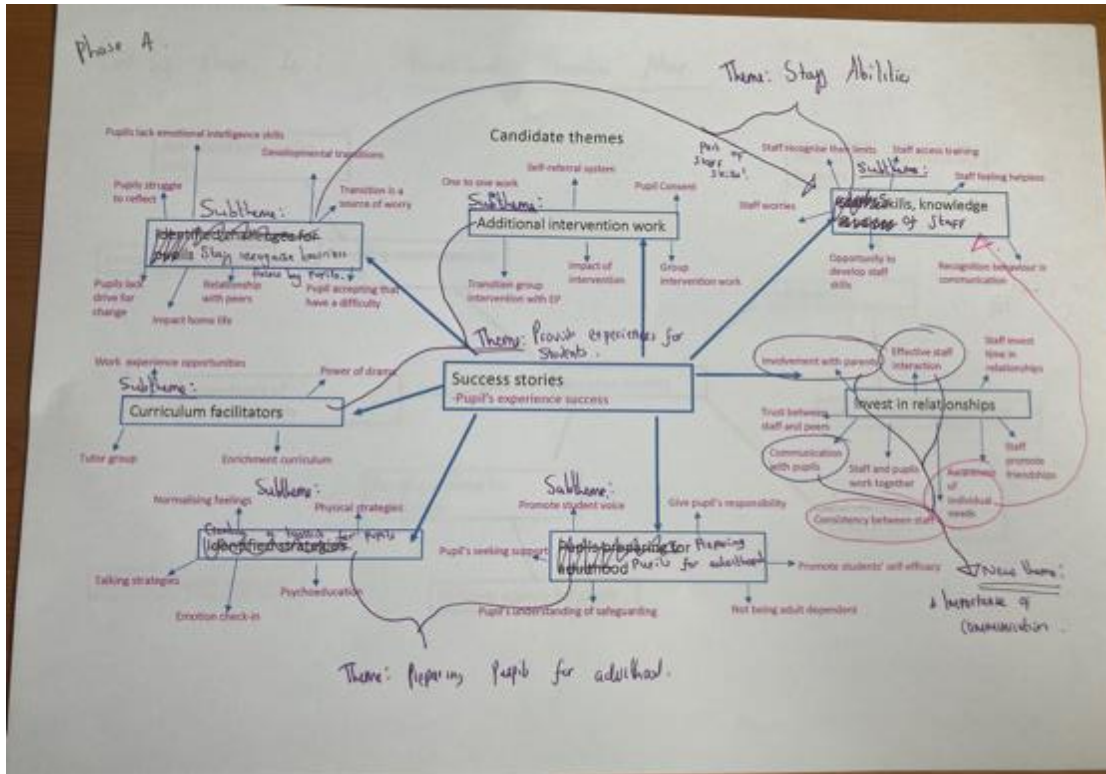
Success Stories

Subtheme	Codes
Pupil's experience success	<p>P1: By the time she left us, she'd got herself a place doing animal care at college, which she really, really, really wanted to do. And she'd moved out...she was moving out of her mum's, into independent living...so she was...she'd had some successes,</p> <p>He ended up going back to his placement and then people had a bit of an understanding of where he was coming from, why and they could...they knew how to...de-escalate him when he was becoming anxious and that was a big success actually...I think.</p> <p>P2: He had a bit of support to get there at first, but once he'd experienced it, he was like, 'This is fine.' And then he was coming on to...on school trips under the trust that he was going to be back at a certain time or...as long as he knew exactly what was going to go on...he was willing to give it a go but it took us.</p> <p>'Do you want to take some time out?' 'No, no, no!' 'If you take some time out, we can have a conversation...go through there...' but by doing that process...repetitively and regularly...she was identifying then, 'I think I'm going to have a meltdown, can I go and take myself away?' And she started to do that.</p> <p>So it's changed her life! She's like, 'I'm just going to use this all the time now!' And it...that's got rid of all that...worry and...anxiety of... 'If I'm going to do a work placement, I've got to do reading or I've got to do writing,' do you know what I mean?</p> <p>But by having the group to have a chat and then go on and having a chance to be a mentor, it really helped her understand her identity and who she was as an individual.</p> <p>Yeah, like X [pupil 5]'s getting a lot better at it...where she would have to be told, 'You need to go and take some time,' she will...she will say, 'I need to take a time out,' and she'll go and take that time out.</p> <p>The achievement that you get of someone being able to go on a work experience that takes three years to get to, that's unbelievable</p> <p>Oh, his mum couldn't believe it...his mum could not...When I told her, 'I'm going to get him to do work experience this year,' she was like, 'Yeah...I can't even get him to leave his bedroom, never mind go on a work experience.' And it was so rewarding – it was amazing.</p> <p>P3: Then you see the kind of positive impact and you think actually it was worthwhile, it was...kind of the right thing to do.</p> <p>P4: But...he said, 'Oh yeah, I will talk to him.' I couldn't believe it. So hopefully...we've not let it go, but we've not pressurised him. But we...and you know it will...he will come round to it if he realises what it all is and he did.</p> <p>They bought into it...they...they...it was offered out and a small group of them...were involved and X [EP/participant 3] started that group off a couple of years ago and it really, really helped them.</p> <p>Eventually...we got...we were talking about the things she liked in school...we got her in actually in the end, it worked. I don't know how!</p>

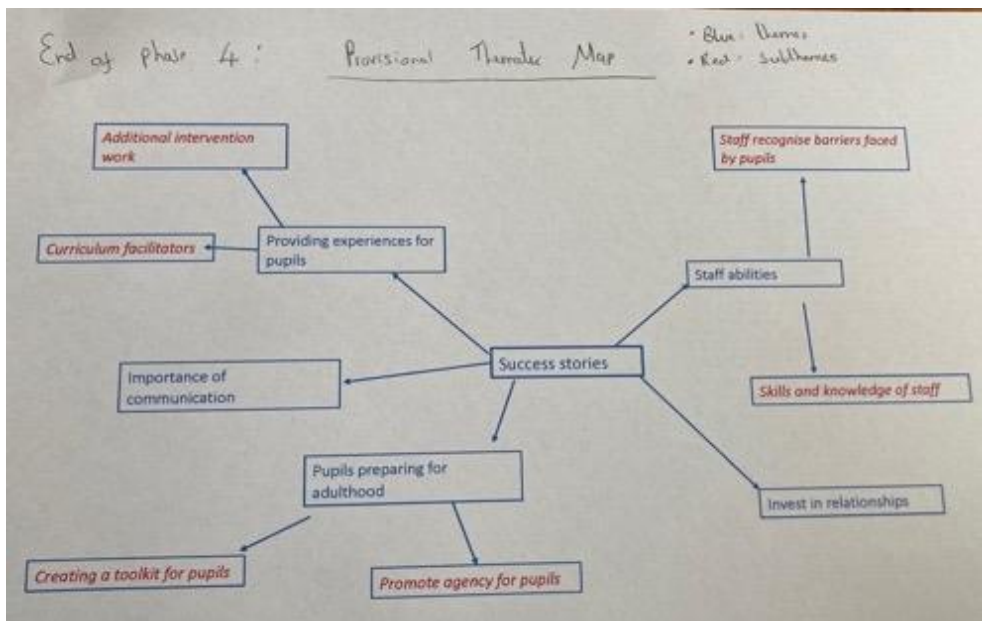
Exert of tables with candidate theme, code, corresponding data

Stage 4: Review themes

The researcher then re-read all the corresponding codes and data-extracts for each candidate theme, which led to relocating some codes and renaming of some of the candidate themes. For example, the researcher felt that codes and data within the 'invest relationships' did not conceptualise the pattern of the data and the role communication played in promoting student well-being. Therefore, the researcher generated a new theme: 'Importance of communication'. This phase also led to the development of subthemes, as this helped to tell the story of the data. Finally, the entire data set was re-read to ensure the themes accurately represent all meaningful data. At this point, any missed data can be identified and coded; however, the researcher did not find any.



Researcher's reassignment of themes/subthemes after rereading data extracts



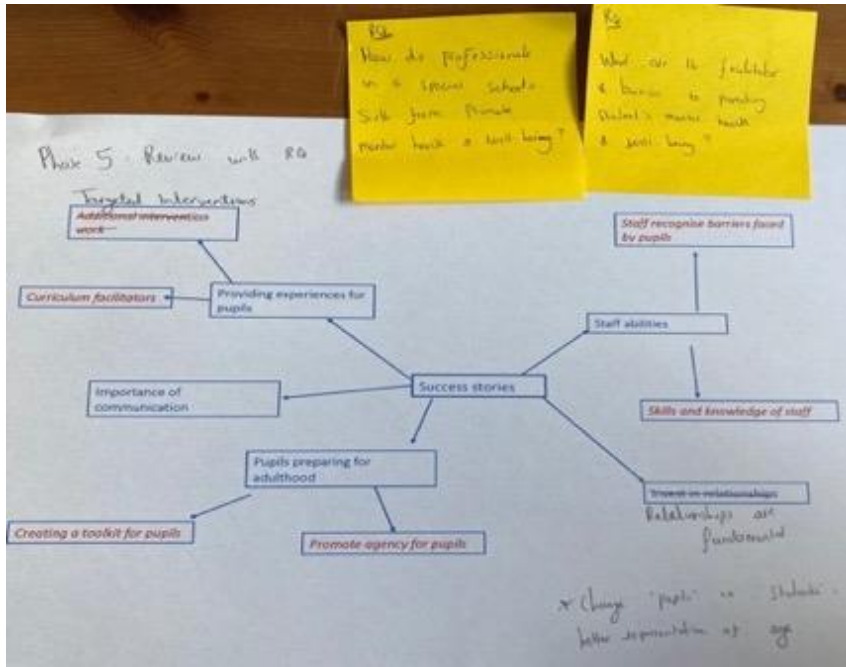
Provisional thematic map

Stage 5: Define themes

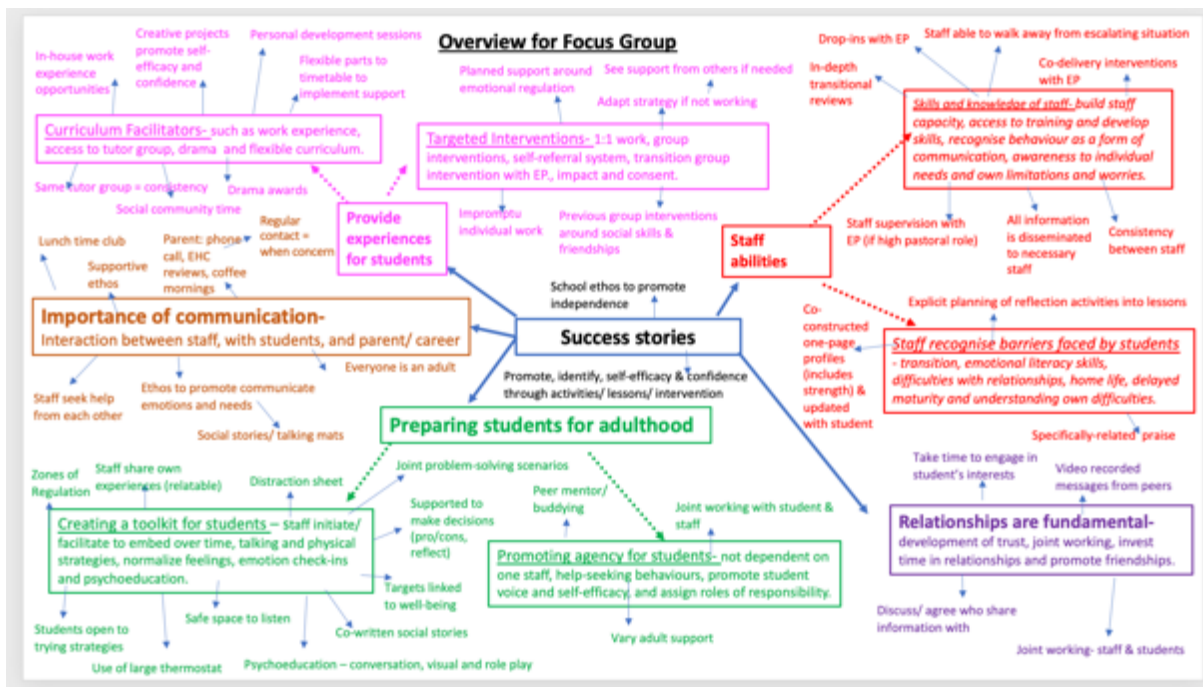
The researcher considered both research questions in relation to the candidate thematic map created. The researcher relooked at the themes and associated sub-themes to

refine them further and consider how each fitted into the overall story of the data. This led to the name change for 'invest in relationships' which was amended to 'relationships are fundamental' as the researchers felt 'invest' was misleading for the data represented by the codes. Also, the subtheme 'additional intervention work' was renamed to 'targeted interventions' to reflect the data and used terminology within the literature (Weare, 2015). The researcher also felt that 'pupil' did not reflect the post-16 population, therefore the term 'students' was selected as a more appropriate description. At this point the researcher also relooked at the codes and data extracts to explicitly identify the facilitators and barriers that emerged from the data.

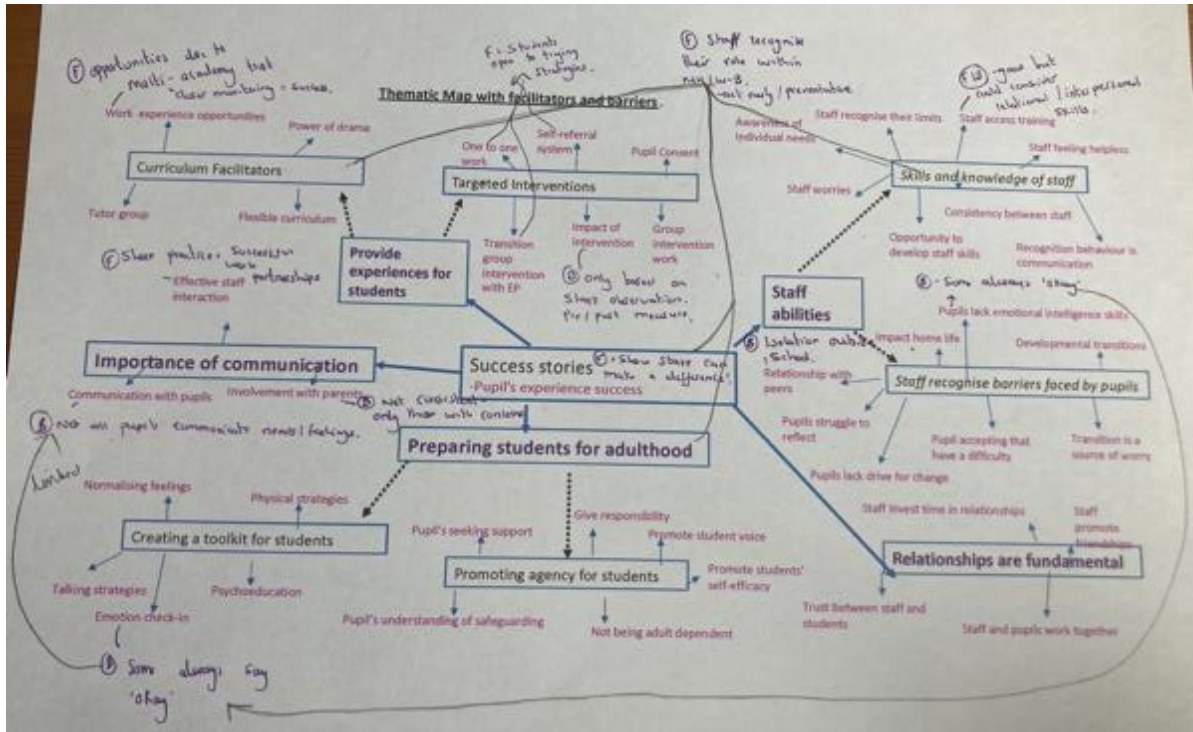
This was shared with the researcher's supervisor and each theme was discussed in relation to the research questions and the codes they represented . It was felt that although the research questions were answered, the findings lacked practitioner utility that would add richness to the data. Therefore, the researcher gained additional ethical approval for a virtual focus group, using this as an opportunity to member check and also explore further strategies and provision that participants use in their practice around the themes identified. The focus group was complimentary to the thematic analysis and the data collected led to the contribution of tangible strategies to themes (Appendix 12).



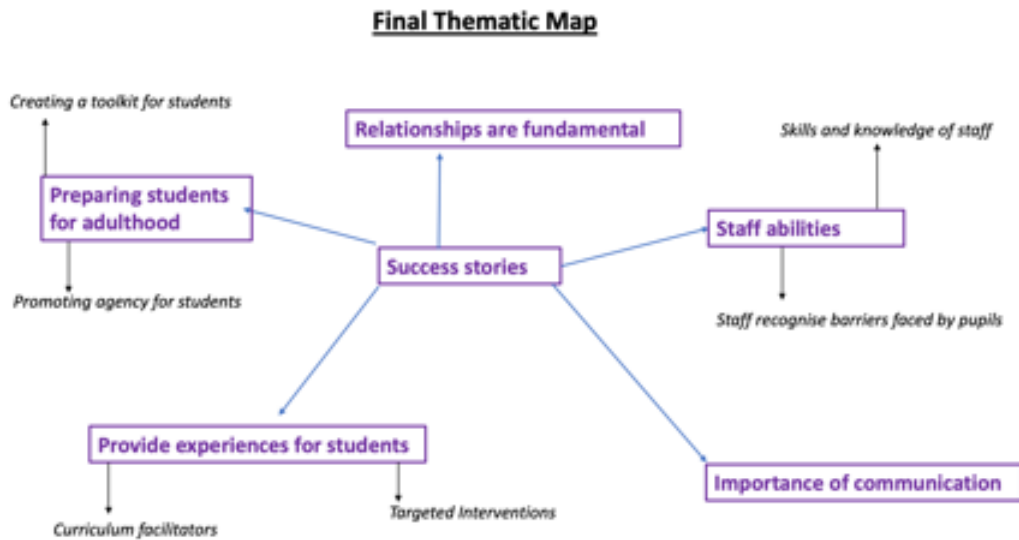
Review of provisional thematic map



Thematic map with additional tangible strategies (table available in Appendix 12)



Thematic map with identified facilitators and barriers



Thematic map (subthemes in black italics)

Stage 6: Writing the report

Producing the report provided the final opportunity for analysis. In discussion with their supervisor, the researcher decided to write the result sections in tandem to both research questions, as this felt to be more coherent for the reader. In the write up the researcher

selected extracts that best told the story using the participants' own words to help answer the research questions.

References

Department for Education & Department of Health. (2015). *Special educational needs and disability code of practice: 0-25 years. Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities*. London: Department for Education & Department of Health.

Appendix 12: Findings from the focus group

The focus group was audio recorded by the researcher. The focus group data was not incorporated into the thematic analysis; instead the researcher listened to the recording and identified provision that linked to areas of the thematic map and documented them in the table below. Therefore the focus group was used to add richness to the original data collected and provide further tangible strategies for practitioners. Below are the tangible techniques and strategies in relation to the themes and subthemes (in italics).

Theme	Strategies
Success Stories	<ul style="list-style-type: none"> • School ethos – to promote independence • Promoting students identity, self-efficacy and confidence – through activities, lessons & interventions (further details below)
Relationships are fundamental	<ul style="list-style-type: none"> • Take time to know student’s interests and use this to engage in conversation • Video recorded messages from peers for students • Joint working between staff and students where everyone is considered an ‘adult’ (no battles for ‘wins’ as can happen in mainstream) • Focus on building trust, such as asking to share information with parents
Staff abilities	<p><i>Staff recognise barriers faced by students:</i></p> <ul style="list-style-type: none"> • One-page profiles that provide in-sight into a student and their needs, co-constructed with parents and students and updated/ reviewed at least once a year. Provides opportunity to build upon their strengths • Explicit planning of reflection activities so students can recognise barriers • Use of explicit praise so students know what they have done well / why they are being praised <p><i>Skills and knowledge of staff:</i></p> <ul style="list-style-type: none"> • Staff with high pastoral workload can book supervision with EP • Consistency between staff in relation to expectations, boundaries and for some use of specific phrases • Staff feel able to walk away from situations and let someone else intervene when needed • Knowledge of students is imperative to helping and supporting them in the most effective way • Access to outside professionals acknowledged and ensuring this information is disseminated to those involved with the student • In-depth transitional reviews to sixth form which includes a discussion with all staff involved with the student and transitional visits for them • Opportunity to book a drop-in with the EP to discuss strategies to support students (all referrals tends to be social, emotional and mental health related) • Staff have access to training (mainly to increase knowledge and strategies) • Co-delivery of interventions with outside professionals (e.g. EP) to build staff capacity in the future

<p>Provide experiences for students</p>	<p><i>Targeted interventions:</i></p> <ul style="list-style-type: none"> • 1:1 impromptu support (speaking to students when noticing change, giving them space, communicating with other staff on their behalf, emotional check-ins) • 1:1 planned support (e.g. regulating emotions, friendships) • 1:1 therapeutic support with EP accessed via the self-referral system • Group interventions around a particular area of difficulty e.g. social skills and friendships • Adapt strategy or plan if it is not working for a student <p><i>Curriculum facilitators:</i></p> <ul style="list-style-type: none"> • Work experience opportunities (use of in-house facilities e.g. care-taking, catering facilities) as well as wider options • Creative projects – such as use drama- helps promote self-efficacy and emotional literacy skills • Drama awards to promote self-esteem & confidence and • Flexible curriculum so staff can respond to needs of the cohort and plan interventions that are needed. • Social Community Time every Friday pm – explicit opportunity for students to interact with whole of sixth form. Opportunities for less structure so they have to make choices for themselves. • Tutor group – opportunity to see tutor every morning so they can check-in. Opportunity to ensure students are ready for their day ahead. Ensure 3 staff at least so staff can respond to needs of students easily e.g. offer 1:1 support. Staff are flexible with roles. • Personal development sessions which includes activities such as mindfulness and relaxation techniques
<p>Importance of communication</p>	<ul style="list-style-type: none"> • Communication between staff: in-depth transitional reviews to sixth form with all staff involved, informal lunch time club, staff seek out others and ask for advice for those that they may be struggling to engage with, supportive ethos so staff feel they can and do ask others for advice • Communication with students: use of talking mats and social stories, ethos to ensure students can communicate their needs and feelings/ emotions • Communication with parents – tends to be when concerned about a student. Phone calls, meetings, EHC reviews, parental coffee mornings.
<p>Preparing students for adulthood</p>	<p><i>Creating a toolkit for students:</i></p> <ul style="list-style-type: none"> • Emotional regulation, use of Zones of Regulation or use of visual such as large thermostat, so students can communicate how they are feeling • Use of distraction sheet so students can trial and error coping/ regulation strategies – use of whiteboard so can edit these. • Psychoeducation through conversations and interventions in relation to coping with emotions (e.g. role play and visuals diagrams) • Co-written social stories • Joint-problem solving situations • Provide students with a safe space to talk • Staff share their own experiences to help validate emotions

	<ul style="list-style-type: none"> • Students supported to make decisions/choices by planning this into curriculum (social community time, less structure & have to plan their time). When making decisions - talk them through pro/cons visually. • Use of targets linked to well-being for students to work towards (some informed from EHCP) <p><i>Promote agency for students:</i></p> <ul style="list-style-type: none"> • Students given roles of responsibility e.g. peer mentoring • Joint working with students (e.g. updating information on one-page profile, deciding what strategies to work on). • Vary adult support so don't become dependent on one adult
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