

# EDUCATIONAL SUPPORT NEEDS OF INJURED CHILDREN AND THEIR FAMILIES: A QUALITATIVE STUDY

Samantha JONES, PhD<sup>1,2,3</sup>, Sarah TYSON, PhD<sup>1,3</sup>, Naomi DAVIS, FRCSEd (Tr. Orth.)<sup>2,3</sup> and Janelle YORKE, PhD<sup>1,3</sup>  
 From the <sup>1</sup>University of Manchester, Division of Nursing, Midwifery and Social Work, School of Health Sciences, Faculty of Biology, Medicine and Health, <sup>2</sup>Manchester Foundation Trust, Royal Manchester Children's Hospital, Department of Trauma and Orthopaedics and <sup>3</sup>Manchester Academic Health Science Centre Manchester, Manchester, UK

**Objective:** To explore the educational support needs of injured children and families.

**Patients:** Thirteen injured children and/or their parents ( $n=19$ ) discharged from a major trauma centre within 12 months.

**Methods:** Semi-structured interviews analysed with thematic analysis.

**Results:** Theme 1: communication and information needs. Schools need help to understand the effects of children's injuries and the adjustments required for their return to school, such as how to involve children in the more active elements of the curriculum. Thus, effective communication between the injured child, their family, health and education professionals and outside agencies is needed. A specialist key-worker could co-ordinate communication and school return. Theme 2: Educational support needs. Injured children experience changes to their appearance, new symptoms, and altered physical and cognitive abilities. Their absence from school often adversely affects their friendships. Consequently, injured children need continued access to education throughout recovery, support with learning, a flexible timetable, opportunities for social integration, involvement in all aspects of the curriculum, and environmental adaptations to maintain their health and safety.

**Conclusion:** Children with different types of injuries have similar needs for flexible learning and environmental accommodations. Social integration and participation in physical activity should be specific goals for school return.

Key word: children; injury; rehabilitation; education; needs

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Correspondence address: Samantha Jones, Trauma Office, Royal Manchester Children's Hospital, Oxford Road, Manchester, UK. E-mail: Samantha.jones@mft.nhs.uk; Samantha.jones-3@manchester.ac.uk

Childhood injuries are a key cause of disability with wide-reaching impacts for injured children and their families (1). Major Trauma Centres (specialist centres that manage severe injuries) were implemented in England in 2012. Although survival has improved, rehabilitation and functional outcomes, such as injured children's return to school have received less attention. The wide range of injuries managed in Major Trauma Centres often result in immediate, and sometimes

## LAY ABSTRACT

Serious injuries in children can have significant impacts on their school life, which often result in prolonged absence, which may affect their success. Teachers and health professionals need to understand how to make the return to school as quick and easy as possible. To understand more about their needs when returning to school we interviewed children with a variety of injuries and their families. Schools needed help to understand how to support injured children and the changes required for their return. These included: access to education throughout recovery, a flexible timetable, help to "catch up", and changes to make the school environment safe. A health professional (key worker) could provide this advice and assist communication between the hospital and the school. Adjustments need to ensure that children remain with their friends and are involved in all types of school activities.

prolonged, disruption to the injured child's education, (2, 3), which can adversely affect their academic attainment (4, 5). It is important for health and education professionals to support injured children's timely return to education and minimize any negative impacts (5). Apart from facilitating academic attainment, school can play a vital role in shaping children's emotional maturity, social development, and life trajectory (6).

Most school children with disabilities have chronic and/or long-term disabling conditions which can also affect their educational outcomes (7). Although some of the educational supports used for chronic conditions may be transferable to injured children, there are important differences. Chronic conditions tend to be stable or progress gradually. Consequently, children and their families are aware of their needs over time and develop expertise in managing them (8). In contrast, injuries occur suddenly, improve during recovery and mostly have good outcomes (9), thus rapid (but usually temporary) educational adjustments are required. Injured children and their families have limited knowledge or experience of managing their injury and its consequences, and may not know what is needed to optimize their education. The research to date on educational support needs after injury focusses on head injuries (3, 10–18). This may be because head injuries cause the greatest disability (9), potentially dramatically affecting long-term educational support needs (12). Unmet educational needs for children with head injuries are widely reported, (11, 15), but other

injuries have received less investigation. Whilst the long-term impacts for such injuries may be less significant than for head injuries, they can cause symptoms and disabilities (such as fatigue and limited mobility), which affect school attendance and psychosocial functioning (19). Our previous publications regarding injured children's rehabilitation needs demonstrate that children with a wide range of injuries (and their families) consistently identify similar needs and preferences about how services are delivered (20, 21). The aim of the current study is to explore the educational support needs and experiences of children with a range of injuries, and their families. This will inform and improve the provision of support for return to education.

## METHODS

### Study design

An exploratory interview study to understand education support needs from the perspectives of injured children and their parents.

### Setting and participants

Purposive sampling was used to ensure participants reflected the diversity of injured children typically managed on the major trauma pathway (9, 22).

Inclusion criteria: school-age children (aged 5–16 years) with an Injury Severity Score (ISS) > 8 who were discharged from specialist Major Trauma Centres in England, within the previous 12 months. An ISS > 8 was selected, as this is the criterion for the management of an injury at a Major Trauma Centre (23). The parents of injured children were also included.

Participants were excluded if they had been discharged within the previous 2 weeks (as they would have insufficient experience of living with their injuries since discharge to make an informed contribution), were pre-school age, had isolated burn injuries, suspected non-accidental injuries, or significant safeguarding concerns. Burn injuries were excluded because they are managed on a separate clinical pathway.

### Recruitment

The study was approved by the National Health Service (NHS), North West-Greater Manchester South Research Ethics Committee (REC reference 17/NW/0615) and the Health Research Authority. Trauma/rehabilitation co-ordinators in the participating centres screened admission records to identify potential participants, whom they then provided with age-appropriate study information packs (in-person or via post). The lead researcher (SJ) explained the study to participants who were interested in taking part. Before the interview, SJ asked parents to sign a consent form and, where possible, children signed a child friendly assent form.

### Data collection

All interviews were conducted by SJ who is a clinical academic based at a children's Major Trauma Centre. She was not involved in the care of the participants. Semi-structured interviews were conducted either jointly (child and parent) or separately, on the telephone or in person (depending on the participants'

preference). The supplementary material provides a copy of the topic guide, which explored the educational support needs and experiences of injured children and their families. As this paper is part of a larger programme of work, some questions relate to issues reported in companion papers (20, 21). The semi-structured format allowed participants to explore their needs and experiences irrespective of their educational pathway (home tuition, return to school), age or type of injury. Interviews were digitally recorded and transcribed verbatim.

### Analysis

A deductive semantic analysis was used. SJ identified themes and sub-themes primarily on their relevance to the research question, her pre-existing knowledge of the field, and because the topics of interest were explicit (24). SJ read the transcripts several times to become familiar with the data, and identify patterns and themes across all transcripts. As educational support needs for children with different types of injuries have been relatively unexplored in previous research, our aim was to provide a rich thematic description across all the transcripts to present the main themes to better understand injured children's educational support needs.

Child and parent data were analysed together. Firstly, because much of the parents' testimony was about their child's experiences and needs, and, secondly, because the injured child and their parents' needs are inextricably linked. In clinical practice they are considered as a single family unit. Although the educational support needs were the children's, their parents often played a lead role in managing them or advocating for them to be met.

Initial codes were applied to the data using NVivo 11, QSR International Pty Ltd and the final thematic analysis was performed in Excel, Microsoft, Washington, USA. Transcripts were not returned to participants for comment or correction.

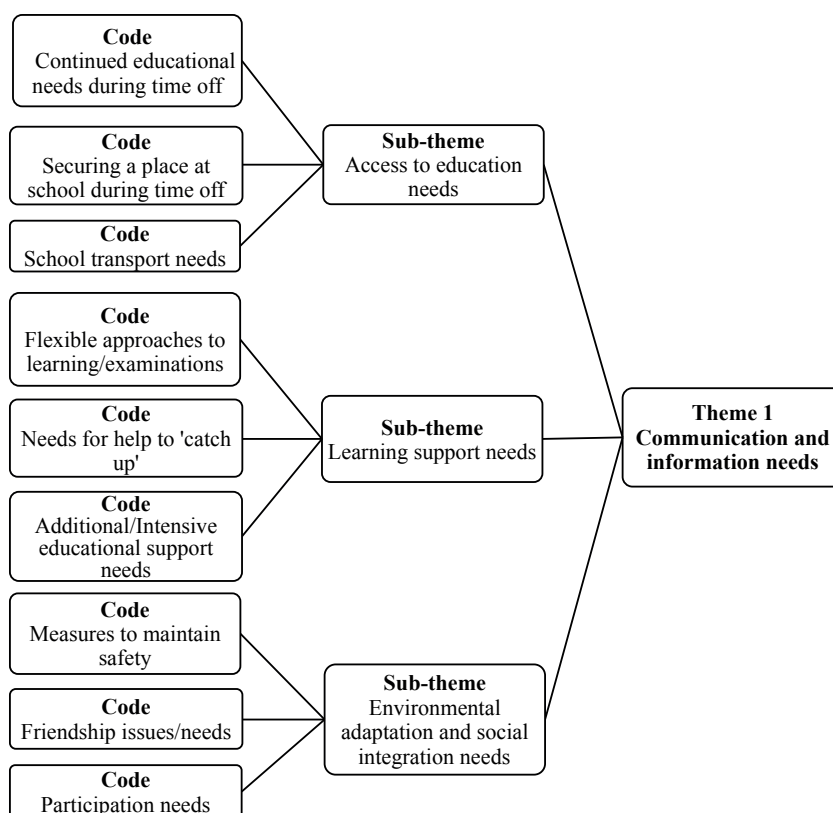
## RESULTS

Twenty-six interviews were conducted involving 32 participants; 13 children and their parents/guardians ( $n = 14$ ) and 5 parents whose injured child was too young, or who declined to participate. Twelve injured children and their mothers were interviewed,

**Table 1.** Characteristics of injured children (13 participants, and 5 who did not participate but whose parents were interviewed)

Characteristics	
Sex, $n$	Male 11 Female 7
Child's age at time of interview, years	Range 5–16 (median 13.0, IQR 3.5)
Parents/guardians	19 parents (17 mothers, 1 father and 1 guardian)
Injury mechanisms	4 Road traffic accidents 3 Sport 1 Fall > 2 m 5 Fall < 2 m 5 Other mechanisms
Body-part injured	1 Isolated head injury 1 Isolated spinal injury 3 Isolated abdominal injuries 1 abdomen & chest 6 Injuries to limb(s) 6 Multiple injuries
Time since injury (months)	Range 1–12.5 (median 8.5, IQR 9.3)

IQR: interquartile range.

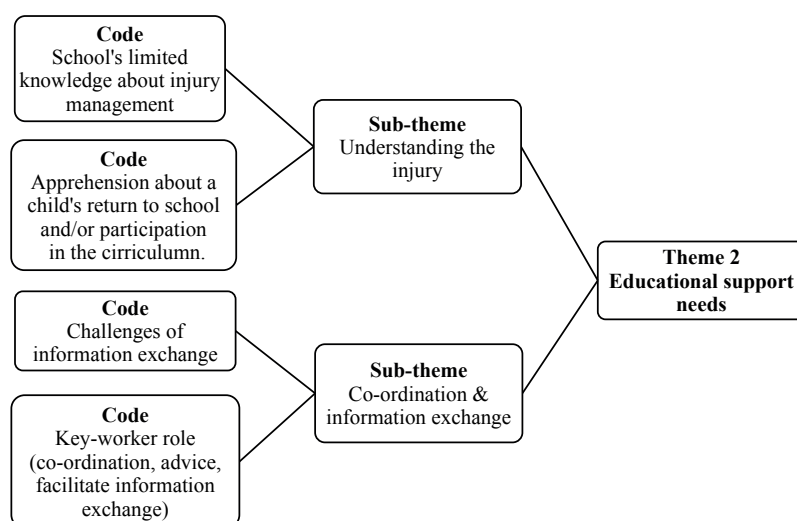


**Fig. 1.** Coding tree for Theme 1: Communication and information needs.

either together ( $n=10$ ) or separately ( $n=14$ ). In one family the mother and father were interviewed together ( $n=2$ ), and their child separately ( $n=1$ ). Five interviews were conducted solely with mothers, 3 of which were by telephone. All other interviews were conducted in person. Interview duration ranged from 11 to 76 min. Table I details the characteristics of participating injured children or the children who were the focus of the interview.

All the participating children had experienced varying periods of school absence because of their injury, but had returned to mainstream education or had plans to do so. The parents of the 2 children who had not returned to education discussed arrangements for their return and/or initial experiences.

Fig. 1 and Fig. 2 present the coding tree for the 2 main themes and associated sub-themes, which the authors identified using a thematic analysis.



**Fig. 2.** Coding tree for Theme 2: Educational support needs.

## 1. Communication and information needs

**Understanding the injury.** Schools were keen to facilitate the child's return and were receptive to advice from health professional and parents, as they lacked knowledge and experience in managing such injuries.

*"they just sort of held their hands up and said "we didn't know how to handle it". And you know, they've been really, really helpful since ...." (Parent 12).*

In such cases, all parties were often apprehensive about the child's return; as parent 2 explained *"everybody was just very nervous when he first went back"*.

Staff and pupils needed to understand the injury and its impact, in order to provide consistent and appropriate support. It usually fell to the parents to provide such education. Children needed teachers to be understanding. They appreciated teachers who; *"showed a big interest"* (Child 6) and *"didn't forget me ...made sure [I] were ok"* (Child 9). When these issues were not fully understood, teachers and pupils were either very protective or did not seem to understand the need for caution or adaptations. This was more pronounced when there were no visible signs of the injury, as was the case for head and abdominal injuries.

*"Because like they [are]....still letting people like barge into me and stuff...I don't think they understand how bad the injury actually is." (Child 13 with an abdominal injury)*

Participants highlighted that teachers and pupils needed further education to understand the difficulties associated with the invisible types of injuries.

*"if he had crutches or a cast on his arm...., other kids would just automatically clock that...and just give him the space in the corridor..., because his injury's internal... there's nothing to see." (Parent 18 of a child with a head injury)*

The return to physical education represented a key challenge, as teachers were apprehensive about what injured children could do and needed help from health professionals to understand their physical capabilities.

*"I think people, like, really worry about it ... they're... really over ...protective and people go "are you sure you can do that?"... And I just... want to do it without... [being] worried about." (Child 21)*

**Co-ordination and information exchange.** Co-ordinating education after an injury was often challenging because of the multiple agencies involved including: teachers, other pupils, the injured children and their parents, health professionals, education authorities (home tutors, exam boards etc.), plus (in some cases) community services.

*"every term they had a big meeting and the hospital still got involved with them, the teachers from the high school [and some from the] primary school. The occupational therapists all got involved. All got together to.... see how [injured child] was getting on." (Parent 4).*

The responsibility to advise and inform agencies about how to manage their child's injury was a cause of frustration and anxiety for parents. However, support improved when a specialist key-worker was available to act as a central point of contact and to co-ordinate the process. This was greatly appreciated by the parents and they felt strongly that the co-ordinator needed to be someone whom the family trusted and ensured they were involved in discussions and decision-making processes. Participants described several different professionals who fulfilled this role: healthcare professionals, teachers, home tutors, victim support workers and charity workers.

*"He [victim support worker] just reassured me a lot and answered a lot of questions that I had about going ...back to school and sorting things out." (Child 21)*

Information sharing processes were extremely variable and it was often unclear who had responsibility for providing the school with information.

*"she [Occupational Therapist] ... was quite happy to ring them [school] for me in the end. But, ... I did speak to them myself." (Parent 20)*

Communication with the school was particularly difficult when the injury occurred during school holidays (as was often the case).

*"That two-week holiday happened two days after his accident. So, there was this two-week void...with nobody being in touch, and we were like, we were traumatised." (Parent 18)*

Participants found communication and collaboration with the school easier when relationships with teachers/school were already established.

*"Then one of his teachers rang. They're a really close school, it's like a little family." (Parent 28)*

## 2. Educational support needs

**Access to education.** Injured children's educational support needs differed from children with chronic conditions who require long-term adaptations. Firstly, their difficulties had a sudden, rather than life-long or gradual onset, which resulted in an unpredicted (sometimes prolonged) absence from school. Secondly, the injured children's support needs changed with time and were often temporary, as most were still recovering when they returned to school. Thus, injured children often needed adaptations that differed from those for children with chronic conditions and were specific to their situation.

Participants reported that the injured children needed access to education throughout their recovery, including the time when they were unable to attend school, which, for some was prolonged. Education was provided in the form of hospital tutoring and/or home tutoring or work sent home from school. Participants' experiences were very varied, but individualized support was considered to be comprehensive.



*"They brought over some work as well... like my English teacher explained what I'd missed and what my class had gone over. So the school helped a lot." (Child 10)*

Conversely, access to education was made difficult by bureaucratic and inflexible systems that could not accommodate the specific needs caused by the injury. Parents wanted to do everything they could to help ensure their child's educational needs were met. They fought to protect their child's place at school, organized for work to be sent home, and provided help with such work. However, they felt a professional was needed to help access education outside school, co-ordinate inter-agency working, transfer information (particularly between the hospital and school) and ensure that injured children and their parents received appropriate support.

*"Because he was medically fit to be in school, we couldn't get home schooling for him. But school still wouldn't let him in.... She [trauma co-ordinator] had to really, really fight with school and the local authority ...for them to keep his place [at the school], 'cos they were trying to give it away." (Parent 2)*

School transport was another important issue, as previous arrangements (such as using the school bus) became impracticable. For example, systems which lacked the flexibility to provide alternative transport arrangements for children with injuries that were invisible or required the use of mobility aids. It fell to parents to provide alternative transport, which impacted on their work and other responsibilities.

**Learning support needs.** The return to school highlighted that the children's recovery was far from over. Symptoms such as fatigue, pain and poor concentration often only developed as the child returned to school, when they became more physically and mentally challenged. This made participating in the full curriculum difficult. Fatigue was the most common problem for children with all injury types. A flexible approach to learning and examinations was imperative to accommodate injured children, who were often trying to cope with new physical symptoms as well as changes to cognitive and physical abilities with wide-ranging repercussions. These impacted on their educational and social progress. For example, being unable to complete a music examination because they could no longer play a musical instrument, or having to learn how to write with their non-dominant hand.

Ongoing symptoms also necessitated time for rest and "time out", plus other on-going commitments, such as hospital appointments that also detracted from school attendance. A graduated return to school was often needed to allow children to attend such appointments and cope with the demands of school life.

*"[The school said] 'we're not going to be pushy with [injured child]' .....He don't have to arrive on a certain time in school. We'll give him [time] .... Slowly, slowly, slowly, we will increase his hours. So that was helpful." (Parent 7)*

When diminished physical and cognitive abilities created new learning needs more intensive educational supports were implemented, such as a one-to-one teaching assistant or an education health and care (EHC) plan. Consequently, these participants tended to have a more satisfactory experience. They described a structured approach with clearer systems and explicit processes than children with less severe limitations.

*"She [teaching assistant] was with him every single day 'til they finished. Yeah, really good, she looked after him well." (Parent 30)*

On their return to school, injured children needed help from teachers to catch up with missed work and examinations. This was challenging, as the curriculum progressed rapidly, but was addressed by providing extra work, additional explanations from the teachers and attending revision classes. "Help to catch up" and "access to education" were interlinked. Better access to education during the injured children's absence from school resulted in them requiring less help to catch up. For example, the provision of intensive home tutoring resulted in significant progression through the curriculum.

Injuries sustained during the time when children were preparing for or taking important examinations were a cause of concern. Collaboration was needed between the injured child, parents, teachers, education authorities/examination boards and health professionals to determine whether it was possible to undertake the examination(s) and to make any necessary allowances or adaptations.

*"He's only in school now because the teachers were pushing on that because of the SATS [national school assessments]." (Parent 14)*

*"The hospital is also doing letters – to the various exam boards.....taking [the injuries] into account for his marks." (Parent 11)*

**Environmental support and social integration needs.** On return to school, injured children were often physically separated from their classmates during lessons and excluded from active elements of the curriculum (such as physical education). Limited access around the school building for children with reduced mobility (such as long distances, stairs and crowded corridors during lesson changes) resulted in the injured children spending lesson time in a separate area from their peers. This was described as a "hub" or "learning zone"; an area for children who did not join the mainstream classes.

*"If there was a fire he wouldn't be able to get out. ....so he has to stay on the one floor; and it's called the Progress Zone, so....he doesn't get to see his friends as much, apart from breaks and stuff like that." (Parent 20)*

However, this area was primarily for children with behavioural problems or who were excluded as a punishment. Injured children found working in a separate area unhelpful and fought to remain with their peers.

*"It was like an isolation room. Not the best environment to go in."* (Child 24)

The school environmental adaptations were sometimes needed to protect the injured children's health and safety. Children were encouraged to avoid crowds, a common feature of most school environments. This was addressed by leaving lessons/school early, having lift passes and avoiding busy areas.

*"I wasn't allowed in the cloakroom with other people. (Child 29) ... "You couldn't be around a big crowd in case you got knocked."* (Parent 30)

Another safety measure was a buddying system, whereby the injured child could choose a peer to stay with them at playtimes or assist them with functional tasks, e.g. carrying their school bag or helping them move around the school safely.

Working in isolation was considered unnecessary by injured children. In fact, friendships formed an important part of school life and the opportunity to re-connect with friends was a key motivation for the return to school after the injury.

*"I just liked to be with my own friends again and everyone working, [the] environment, ..... it was just better"* (Child 5)

Friendships were an important source of support for injured children, especially when their peers adopted a protective role. However, challenges occurred when children found it difficult to relate to their peers after such a major life event or felt their friends had "moved on" during their absence. This was particularly true for those who were injured during the long summer holidays and/or when transitioning between schools.

*"obviously when you first start, you do have some friends from primary school. But you make new ones as well .....but [by] the time he went, those little social groups were already formed. So it was tricky for him."* (Parent 2)

Another factor affecting socialisation was the self-consciousness children felt about changes to their physical appearance. For example, reluctance to attend school as a result of a limp, or to undress in the communal area because of their scars.

Physical education, school trips, playtime activities, dance, music or drama represented both learning and social opportunities in school. The injured children wanted and needed the same opportunities as their peers, but all of the participants were excluded from one or more of these activities. The reasons for exclusion were multifactorial and often (but not always) based on the advice of health professionals and the application of health and safety regulations. Physical education was often an issue. Teachers involved injured children in other ways, such as refereeing or recording scores, but other children had to watch from the side-lines or work in a separate area. The inability to "join in" was a significant source of frustration and boredom for injured children.

*"I want to be doing the actual activity...what they're doing. Yeah I just want to be back."* (Child 24)

*"A bit annoyed..... because the main thing I like to do is play football and run around, stuff like that."* (Child 27)

## DISCUSSION

This study has shown that children with a variety of injuries share needs for support with: the return to education, flexible learning, school environmental accommodations, and social integration. Schools need help to understand the broad adjustments that would be beneficial for all injury types. For all, a key worker was needed to maintain education with support at home (or hospital) before children returned to school.

Statutory guidance in England recommends arrangements to provide "suitable full-time education" for children with health needs (25). However, this was often problematic because protocols or criteria to determine eligibility did not account for the difficulties caused by sudden onset injuries, or for which restricted mobility was not the primary issue. Policies need to be amended or expanded to cover the full scope of disabled children's needs, whatever the cause. A greater understanding and accommodation of injured children's needs would be achieved by a key worker providing training and effective inter-agency co-ordination (11, 13, 17, 26–28). This role may be described by many terms, such as "school rehabilitation facilitator" or an "education co-ordinator" (29).

In agreement with previous research, we found that injured children's return to school was reliant on parents' proactive involvement (3). This added to the demands on families who were already managing the additional care needs of the injured child, their own responsibilities and the array of emotions triggered by their child's return to school (3, 16, 17, 18, 21, 30). Although "our parents" were able to take on this role, others may lack the confidence or have insufficient understanding of their child's needs to do so (11). As previously highlighted, parents felt a key worker was needed to lead and co-ordinate accommodation for injured children's educational needs (20). This was particularly important during school holidays when the schools are closed and communication with the school was difficult.

Interestingly, participants with extensive educational support needs experienced a more robust, structured approach and expressed greater satisfaction than those children who "merely" needed to catch up and/or had temporary support needs. This concurs with previous research reporting a relationship between injury severity and educational service provision or recognition of needs (13–15). By involving a wide range of injuries in this study, we have shown that that even children

with relatively minor and transient educational support needs require similarly robust, effective policies and procedures. Further research is required to investigate how best to address such needs.

A key motivation for injured children's return to school was to reconnect with their friends, but they often experienced problems with social integration. Studies of children with traumatic brain injuries have reported similar difficulties (10, 26, 31, 32), which were attributed to concerns about body image, changed behaviour or personality (26), family dysfunction (31) and impaired cognitive and/or social skills (10, 31, 32). We also found that body image was an issue for children with all types of injuries. However, the main cause of social isolation was the physical separation from their peers, whether this was during class, physical education, playtimes or extra-curricular activities. The latter accommodations are likely to reflect a lack of understanding of their needs. The children in the current study expressed a strong preference to remain with their peers, who are often an important source of support (16, 21). This suggests that schools need to consider social inclusion from a wider biopsychosocial perspective (33). Innovative thinking, more flexible policies, and ways of working are required to facilitate social integration as a specific goal for the children's return to school. This may, in turn, foster understanding and acceptance by their peers (34, 35). Another potential benefit of integration is that teachers gain experience and understanding of the needs of injured children, which is less likely when they are in a separate classroom.

Participation in physical education improves social integration and promotes physical and mental wellbeing, as well as enhancing academic performance (36, 37). Thus, it is important to involve injured children in physical education during their recovery. This may be supported by the provision of a "school fit note", which "includes both a summary of identified issues and a standardised set of recommendations and adaptations to facilitate re-integration to education and school physical activity." (2020, personal communication with Dr D. Roscoe, Royal Manchester Children's Hospital, Manchester, UK). In addition, hospital-based physical education (PE) teachers and physiotherapists need to work collaboratively to address children's involvement in physical activity at the very earliest point in their recovery. This approach and ongoing advice may enable schools to work more proactively to involve injured children in physical activity. Further research is required to investigate feasible ways to facilitate injured children's participation in physical education and extra-curricular activities as part of their rehabilitation. This would help to reduce time away from school to attend therapy and promote more positive attitudes to physical activity, which are often shaped by children's experiences at school (38). Schools need to be mindful

about the messages they give relating to children's ability to participate. An overly cautious or inflexible approach may give a negative impression about the injured child's potential to take part in physical activities and affect their confidence. Furthermore, injured children should have the same opportunities to achieve the attainment targets for physical education, as they do for the other elements of the national curriculum.

This study has several limitations. Purposive sampling was used to ensure representation of a broad range of ages, types and combinations of injuries, timeframes post-injury and different points of return to education. However, the limits to generalization are that our parents were notable in their proactive involvement in their child's education. It may be that parents who are willing to participate in research are also more engaged in their child's care and different experiences may have been captured for parents who took a less proactive stance. As highlighted in our companion papers, most participants were mothers (20, 21). This probably reflects the distribution of child-care responsibilities within UK families, but the inclusion of more fathers or extended family members may have resulted in different perspectives.

Another potential limitation is that we did not specify a timeframe for return to education. Thus, some participants may have had insufficient time to experience the full spectrum of their support needs. However, conducting interviews at the different points of return to education gave in-depth insight into the needs of injured children and their families at various stages.

In conclusion, schools often minimize the risks associated with injured children's return to school by segregating them from their peers and excluding them from more active components of the curriculum. We found that regardless of their type of injury, the participating children had similar needs for flexible environmental and learning accommodations, and the provision of information about how to make them. These should involve the injured child in the full curriculum and meet their needs for social inclusion. Participation in physical education should be given the same level of priority as the other academic elements of the national curriculum.

Injured children, families, schools and other agencies would benefit from a key worker to co-ordinate educational provision and communication. The key worker needs to provide advice about the adaptations needed for the return to school and involvement in the full curriculum. This requires collaboration and innovation from healthcare and educational professionals.

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## Supplementary Material

	Guide to Questions
Generic needs	Tell me about what was different for <b>you/you and your child</b> following your injury? What help did <b>you/your child</b> need after your injury?
Discharge specific needs	What was it like for <b>you/you and your child</b> when you went home from the hospital? When <b>you/your child</b> went home from the hospital how did you feel? Did you feel <b>you/you and your child</b> prepared to go home? Was there anything that worried <b>you/you and your child</b> about going home? Did <b>you/you and your child</b> need any support/help from hospital staff/health professionals when you went home from the hospital? Did you feel that you got the help <b>you/you and your child</b> needed? Did <b>you/your child</b> have any difficulties when you went home from the hospital? Was there anything that really helped or made things easier when <b>you/your child</b> went home? <b>Probes:</b> Equipment, modifications to home, home visits, advice leaflets, meetings before discharge, follow up appointments, phone calls from the hospital.
Key Worker	Did <b>you/your child</b> have a key worker (a health professional/nurse/physio/occupational-therapist/carer/doctor) who provided help or advice when you went home from the hospital? <b>If answers yes:</b> Did you find this helpful? Why was this helpful? What did the key worker do for you? <b>If answers no:</b> Do you think that a key worker would have been helpful? What help/support could have they provided?
Information needs	Was <b>your/your child's injury</b> explained to you in the hospital? Did you understand the explanation of <b>your/your child's injury</b> ? Did you understand how the injury would affect <b>you/your child</b> ? Were you provided with advice about <b>what you/your child</b> was allowed and not allowed to do following <b>your/your child's injury</b> ? Was this easy to understand? Did you receive any advice or information when you were discharged from the hospital? <b>Probe:</b> information booklet, helplines, follow up appointments/follow up phone calls. <b>If answers yes:</b> Was the information helpful/how? Were you given enough information? Was it easy to understand? Who gave you the information? <b>If answers no:</b> Was there you wanted to know when you went home from the hospital, which you were not told? Was there anything you had to find out for yourself?
Educational needs	How did <b>you/your child</b> deal with returning to school after their injury? Did <b>you/your child</b> have any difficulties returning to school? Did <b>your/your child's teachers</b> know that <b>you/your child</b> had suffered from an injury? <b>Probes:</b> Did they understand the injury/do anything differently? Was there anything that really helped <b>you/your child</b> when you returned to school? Were there any changes made or advice which made <b>your/your child's</b> return to school easier?
Social needs	Did <b>your</b> friends/family know about <b>your/your child's injury</b> ? Do you think they understood what had happened to <b>you/your child</b> ? Were <b>your friendships</b> different in any way following <b>your/your child's injury</b> ? Did your friends and family help <b>you/your child after your child's injury</b> ? Did <b>your/your child's</b> hobbies/play/sporting activities change following your injury?
Physical	Did <b>you/your child</b> have any physical problems following the injury? <b>(Probes:</b> will depend on the age of child: difficulties walking, talking, crawling, eating, speaking hearing, toileting, returning to their usual activities) Did <b>you/your child</b> need crutches/walking frame/wheel chair after your injury? Did <b>you/your child</b> have any treatment from therapists /health professionals to help with the physical problems after the injury? Therapists and Health Professionals are: physiotherapists/occupational therapists/dieticians/speech therapists/nurses/doctors. Did you need additional care/help at home? <b>Probe:</b> adaptations to the home, downstairs living. Was there any change to <b>your/your child's</b> appearance after their injury? <b>Probes:</b> scars, cuts & bruises, weight gain or loss, items your child had to wear: supports, casts, brace, breathing pipe.
Psychological	Were <b>you or your child</b> scared or worried after <b>your/your child's injury</b> ? Did <b>You or your child</b> have any problems sleeping following their injury? Did <b>your child's/your behaviour</b> change following the injury?
Emotional needs	How did you feel after <b>your/your child's injury</b> ? Did <b>your/your child's injury</b> affect you emotionally? Did you receive any emotional support from staff at the hospital or people in your local community? <b>Probes:</b> worried, concerns for the future, upset, scared.
Family/work needs?	Did <b>your/your child's injury</b> affect the family or family life? <b>Probes:</b> Was there any change to the daily routine? • Was there any change to roles/responsibilities within the family? • Do you have other children? Was it difficult to look after them at the time of your child's injury? • Were you working at the time of your child's injury? Did their injury affect work in any way? • Was your place of employment supportive after your child's injury? • Did you need any support to look after your child ?
Current situation	What are things like for <b>you/your child now</b> ? Are you receiving help from either the hospital or your community services? Have you/ your child regained their previous level of activities at home? And at school?
Unmet needs/met needs	Looking back over the time since the injury, is there anything that could have been done differently to help <b>your/your child's</b> recovery? With hindsight were there any services which you did not receive which you think would have helped you and your child/you? What really helped you after your injury/ you and your child after your child's injury. <b>Probes:</b> Advice/information/people (health professionals/family, friends/people in the community), equipment, support groups, follow ups.
Closing	Thank you for much for talking to me today. Do you have any questions or is there anything else you would like to tell me which we haven't covered?