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Critical Review of the Literature

Background: Increasing numbers of Children and Young People on the Autism Spectrum (CYP-AS) are attending mainstream education in the United Kingdom, yet little is known about how their school experience affects their psychosocial wellbeing.

Objectives: To examine the qualitative literature examining the experiences of CYP-AS in British mainstream schools.

Data sources: PsycINFO, Web of Science, Educational Resources Information Center (ERIC), the British Education Index, CINAHL, Applied Social Sciences Index and Abstracts (ASSIA), Scopus, ProQuest Dissertations & Theses Global, and EducatiOn-Line.

Study eligibility criteria: Qualitative studies exploring the experiences of CYP-AS aged 0-18 years in mainstream British schools, published in peer-reviewed journals.

Participants: CYP-AS, their parents, and educational staff.

Study appraisal and synthesis method: A combination of narrative synthesis and critical review described and synthesised studies' findings and assessed risk of bias.

Results: 22 papers reporting on 19 studies met the inclusion criteria. Six main themes arose: awareness and understanding of ASD, identity and belonging, interactions with peers, interactions with educational staff, school environment, and school culture.

Limitations: Several papers insufficiently reported on study design, methodology, data collection and analysis, presenting threats to the validity of findings. Potential bias on behalf of the authors in interpreting the data and developing themes may impact on the objectivity of this review.

Conclusions and implications of key findings: Integration of CYP-AS in mainstream education alone is insufficient for the development of positive psychosocial outcomes. Social

connectedness and belonging may be critical factors that improve mainstream school experiences for this population.

Systematic review registration number: CRD42020158737

Service Improvement Project

Objective: Relatively little is known about the impact of brief paediatric admissions on treatment trajectory for children and young people (CYP) admitted for medical complications of their eating disorder, i.e. whether young people are more or less likely to go on to an inpatient psychiatric admission afterwards. This service improvement project aimed to identify factors that influenced treatment trajectory and ways of improving families' experiences during paediatric admissions. **Method:** Retrospective NHS data was analysed to explore differences between paediatric admissions that are followed by (1) community-based care and (2) inpatient psychiatric care within three months of discharge. Twelve parents provided feedback in interviews that were thematically analysed to understand useful components of paediatric admissions and how they could be improved. **Results:** CYP who went on to receive inpatient psychiatric care were unwell for longer before the paediatric admission, stayed on the paediatric ward for longer, had more crisis team input, were more likely to have had previous paediatric and psychiatric admissions, and had higher parent-reported anxiety and depression. The groups did not significantly differ in the severity of eating disorder symptoms, clinical impairment, physical risk, child-reported anxiety or depression, or presence of self-harm or suicide risk. Four key themes were identified from interviews: impact of the admission on mental health, communication, role of different systems, and knowledge and expertise. **Discussion:** Identifiable factors linked with illness severity appear to explain why some CYP return to community-based care, and some require more intensive psychiatric input following brief paediatric admissions. These factors may be useful indicators in predicting who may require subsequent inpatient care, allowing clinicians

to target more intensive support earlier in treatment and to facilitate smoother transitions between services where required. Recommendations for improving families' experiences in paediatric hospitals include improving paediatric staff's understanding of eating disorders, enhancing communication channels, and providing psychological support for parents as well as the young person.

Main Research Project

Objective: To investigate whether traumatic childbirth affected new mothers' social identity and their psychological wellbeing, and whether strength of identity as a new mother protected psychological wellbeing following traumatic childbirth.

Method: 123 new mothers completed digital questionnaires about their birth experience, social identity, mental health and psychological wellbeing.

Results: Compared to women who did not have a traumatic birth (*N*=39), women who had a traumatic birth (*N*=84) had significantly lower psychological wellbeing but did not differ in the strength of their new mother identity, which was generally high across both groups. Strength of identity did not moderate the relationship between traumatic childbirth and psychological wellbeing. All analyses controlled for emotional and practical support, perceptions of healthcare staff, and mode of birth. Having a caesarean section independently reduced strength of the new mother identity. Common reasons for childbirth being traumatic included physical health complications that interrupted mother-and-baby bonding, unanticipated separation from birth partners, and negative interactions with healthcare staff.

Conclusions: Having a traumatic birth does not appear to have a clear effect on the strength of new mother identity and may be mediated by factors such as mode of birth. Further research is needed to understand the relationship between these constructs. Investigating the relationship between caesarean sections and strength of the new mother identity may identify effective ways of protecting new mothers' mental health.

Critical Review of the Literature

Experiences of Mainstream School for Children and Young People on the Autism Spectrum in the United Kingdom: A systematic review

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External supervisor: None

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Target journal: British Journal of Special Education

The journal was chosen as it is specifically interested in the experience of children with special educational needs in schools and is widely read by practitioners, teachers, and researchers in the UK and overseas.

My supervisor has read and provided feedback on this work and deems it suitable to submit for assessment.

Abstract

Background: Increasing numbers of Children and Young People on the Autism Spectrum (CYP-AS) are attending mainstream education in the United Kingdom, yet little is known about how their school experience affects their psychosocial wellbeing.

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Introduction

Autism spectrum disorder (ASD) refers to a range of neurodevelopmental conditions characterised by persistent difficulties in social interaction and communication, and restricted and repetitive patterns of behaviours, activities or interests (American Psychiatric Association, 2013). ASD tends to begin in childhood and persists throughout adult life, often having profound effects on functioning. Prevalence rates suggest ASD affects 1% of the child population in the United Kingdom (UK), whilst global rates are thought to be lower at 0.006% (Baird et al., 2006; Baron-Cohen et al., 2009; Elsabbagh et al., 2012). It tends to be identified before the age of five, with an average age of diagnosis at 55 months of age in the UK (Brett, Warnell, McConachie, & Parr, 2016). The clinical features of ASD can impact various life domains and difficulties appear particularly evident at school where Children and Young People on the Autism Spectrum (CYP-AS) can find it difficult to interact with peers and teachers and participate in classroom activities (Falkmer, Granlund, Nilholm, & Falkmer, 2012).

Various forms of educational provision have been set up in the UK to meet the diverse needs of CYP-AS. These include mainstream schools, specialist schools, Alternative Provisions (AP), Specially Resourced Provisions (SRP) and Units (Department for Education, 2015a). Mainstream schools are the primary option for all children, offering an education alongside typically-developing peers (i.e., those without developmental disabilities). They tend to be split into preschools for 0-5 year olds, primary schools for 5-11 year olds, and secondary schools for 11-18 year olds, though in some areas of the UK middle schools exist for children aged 9-13 years as an intermediary provision between primary and secondary levels. Specialist schools tend to enrol students from a wider age range who have Education, Health and Care (EHC) Plans or Statements of Special Educational Needs (SEN), and whose needs

cannot be met at a mainstream school. Often seen as provisions in-between mainstream and specialist schools are AP, SRP and Units. AP tends to temporarily accommodate pupils who cannot attend mainstream schools for reasons such as exclusion or mental and physical health difficulties until a student can return to mainstream education or move to a specialist school. SRP and Units provide additional specialist facilities on a mainstream school site for a smaller number of students who usually have EHC Plans or Statements of SEN. They are physically attached to mainstream schools, so CYP-AS are educated alongside typically-developing peers whilst receiving more intensive support than a mainstream school usually provides.

CYP-AS have historically been supported in specialist schools. However, over the last three decades increasing numbers have attended mainstream settings. In England, an estimated 70% of CYP-AS are enrolled in mainstream schools (National Statistics, 2014). This is thought to be largely influenced by a global shift in societal views towards a human rights-based perspective, reflected in policies and recommendations advocating for education for all regardless of disabilities (e.g., Department for Education, 2015; Department for Education and Employment, 1997, 1998; Education Act, 1981; Warnock, 1978). UNESCO's Salamanca Statement (1994) was a key driving force behind the inclusive education agenda. The Statement advised that mainstream schools should accommodate all children regardless of disabilities and encouraged governments around the world to adopt the principle of 'inclusive education' for all children, unless there were compelling reasons for doing otherwise. It was proposed that mainstream schools promoting the principle of inclusion were the most efficient and cost-effective method of providing education and for "combating discriminatory attitudes, creating welcoming communities, building an inclusive society, and achieving education for all" (UNESCO, 1994, p. ix).

Providing support for the recommendations outlined in the Salamanca Statement, the work of Wolf Wolfensberger has offered significant contributions to the field. Wolfensberger's (1983)

theory of Social Role Valorisation (SRV) proposed that marginalised groups, such as CYP-AS, should be integrated into mainstream society due to the benefits of holding valued social roles. Wolfensberger argued that marginalised groups are treated poorly by society due to the lower social status attached to physical, mental, or emotional disabilities, and that integration into the mainstream could minimise, prevent, or reverse the negative impact of being viewed differently. Wolfensberger's ideas can be seen as consistent with theories of social identity (Tajfel & Turner, 1979) and belongingness (Baumeister & Leary, 1995), where evidence supports the notion that feeling connected to others and belonging to a group leads to more positive outcomes, such as improved wellbeing and quality of life. Social identity theory (Tajfel & Turner, 1979) proposed that individuals' personal sense of self is derived from connections with other people, and this forms the basis of positive self-esteem, whilst Baumeister and Leary's (1995) theory of belongingness suggested that belonging is a basic psychological need and the failure to develop stable, fulfilling relationships results in higher stress, maladjustment, health problems and psychopathology. Developmental research highlighting the increased importance of one's social group during adolescence (e.g., Rubin, Bowker, Mcdonald, & Menzer, 2013) underscores the significance of these theories for school-aged children.

According to the theories of SRV, social identity and belongingness, mainstream education would be linked to positive outcomes for CYP-AS due to opportunities to feel socially valued and connected to a group that they feel they belong to. There is evidence that attending a mainstream school is linked to some benefits for CYP-AS such as improved quality of life, social development, educational performance, and lower financial costs (e.g. Connor, 1998; Handleman, Harris, & Martins, 2005; Knight, Petrie, Zuurmond, & Potts, 2009; Parish, Bryant, & Swords, 2018; Strain, 1983). However, contradictory evidence suggests experiences of social exclusion, victimisation and bullying are common, and additional factors such as noise, crowding, limited mobility opportunities, curriculum demands and

changes in routine contribute to CYP-AS's stress and anxiety (Gray & Donnelly, 2013; Humphrey & Lewis, 2008b; Mayton, 2005; Saggers, Hwang, & Mercer, 2011; Sciutto, Richwine, Mentrikoski, & Niedzwiecki, 2012; Symes & Humphrey, 2010). Comorbidities of psychiatric problems, and particularly anxiety disorders, are common among CYP-AS (Joshi et al., 2010), and mainstream schools appear to contribute to their exacerbated mental health.

There is growing concern among researchers, educational staff and families about the impact of mainstream education on CYP-AS. Williams, Gleeson and Jones (2019) explored the mainstream school experiences that contributed to CYP-AS making sense of themselves as 'different' from their peers and concluded that mainstream schools increase the risk of low self-esteem and mental health problems. This suggests that being included in mainstream school is not enough to lead to the positive outcomes suggested by Wolfensberger's (1983) theory of SRV. To understand the factors that contribute to CYP-AS being included effectively in mainstream schools, Roberts and Simpson (2016) explored the perspectives of students, school staff, and parents and found that whilst the majority agree with the philosophical principle of inclusive education, several barriers exist to its implementation. Barriers included attitudes towards students with autism, a lack of knowledge and understanding about autism, bullying, and a lack of necessary support at an individual, class and school level. Both reviews highlight a dearth of research into the experiences of CYP-AS and call for further investigation.

Several new studies have since been published which further elucidate the lived experiences of CYP-AS in mainstream schools and many have been conducted in the UK. Considering that global educational systems vary considerably, a review focused on British mainstream schools was thought to assist educational providers and policy makers in making improvements to the school experiences for CYP-AS. The reviews of Williams et al. (2019) and Roberts and Simpson (2016) both had an international focus, which makes it difficult to

apply their findings specifically to the UK. The current review proposes to provide a comprehensive account of the British mainstream school experiences of CYP-AS that incorporates and builds on the knowledge gleaned from previous reviews, with the aim of gaining an in-depth understanding of the psychosocial experiences of CYP-AS from different perspectives.

It is acknowledged that various definitions of 'inclusive education' exist. UNESCO (2005) states that "inclusion is seen as a process of addressing and responding to the diversity of needs of all learners through increasing participation in learning, cultures and communities, and reducing exclusion within and from education" (p.13). According to this definition, inclusive education involves adapting the content and practices within mainstream schools to meet the needs of all children and places the responsibility of education for all with the regular systems that cater for the majority.

Method

Search strategy and selection criteria

This systematic review followed PRISMA reporting guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009). A review protocol was registered in advance on PROSPERO, registration number CRD42020158737. The authors searched the Applied Social Sciences Index and Abstracts, the British Education Index, CINAHL, EducatiOn-Line, ERIC, Proquest Dissertations and Theses Online, PsycInfo, Scopus, and Web of Science. Searches took place on 19 April 2021, with no restriction on publication date or language, using a Boolean search strategy (see Appendix A) and MeSH terms to combine keywords relating to ASD and inclusive/mainstream education. The reference lists of included studies and relevant reviews were hand searched for additional papers. Studies were included if they:

1. Explored the views of CYP-AS, their parents or school staff about the mainstream school experience for students with ASD aged 0-18
2. Used qualitative methods
3. Were conducted in the UK
4. Were published in peer-reviewed journals

The importance of gathering multiple perspectives when exploring the experiences of CYP-AS has been highlighted in previous research (e.g., Humphrey & Lewis, 2008a), therefore a multi-informant approach was chosen to gather the perspective of all those with an input into the educational experiences of this population. The age range was chosen to reflect typical ages of school-aged children in the UK (5-18 years old), whilst also acknowledging that ASD diagnoses are often given earlier. Qualitative research has the advantage of gaining rich descriptions about the lived experiences of populations, therefore it was deemed appropriate to limit the current review to this form of research design. The limit to studies published in peer-reviewed journals was applied with the intention of identifying high-quality, credible research.

Studies were included if they employed novel and creative qualitative approaches as well as traditional interview or focus group formats in an attempt to capture the experiences of a more diverse population of CYP-AS. Exercises based on pictorial representations can be a more helpful way of communicating with CYP-AS and those who have verbal or written communication problems (Kirkbride, 1999). For multiple publications of the same study, the paper with the most complete or pertinent data was included, unless different findings were reported across publications and excluding them would mean disregarding relevant information. Studies were excluded if they focused on the transition between schools, if they were evaluating a specific intervention, such as social skills training, or if they reported qualitative data simply as a frequency list with no development of themes or supporting

participant quotes, for example through implementation of open-ended questions on self-report surveys or questionnaires.

Data analysis

All duplicates were removed from the initial searches and the titles and abstracts of papers were screened against the eligibility criteria. Full-text articles of potentially eligible studies were retrieved, and authors contacted if articles were not found. Two reviewers (SE, ZK) blindly and independently assessed all full-text articles for eligibility, documenting reasons for exclusion. Inter-rater reliability was high at 95%. Any disagreements were resolved by consensus, and a third reviewer (RV) was consulted if an agreement was not reached. This led to one paper being removed from the analysis due to the focus on the experience of teaching assistants. Reviewers were not blind to the journals or authors of the studies reviewed.

A data extraction spreadsheet was used to record relevant information from eligible studies and included the Critical Appraisal Skills Programme's (CASP; 2018) quality tool for assessing risk of bias in qualitative research. High-quality studies were those that met over seven of the CASP criteria, moderate-quality studies met four to six criteria, and low-quality studies met up to three criteria. The first author extracted the data from the included studies and two reviewers (SE, ZK) blindly and independently assessed the quality of the studies. Inter-rater reliability was high at 90%. No study was excluded on the basis of quality appraisal; it was conducted as a way of highlighting potential limitations within papers and the sample overall.

Given that the included studies were qualitative and highly heterogeneous, a meta-synthesis was not possible. A combination of narrative synthesis and critical review was conducted instead, which involved describing the characteristics of included studies and synthesising their findings. The first stage involved reading and re-reading the articles, noting down the

main themes identified by the authors of each study, and recording data extracts (direct quotes from participants) in a database. The second stage involved 'eye-balling' the data and recording the main themes emerging across studies. Finally, themes which frequented the majority of studies were identified as key themes.

Results

The review process resulted in the inclusion of 22 papers relating to 19 studies (see Figure 1 for the PRISMA study selection flowchart; Moher et al., 2009). Two papers (Humphrey & Lewis, 2008b, 2008a) were drawn from one larger research programme. However, the publications reported on different aspects of the study deemed relevant to this review. This was also the case for three other papers included in the review (Goodall, 2018, 2019; Goodall & MacKenzie, 2019). Thirteen papers were published since the reviews of Robertson and Simpson (2016) and Williams et al. (2019) conducted their literature searches.

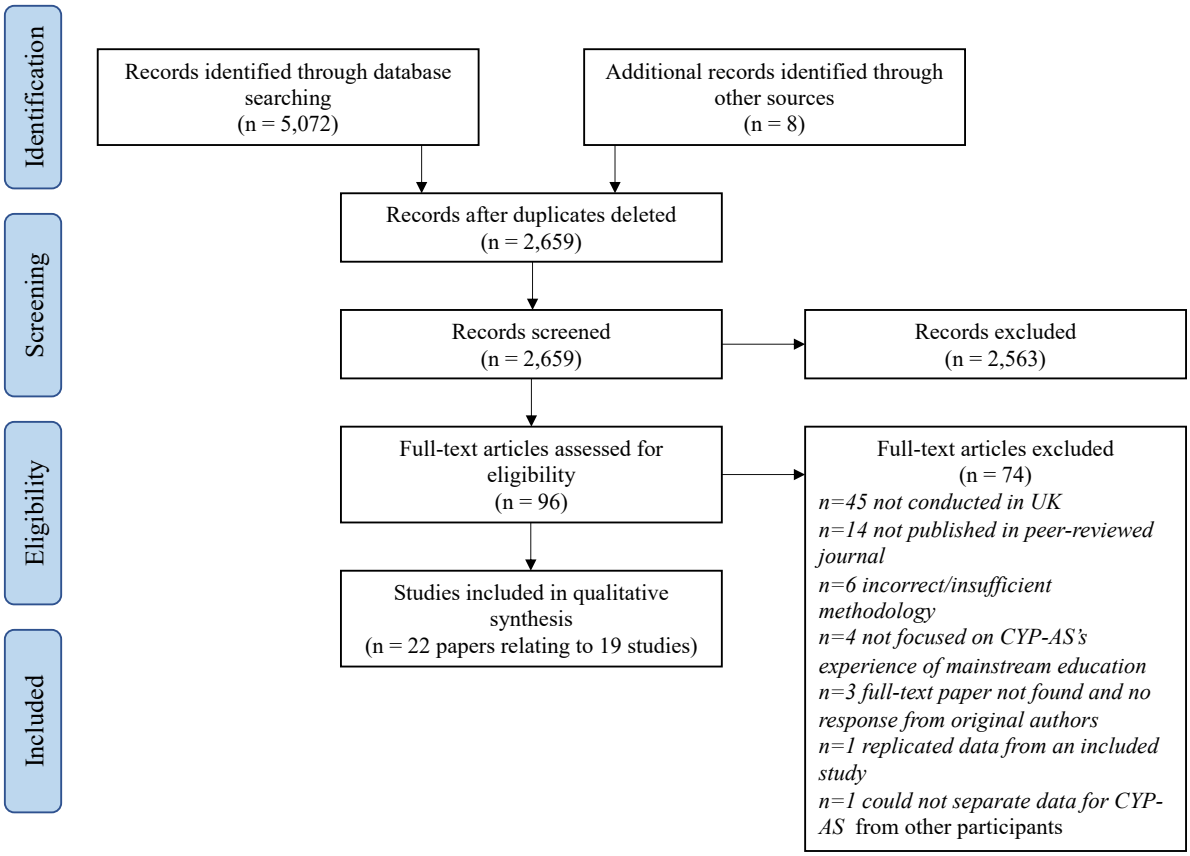

Figure 1. PRISMA flow diagram of searched articles.

At least 499 participants (N=142 CYP-AS, N=256 parents/carers, N=101 educational staff) were included in the review (one study did not report the sample size of parents and school staff; Humphrey & Lewis, 2008b). Of the 142 CYP-AS, only 37 were female, although four papers did not report the gender of participants (Holt, Lea, & Bowlby, 2012; Humphrey & Lewis, 2008a, 2008b; Tobias, 2009). Very few details were given about the demographics of CYP-AS participating in the studies. Only three studies reported participants' ethnicities, which corresponded to 23 CYP-AS of the sample (Calder, Hill, & Pellicano, 2013; Cook, Ogden, & Winstone, 2016, 2018); 16 were 'White British', two were 'White Other', one was 'Mixed Race', and four were 'Black African'. One study reported that the research took place in an ethnically-diverse community but gave no details about its' participants ethnicities

(Hebron & Bond, 2017). Five studies reported on intellectual capabilities (Calder et al., 2013; Emam & Farrell, 2009; Holt et al., 2012; Moyse & Porter, 2015; O'Hagan & Hebron, 2017); all of these CYP-AS had average or above average intellectual abilities or were labelled as 'high-functioning'. One paper described a school involved in the study as catering for students with severe learning disabilities, though gave no details about participants' intellectual functioning (Humphrey & Lewis, 2008b). See Table 1 for the study characteristics of the included studies.

Table 1. Study characteristics.

Study	Participants	Educational setting	Data collection method	Data analysis method	Quality assessment
Calder et al. (2013)	12 CYP-AS* (4F*/8M*) aged 9-11 11 parents 8 teachers	Mainstream primary	Semi-structured interview	Thematic analysis	High
Connor (2000)	16 CYP-AS (1F/15M) aged 11-16 9 SENCOs*	Mainstream secondary	Interview	Not reported	Low
Cook et al. (2016)	5 CYP-AS (0F/11M) aged 11-17 5 parents	Mainstream secondary	Semi-structured interview	Thematic analysis	High
Cook et al. (2018)	6 CYP-AS (11F/0M) aged 11-18 6 parents	Mainstream secondary	Semi-structured interview	Thematic analysis	High
Dillon, Underwood & Freemantle (2016)	14 CYP-AS (3F/11M) mean age 13.57	Mainstream secondary	Semi-structured interview	Content analysis	High
Emam & Farrell (2009)	17 school staff (teachers, TAs*, SENCOs)	Mainstream primary and secondary	Semi-structured interviews, observations	Case study analytic strategies, thematic analysis and grounded theory analytic approach	Moderate
Goodall (2018)	12 CYP-AS (2F/10M) aged 11-17	Alternative Provision and voluntary study hub for home-schooled children	Semi-structured interview, draw and write activities, beans and pots activity, diamond ranking activities	Thematic analysis	High

Goodall (2019)	7 CYP-AS (0F/7M) aged 13-16 (also took part in Goodall, 2018)	Alternative Provision	Semi-structured interview, draw and write activities, beans and pots activity, diamond ranking activities	Thematic analysis	High
Goodall & MacKenzie (2019)	2 CYP-AS (2F/0M) aged 16-17 (also took part in Goodall, 2018)	Voluntary study hub for home-schooled children	Semi-structured interview, draw and write activities, beans and pots activity, diamond ranking activities	Thematic analysis	High
Hebron & Bond (2017)	9 CYP-AS (2F/7M) aged 8-15 16 parents/carers	SRP* in mainstream primary and secondary	Semi-structured interview	Thematic analysis	High
Holt et al. (2012)	16 CYP-AS (gender not reported) aged 11-18 1 parent 4 school staff (head of Unit, SENCO, deputy head teacher, head of separate unit)	Unit in mainstream secondary	Ethnographic observation, semi-structured interviews, self-directed photography	Thematic analysis	Moderate
Humphrey & Lewis (2008a)	20 CYP-AS (gender not reported) aged 11-17	Mainstream secondary	Semi-structured interviews, pupil diaries and drawings	IPA*	Moderate
Humphrey & Lewis (2008b)	19 CYP-AS (gender not reported) aged 11-17 (also took part in Humphrey & Lewis, 2008a) School staff (teachers, LSA, SENCO, senior	Mainstream secondary	Interviews, examination of school documents, student diaries	Content analysis	Moderate

	management; number not reported) Parents (number not reported)				
Landor & Perepa (2017)	8 parents 7 school staff (head of Unit, teachers, LSAs*)	Unit in mainstream secondary	Semi-structured interviews with staff members and questionnaires with parents	Thematic analysis	Moderate
Moyse & Porter (2015)	3 CYP-AS (3F/0M) aged 7-11 3 parents 6 school staff (teachers and SENCOs)	Mainstream primary	Observations, interviews, drawing, photographs, sorting activities	Organisational framework	High
Myles, Boyle & Richards (2019)	8 CYP-AS (8F/0M) aged 12-17	Unit in mainstream middle and mainstream secondary	Semi-structured interview	Thematic analysis	High
O'Hagan & Hebron (2017)	3 CYP-AS (0F/3M) aged 13-15 3 parents 3 school staff (support worker, TA, head of SRP)	SRP in mainstream secondary	Semi-structured interview	Thematic analysis	High
Tobias (2009)	10 CYP-AS (gender not reported) aged 14-16 5 parents	SRP in mainstream secondary	Focus groups, discussions	IPA for focus groups, not reported for discussions	Moderate
Tomlinson, Bond & Hebron (2021)	3 CYP-AS (3F/0M) aged 14-16 3 parents 1 school staff (psychotherapist)	Mainstream secondary school	Semi-structured interviews	Thematic analysis	Moderate

Waddington & Reed (2006)	23 parents 25 school staff	Local authority	Focus groups	Content analysis	High
Warren, Buckingham & Parsons (2020)	5 CYP-AS (0F/5M) 6 school staff (teacher and TAs)	SRP in primary school	Storyboard method and semi-structured interviews	Categorisation approach	High
Whitaker (2007)	172 parents	Mainstream (level of education not reported)	Survey	Grounded approach	High

*CYP-AS = Children and Young People on the Autism Spectrum; F = Female; IPA = Interpretative Phenomenological Analysis; LSA = Learning Support Assistant; M = Male; SENCO = Special Educational Needs Coordinator; SRP = Specially Resourced Provision; TA = Teaching Assistant.

The papers were published between 2000-2021, with three in Northern Ireland (Goodall, 2018, 2019; Goodall & MacKenzie, 2019) and the remaining 19 in England. Three studies were conducted in primary schools (Calder et al., 2013; Moyse & Porter, 2015; Warren, Buckingham, & Parsons, 2020), six in secondary schools (Connor, 2000; Cook et al., 2016, 2018; Dillon et al., 2016; Humphrey & Lewis, 2008a, 2008b), one across primary and secondary schools (Emam & Farrell, 2009), three in an AP and a voluntary study hub for home-schooled children (Goodall, 2018, 2019; Goodall & MacKenzie, 2019), seven in an SRP or Unit attached to mainstream schools (Hebron & Bond, 2017; Holt et al., 2012; Landor & Perepa, 2017; Myles et al., 2019; O'Hagan & Hebron, 2017; Tobias, 2009; Tomlinson, Bond, & Hebron, 2021), one in a Local Authority that did not specify the type of mainstream school (Waddington & Reed, 2006), and one in mainstream schools where the school level was not reported (Whitaker, 2007).

Quality appraisal

Fourteen papers were deemed high quality, seven moderate quality, and one low quality (see Table 1). Authors of high-quality studies clearly reported research aims and findings, adopted appropriate methodology and recruitment strategies, collected and analysed data rigorously and ethically, and outlined the value of the research to the wider literature. Only one study reporting data across three papers commented on the relationship between researchers and participants (Goodall, 2018, 2019; Goodall & MacKenzie, 2019), which is concerning considering the subjective nature of qualitative research. Papers of moderate quality insufficiently reported recruitment strategies and data analysis, which introduces potential threats to the reliability and validity of results. The paper regarded as low quality (Connor, 2000) did not report on research design, recruitment strategy, data collection, analysis, or ethical issues, which made it difficult to assess the accuracy and reliability of its results. The lack of reporting on ethical issues across six papers (Connor, 2000; Dillon et al., 2016; Emam & Farrell, 2009; Humphrey & Lewis, 2008b; Waddington & Reed, 2006; Whitaker, 2007)

was particularly alarming, considering the research was conducted with individuals where issues surrounding capacity, communication, and consent are frequent.

Key themes

Six key themes were identified and discussed with the third reviewer: awareness and understanding of ASD; identity and belonging; interactions with peers; interactions with educational staff; school environment; and school culture. Similar themes arose among CYP-AS, their parents, and educational staff, therefore data is presented together for the stakeholders.

Awareness and understanding of ASD

Discussions around awareness and understanding of ASD frequented eight high-quality papers and five moderate-quality papers (Cook et al., 2016; Dillon et al., 2016; Goodall, 2018, 2019; Hebron & Bond, 2017; Humphrey & Lewis, 2008a, 2008b; Landor & Perepa, 2017; Myles et al., 2019; Tobias, 2009; Tomlinson et al., 2021; Warren et al., 2020; Whitaker, 2007). There were several reports of peers having little understanding of ASD and the negative impact this had on interactions and CYP-AS being viewed differently (Goodall, 2018; Landor & Perepa, 2017; Tomlinson et al., 2021; Warren et al., 2020). However, when peers had some understanding of ASD, there were accounts of them targeting characteristics such as sensory sensitivities to cause upset: "*it would be things like, things stuck on his back, it'll be tapping, it'll be looks, it would be scraping*" (Cook et al., 2016, p.259). A lack of awareness and understanding of ASD among teachers was also reported as challenging. Many CYP-AS felt teachers did not understand their needs and in some cases were not motivated to support them: "*[bad teachers] don't use training they have to help"* (Goodall, 2019, p.24). This raised concerns around CYP-AS's needs not being met effectively as a result (Myles et al., 2019; Tobias, 2009).

Parents in Hebron and Bond's (2017) study felt it was vital for all staff to be autism-aware as their children had experienced prolonged episodes of bullying and exclusion as a result of educational staff not effectively managing difficulties: "*I would be like drop him off at nine … by the time I reach work I had to go and pick him up*" (p.563). This suggests ASD training could be a useful approach for increasing understanding. However, as a young person in Goodall's (2019) study suggested, ASD training is not a straight-forward solution as "*training can make [teachers] bad as they use it to treat kids as thick*" (p.24). This raises a question about how understanding can be facilitated sensitively and effectively. In Whitaker's (2007) study, which rigorously analysed data and had a considerably larger sample size than other studies in this review, parents described the importance of teachers understanding the condition whilst also understanding the individual and the challenges they face. One mother powerfully expressed "*I would like the staff to understand who my daughter is and what it feels like to be her*" (Whitaker, 2007, p.175).

Although most of the studies that contributed to this theme discussed understanding and awareness of ASD in relation to peers and educational staff, two studies of high and moderate-quality discussed CYP-AS engaging in a process of self-understanding (Dillon et al., 2016; Tobias, 2009). CYP-AS in Dillon, Underwood and Freemantle's (2016) study showed a level of self-awareness that challenges the frequently held belief that individuals on the autism spectrum are incapable of self-reflection: "*I'm getting more angrier now than I was in year 6. And even from now it could start to get more worse. I'm quite concerned*" (p.225). It is likely that such self-reflection also occurs in other educational settings and points towards the benefit of schools supporting CYP-AS to develop greater self-understanding.

Identity and belonging

Issues relating to how CYP-AS saw themselves and felt part of their school community were described by CYP-AS, their parents, and educational staff across 16 papers (Calder et al., 2013; Connor, 2000; Cook et al., 2018; Goodall, 2018; Goodall & MacKenzie, 2019; Hebron & Bond, 2017; Holt et al., 2012; Humphrey & Lewis, 2008b; Moyse & Porter, 2015; Myles et al., 2019; O'Hagan & Hebron, 2017; Tobias, 2009; Tomlinson et al., 2021; Waddington & Reed, 2006; Warren et al., 2020; Whitaker, 2007). CYP-AS spoke frequently about wanting to fit in with their peers and how social inclusion underpinned feelings of belonging at school: "*it's like wanting to be there and feeling that people want you to be there*" (Myles et al., 2019, p.11). Feeling valued and accepted resulted from experiences where CYP-AS were heard and listened to within classrooms and actively included in activities. Unfortunately, the studies in this review revealed an overall picture suggesting experiences of loneliness, social exclusion, and feeling different were common.

Limited social and communication skills regularly presented barriers for CYP-AS connecting with their peers: "*he probably tries too hard, which is why he annoys people so much because he doesn't understand the rules, and he makes the wrong comments*" (O'Hagan & Hebron, 2017, p.16). This appeared to accentuate feelings of being different in a negative way: "*I don't like having autism. I think it makes me different to other people and I think other people treat me as being different … I was often called a geek or weirdo*" (Goodall & MacKenzie, 2019, p.508). CYP-AS in Humphrey and Lewis's (2008a) study chose words such as "retard" and "freak" to describe how they saw themselves (p. 31). Such value-laden terms illustrate the powerful descriptions that some CYP-AS incorporate into their self-concepts. In contrast, some CYP-AS thought more positively about feeling different, though this was more likely in individuals who had strong friendships and were doing well academically (Humphrey & Lewis, 2008a). Warren et al. (2020) reported evidence of an identity clash for CYP-AS who attended an SRP attached to a mainstream school, with one staff member describing a student

feeling like "*a big fish in the base but a very small fish in mainstream*" (p.10-11), although the CYP-AS in the study did not report any difficulties with being different due to attending both settings, describing it instead as "*cool*" and "*exciting*" (p.10).

Humphrey and Lewis (2008a) hypothesised that the negative view of being different had likely arisen through feedback from other people, leading CYP-AS to feel forced to adapt their behaviour to fit in. This seemed particularly common in females, consistent with research suggesting masking behaviour is associated more with the female-expression of ASD (Baldwin & Costley, 2016; Cridland, Jones, Caputi, & Magee, 2014; Kenyon, 2014; Rynkiewicz et al., 2016). A girl in Cook et al.'s (2018) study explained *"I thought if I changed to be like my other friend, they'll listen to me, and they all did, so I was like, I'll keep it that way"* (p.310). Whilst masking seems to enable CYP-AS to hide their differences to be accepted and feel a sense of belonging, parents were often concerned that it led to symptoms being missed and more significant problems subsequently developing (Cook et al., 2018; Whitaker, 2007). Interestingly, parents and a school psychotherapist in Tomlinson et al.'s (2021) study reported that receiving an ASD diagnosis had positively reduced masking tendencies and improved the young person's self-awareness. However, this study insufficiently described their recruitment strategy and data analysis process, therefore the reliability of this finding is unclear.

Interactions with peers

Mainstream school is an intensely social environment and ASD characteristics often present unique challenges to peer relationships. Many CYP-AS, their parents and educational staff highlighted commonplace experiences of rejection, isolation, and bullying: *"I was isolated and separate, in like a bubble of depression and anxiety . . . but, I still felt the centre of attention with others looking at me and judging"* (Goodall & MacKenzie, 2019, p.507). ASD

characteristics such as social naivety appeared to make CYP-AS particularly vulnerable to bullying (Humphrey & Lewis, 2008a). It is not clear whether bullying was always because a young person had ASD. However, the victimisation through targeting of specific sensory sensitivities described earlier suggests bullying and stigma related to the experience of ASD certainly does occur.

Negative peer interactions linked to ASD characteristics pose an interesting dilemma related to the disclosure of diagnoses in the school setting. It appeared to be a contentious issue among CYP-AS, with some preferring to disclose in order to elicit support and understanding from others, whilst others preferred to keep it private for fear of attracting the stigma that diagnostic labels often create. For some CYP-AS any level of disclosure was perceived as a barrier to being considered 'normal': "*I'd rather they not know because then I wouldn't be treated differently*" (Humphrey & Lewis, 2008a, p.40). However, there were also examples of sensitively handled disclosures to peers facilitating positive peer relationships: "*the more they learn about Asperger's the more sympathetic they feel*" (Humphrey & Lewis, 2008a, p.40). In these circumstances, Humphrey and Lewis (2008a) suggested that CYP-AS feel more capable of navigating the complex world within a mainstream school, due to the support from peers contributing to a positive sense of self.

Experiences of friendships for CYP-AS were reported across ten studies, with high consistency across the accounts of CYP-AS, parents, and educational staff (Calder et al., 2013; Cook et al., 2016, 2018; Hebron & Bond, 2017; Holt et al., 2012; Humphrey & Lewis, 2008a; Myles et al., 2019; Tomlinson et al., 2021; Warren et al., 2020; Whitaker, 2007). CYP-AS in Myles, Boyle & Richards' (2019) study – which was one of five high-quality studies with a female-only sample – described friendships as an important factor for overall happiness at school by providing a sense of social security that helped CYP-AS to cope with the school environment. However, friendships were often described as confusing,

unreciprocated, and impacted significantly by limited social and communication abilities. It was common for CYP-AS to befriend peers with ASD or other differences (Cook et al., 2016, 2018; Tomlinson et al., 2021), which is consistent with ideas proposed by social identity theory (Tajfel & Turner, 1979) suggesting individuals seek out relationships with similar others to bolster their personal identity. In contrast, some CYP-AS preferred being alone (Calder et al., 2013), suggesting individual differences in motivation to develop friendships. Studies conducted in SRPs or Units indicated that these educational provisions seem to facilitate friendships in a way that felt safe and contained, and where help is available to support the navigation of complex social interactions (Hebron & Bond, 2017; Holt et al., 2012; Warren et al., 2020).

Interactions with staff

The importance of relationships with educational staff for CYP-AS in mainstream schools was discussed frequently. In Dillon, Underwood & Freemantle's (2016) study, these were mostly seen positively and were linked to staff being seen as caring and helpful. Relationships were viewed negatively when there was little interaction between CYP-AS and their teachers and when teachers did not adapt lessons to meet the needs of CYP-AS. In Emam and Farrell's (2009) study, ASD characteristics seemed to create tension and frustration for teachers, where they found the task of modifying their language difficult to accommodate the literality of thought often exhibited by CYP-AS: "*She used to take things very literally … if I say to somebody… 'pull your socks up'… she would not understand*" (p.414). Many teachers reported feeling conflicted about whether their responsibilities lay with CYP-AS or with other students, and many found it hard to tailor their practice to meet the diverse needs of the classroom (Emam & Farrell, 2009; Humphrey & Lewis, 2008a, 2008b). This was mirrored in the perspective of a young person in Tomlinson et al.'s (2021): "*people higher in the school*

think… well I don't need to do it now because we've got curriculum support staff… leave it to that lot" (p.11).

The inclusion of CYP-AS was seen more favourably by mainstream teachers when additional support was offered by support staff. However, several accounts highlighted that the presence of support staff reduced interaction between CYP-AS and their teachers, and increased the likelihood of bullying due to their physical presence signalling that CYP-AS were different from their peers (Emam & Farrell, 2009; Humphrey & Lewis, 2008a, 2008b; Landor & Perepa, 2017; Tomlinson et al., 2021). Schools where support staff helped the whole class rather than just CYP-AS, or where support was provided by a combination of staff and peers, somewhat overcame these problems (Emam & Farrell, 2009; Landor & Perepa, 2017). However, these papers did not describe how they selected participants so sample biases are possible.

School environment

Sensory aspects of the school environment were commonly reported as contributing to the distress of CYP-AS in mainstream schools, and particularly at secondary level where schools were larger and busier. A young person in Tomlinson et al.'s (2021) study shared that "*the fire alarm is horrific… usually I get so annoyed I'd bite my fingers*" (p.9). The order and predictability that many CYP-AS rely on appeared to be challenged by the school environment, where sudden room or timetable changes were common (Humphrey & Lewis, 2008b). This is consistent with reports from CYP-AS, parents, and educational staff that unstructured times during the school day, such as break and lunch times, were particularly difficult: "*the in between times, when we go to assembly, play, the snack, that's the time they struggle with the most*" (Warren et al., 2020, p.7). Many CYP-AS searched for quiet, safe

spaces to reduce their anxiety (Calder et al., 2013; Connor, 2000; Hebron & Bond, 2017; Moyse & Porter, 2015; Whitaker, 2007), and SRPs and Units often provided an escape from the overwhelming nature of mainstream school (Holt et al., 2012; Humphrey & Lewis, 2008b; Landor & Perepa, 2017; Warren et al., 2020).

Whilst the environmental challenges described so far were consistently reported by CYP-AS, their parents, and educational staff, some differences were apparent. Descriptions offered by CYP-AS focused largely on current distress, whereas parents and educational staff reflected more on the longer-term benefits of exposure to the mainstream environment for later life, which included building resilience and coping strategies, having access to the full curriculum, and opportunities for social skill development (Hebron & Bond, 2017; Landor & Perepa, 2017; Tobias, 2009; Waddington & Reed, 2006; Warren et al., 2020). A parent in Waddington and Reed's (2006) study explained that CYP-AS "*are being forced into social situations that they are going to encounter for the rest of their lives*" (p. 159). If coping with the stress of mainstream schools is beneficial in the long-term, schools must be well-equipped to support CYP-AS to tolerate distress in the short-term.

School culture

Eight studies commented on the impact of the wider mainstream school culture on CYP-AS (Calder et al., 2013; Cook et al., 2016; Hebron & Bond, 2017; Humphrey & Lewis, 2008b; Tobias, 2009; Tomlinson et al., 2021; Waddington & Reed, 2006; Whitaker, 2007). The importance of an inclusive and welcoming school ethos, high-quality communication between staff and parents, and commitment and willingness of all educational staff to include CYP-AS in mainstream schools enabled positive academic, social, and psychological outcomes for CYP-AS. The positive effects of these practices can be understood from a social identity and belongingness perspective, where the structures put in place facilitate a sense of acceptance,

connectedness and collective identity. Tomlinson et al. (2021) concluded that "*adoption of a whole school approach to supporting autistic pupils is a key contributing factor to successful placement [in mainstream schools]*" (p.5).

For parents in particular, good communication between home and school was "*worth gold*" (Whitaker, 2007, p.176), especially when educational staff listened to and acted upon parental knowledge and expertise. Educational staff felt that when leadership teams committed to promoting an inclusive school environment and established effective communication channels with the wider staff team, this helped to better meet the needs of CYP-AS (Humphrey & Lewis, 2008b). Similar considerations were rarely offered by CYP-AS themselves, which may simply reflect the fact that these practices sometimes occur outside of the young person's awareness, though nevertheless highlight the importance of gathering multiple perspectives to shine light on different aspects of experience.

Discussion

The aim of this systematic review was to synthesise the qualitative evidence of the lived experience of CYP-AS in mainstream schools in the UK. Six themes highlighted how issues related to understanding and awareness of ASD, identity and belonging, interactions with peers and educational staff, and the school environment and culture were important aspects of the mainstream school experience for CYP-AS. Four themes were identified in previous reviews (Roberts & Simpson, 2016; Williams et al., 2019), indicating consistency of experiences over time and cross-culturally. However, the current review adds an identity/belonging aspect and takes a wider view of how school culture can facilitate positive experiences in the mainstream. There was considerable consistency among the reports of CYP-AS, their parents and educational staff, suggesting a good level of shared understanding

among stakeholders with an input in the educational experiences of CYP-AS. Stark differences in the experiences of CYP-AS were rare and those that did appear seemed to be examples of understandable individual differences.

This review illustrates that mainstream school can be a confusing and difficult system for CYP-AS to navigate. Barriers related to ASD characteristics often limited positive opportunities for academic, psychological, and social development. Many CYP-AS felt different, devalued, and isolated, which was exacerbated by negative interactions with peers, staff, and the school environment. This suggests the theory of SRV (Wolfensberger, 1983) is insufficient in explaining how mainstream education can facilitate positive outcomes for this population; unsurprisingly, simply attending a mainstream school does not lead to positive outcomes. Incorporating ideas from theories of social identity (Tajfel & Turner, 1979) and belongingness (Baumeister & Leary, 1995) may offer a more comprehensive understanding; feeling a sense of belonging and connectedness to a social group that society deems as socially valuable may help to determine whether positive outcomes are likely to be obtained by CYP-AS at mainstream school. When acceptance and supportive relationships are facilitated by an in-depth, empathetic understanding of the lived experiences of CYP-AS, negative experiences are likely to be counteracted and desired outcomes such as reciprocal friendships and positive self-esteem more accessible. Positive accounts across a few studies suggest this may be the case, as CYP-AS had more positive experiences at school when they had supportive friendships and felt a sense of belonging to their peer group and school as a whole, in addition to where a culture of acceptance was established through the school ethos and commitment to inclusive practices by staff.

A number of limitations are present in the studies included in this review, challenging the validity of their findings. Whilst the majority of studies were deemed to be of high quality afforded by appropriate reporting of the aims, methodology, data collection, analysis, and

contributions to the wider literature (Calder et al., 2013; Cook et al., 2016, 2018; Dillon et al., 2016; Goodall, 2018, 2019; Goodall & MacKenzie, 2019; Hebron & Bond, 2017; Moyse & Porter, 2015; Myles et al., 2019; O'Hagan & Hebron, 2017; Waddington & Reed, 2006; Warren et al., 2020; Whitaker, 2007), several studies were marked as moderate or low quality due to insufficient details being reported (Connor, 2000; Emam & Farrell, 2009; Holt et al., 2012; Humphrey & Lewis, 2008a, 2008b; Landor & Perepa, 2017; Tobias, 2009; Tomlinson et al., 2021). Every study based their findings on samples with CYP-AS who appear cognitively and verbally able, neglecting those less able to engage in traditional qualitative research. Few studies drew on methods that go beyond verbal capabilities, such as activities using photography and pictorial representations about feelings associated with school life (Goodall, 2018, 2019; Goodall & MacKenzie, 2019; Humphrey & Lewis, 2008a, 2008b; Moyse & Porter, 2015; Warren et al., 2020); most of these studies were deemed high quality. Attempts were made to overcome some of the limitations of the included studies by extracting quotes directly from participants as well as the reflections made by study authors. However, it is recognised that choice of published study data is decided upon by individual authors. This review faced the same difficulties in identifying a more diverse population of CYP-AS in research. Few females were included in the studies, which is consistent with the historical underrepresentation of females in autism research. The male bias was 3:1 in this review, which is similar to ratios found elsewhere (Baird et al., 2006; Kasari et al., 2016). Further research would benefit from engaging a more diverse group of CYP-AS in research, both in terms of gender, ethnic backgrounds and intellectual abilities. Considering the diverse range of needs along the autism spectrum, and the varying challenges of developing a sense of identity and belonging for individuals from diverse backgrounds, this would be an important area for further work.

Acknowledging that qualitative research is a subjective process, the first author of this review reflected on the bias that her position and individual perspective may have introduced.

Bronfenbrenner's (1979) ecological systems framework came to mind during data synthesis, which likely influenced how key themes were structured; a different guiding framework may have resulted in alternative key themes arising. Personal interests in social identity are likely to have filtered the lens used to digest information, meaning that other perspectives were possibly ignored. Similar biases may have been active during the development of themes, where links to identity, belonging, and social interactions dominate. These potential biases would have been somewhat mitigated through conversations with the other two authors throughout this review, though should not be minimised when critically analysing the objectivity of how the information is presented. This review nevertheless offers a novel perspective of the under-explored experiences of CYP-AS and draws on the perspectives of multiple informants to provide a holistic view that can be used to identify areas in need of improvement. This is the only review to focus specifically on the UK, meaning that its findings can serve to inform British educational policy and provision.

Notwithstanding the limitations of this review and the studies involved, a novel and useful synthesis of the literature is offered pertaining to the real-world experiences of CYP-AS attending mainstream schools in the UK. Education providers and policy makers are encouraged to draw on the findings when considering improvements to the mainstream school experiences for CYP-AS and those with similar difficulties. Practical recommendations could include co-designing ASD training programmes with CYP-AS to encourage a more empathetic understanding of the challenges they face; quiet spaces to encourage the development of adaptive coping skills that help CYP-AS to build up tolerance to the distressing aspects of the mainstream environment; therapeutic opportunities to support CYP-AS to develop self-understanding and awareness; social clubs for CYP-AS and their peers based on shared interests and hobbies to encourage social connectedness; and adoption of inclusive practices by senior management teams that permeate throughout staff levels to create a culture of acceptance and belonging, for example, by having an explicitly inclusive

school ethos, publicising the school's inclusion policy and creating effective communication channels among staff and with parents. Schools will undoubtedly rely on support from local governments to implement such recommendations. However, these practices could significantly enhance the experiences of CYP-AS by reducing negative feelings of being different, whilst encouraging the formation of strong connections with others and a sense of belonging within an environment that promotes acceptance and values diversity.

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Service Improvement Project

A service improvement project to evaluate the impact of brief paediatric inpatient admissions for children and young people with eating disorders

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This journal was chosen as it publishes leading research in the science and clinical practice of eating disorders focused on important issues and key challenges in the field of eating disorders, such as preventing lengthy inpatient stays.

My supervisors have read and provided feedback on this work and deem it suitable to be submitted for assessment.

Abstract

Objective: Relatively little is known about the impact of brief paediatric admissions on treatment trajectory for children and young people (CYP) admitted for medical complications of their eating disorder, i.e., whether young people are more or less likely to go on to an inpatient psychiatric admission afterwards. This service improvement project aimed to identify factors that influenced treatment trajectory and ways of improving families' experiences during paediatric admissions. **Method:** Retrospective NHS data was analysed to explore differences between paediatric admissions that are followed by (1) community-based care and (2) inpatient psychiatric care within three months of discharge. Twelve parents provided feedback in interviews that were thematically analysed to understand useful components of paediatric admissions and how they could be improved. **Results:** CYP who went on to receive inpatient psychiatric care were unwell for longer before the paediatric admission, stayed on the paediatric ward for longer, had more crisis team input, were more likely to have had previous paediatric and psychiatric admissions, and had higher parent-reported anxiety and depression. The groups did not significantly differ in the severity of eating disorder symptoms, clinical impairment, physical risk, child-reported anxiety or depression, or presence of self-harm or suicide risk. Four key themes were identified from interviews: impact of the admission on mental health, communication, role of different systems, and knowledge and expertise. **Discussion:** Identifiable factors linked with illness severity appear to explain why some CYP return to community-based care, and some require more intensive psychiatric input following brief paediatric admissions. These factors may be useful indicators in predicting who may require subsequent inpatient care, allowing clinicians to target more intensive support earlier in treatment and to facilitate smoother transitions between services where required. Recommendations for improving families' experiences in

paediatric hospitals include improving paediatric staff's understanding of eating disorders, enhancing communication channels, and providing psychological support for parents as well as the young person.

Introduction

Eating disorders (EDs) in children and young people (CYP) are serious conditions that can have harmful and long-lasting medical consequences (Campbell & Peebles, 2014). Although evidence suggests that treatment provided by community-based Child and Adolescent Eating Disorder Services (CAEDS) is linked to better outcomes and cost-effectiveness, a minority of patients still require periods of high intensity care delivered in inpatient settings (Gowers et al., 2010; Herpertz-Dahlmann et al., 2014; Madden, Hay, & Touyz, 2017; NHS England, 2015; NICE, 2017). Two types of inpatient care are typically used in the UK: brief paediatric admissions (a few days or weeks) are generally used to stabilise acute medical complications of an ED under the care of paediatric trained medical and nursing staff; whilst longer-term psychiatric admissions (usually several months) tend to be used when there is a significant risk to self and the young person is deemed to need longer-term intensive psychiatric care (NHS England, 2015). Given the high cost, poorer outcomes and additional risks of inpatient psychiatric care, there is considerable interest in alternative treatment pathways for young people with EDs who become severely unwell (BEAT, 2015; Gowers et al., 2007). Although brief paediatric admissions are not an alternative to psychiatric admissions, it is possible that for some they may both stabilise the patient and avoid a longer psychiatric admission (Wootton et al., 2014). Little is known about the impact of brief paediatric admissions on treatment trajectory and whether for some they negate the need for a longer psychiatric admission altogether.

Paediatric management of eating disorders

EDs now present a significant health issue for paediatric medical services. The incidence matches many more 'traditional' paediatric chronic conditions and outnumbers illnesses such as meningitis for most age groups (Hudson & Court, 2012). However, management of EDs in

CYP is often provided by paediatric staff who have minimal training in the management of EDs, and admissions for EDs are often unplanned, unprepared and sometimes done unwillingly by paediatric teams leading to potential risks and adverse events (Hudson et al., 2013). There is concern about the provision of mental health services for CYP and the high proportion of inpatient beds being used for EDs despite evidence suggesting treatment in the community is best (House of Commons Health Committee, 2014; NHS England, 2014). This concern has escalated during the Covid-19 pandemic. In response, the 2015 'Access and Waiting Time Standard (AWTS) for Children and Young People with an Eating Disorder' was developed to provide commissioning guidance on establishing and maintaining community-based CAEDS and related treatment pathways including paediatric inpatient care (NHS England, 2015). The primary aim of the AWTS is to improve timely access to NICE-concordant treatment. However, it makes secondary recommendations for effective joint working with paediatric services and for workforce planning to include paediatricians to improve the sharing of knowledge and expertise between community and paediatric services.

Local service

The CAEDS in Oxford Health NHS Foundation Trust (OHFT) was established in 2016 and provides outpatient treatment for CYP with EDs up to the age of 18 years. In line with the AWTS, the team has employed a consultant paediatrician since May 2017 and has refined its standard operating process for inpatient admissions, which involves continuous contact between community and paediatric services (see Figure 1). Since the CAEDS has worked more closely with paediatric services, they have become particularly interested in the difference between CYP who have a brief paediatric admission and either return to community-based care or require longer-term inpatient psychiatric care. If factors can be identified that account for the difference in treatment trajectories, the team may have an opportunity to intervene during a paediatric admission and strengthen the factors that might prevent longer stays in hospital. The CAEDS hypothesised that the impact of brief paediatric

admissions on the young person or their parents may be one of these factors, in that the admission may encourage engagement with treatment, perhaps due to the realisation that the child's condition is critical. This can be thought of as representing a move into the 'action' stage of the transtheoretical model of behaviour change (Prochaska & DiClemente, 1992), where families are mobilised into action after recognising the life-threatening aspects of the ED.

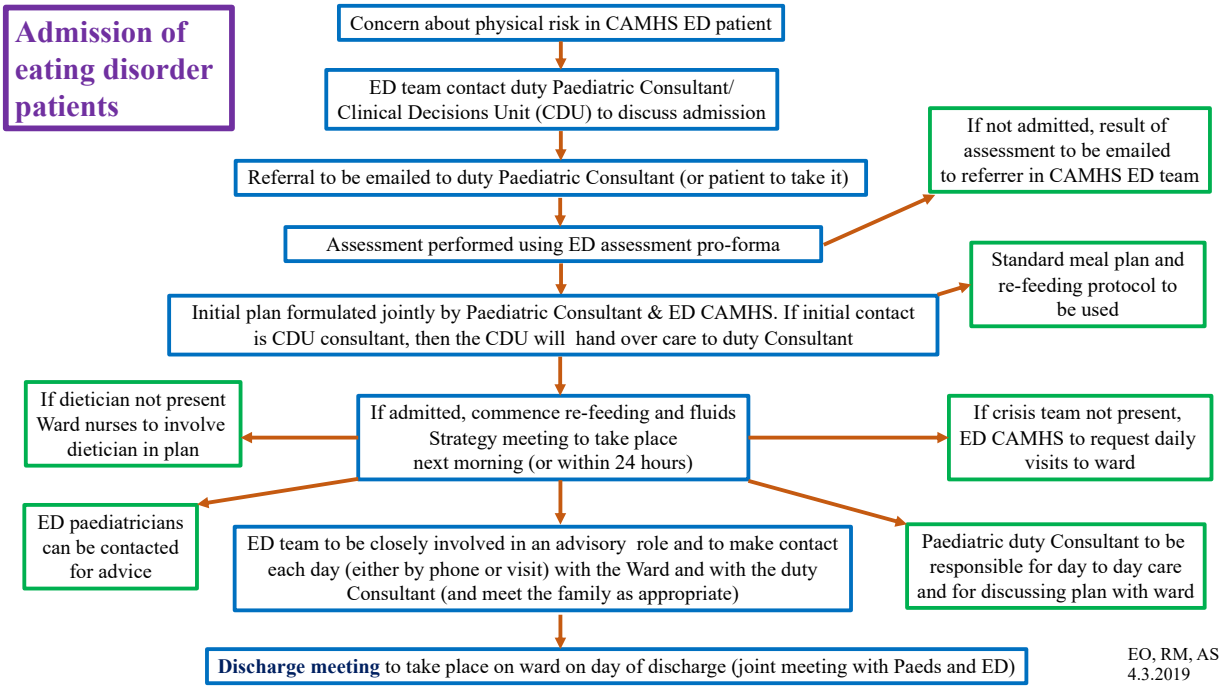

Figure 1. Standard Operating Procedure for eating disorder admissions in Oxford Health NHS Foundation Trust.

This service improvement project aimed to help the service better understand the impact of paediatric admissions as a component of the local ED treatment pathway by identifying factors influencing treatment trajectory. It intends to facilitate a better understanding of local treatment pathways for CYP with EDs and strengthen collaborative working between the CAEDS and paediatric services, as recommended by the AWTS. For example, allowing for earlier intervention to reduce the risk and/or more time to coordinate transfer between services. This may ultimately help to facilitate shorter inpatient stays.

Aims

- To identify factors that might explain why some CYP returned to community-based care following a brief paediatric admission and some required longer-term inpatient psychiatric care
- To explore what parents* found helpful and unhelpful about their child's brief paediatric admission

*For the purpose of this report, the term 'parents' refers to the person(s) most closely involved with the CAEDS in the management of the young person's ED treatment.

Method

The trainee met clinicians in the CAEDS to elicit feedback about the project during its initial stages and ensure the scope of the project was realistic in line with available service data. This led to an assistant psychologist checking information held in the service's database and two consultant paediatricians working across the CAEDS and paediatric services agreeing to obtain missing hospital data. The project was assessed by the Clinical Trials and Research Governance Team at the University of Oxford and was deemed to be service evaluation, therefore ethical approval from the Health Research Authority was not required. Approval was instead gained from the local NHS Trusts where CYP had been admitted to hospital (OHFT, Oxford University Hospitals NHS Trust and Buckinghamshire Healthcare NHS Trust). To maintain patient confidentiality, the CAEDS de-identified all data before sharing it with the trainee and initiated contact with all potential participants as it was unclear whether patients had previously given consent to be contacted for research purposes. All data was transferred securely using NHS email systems.

The project employed a mixed-methods design. Part 1 involved analysis of retrospective NHS data to compare CYP who had a paediatric admission and (1) returned to community-based care ('community group') or (2) went on to receive inpatient psychiatric care within three months of discharge ('psychiatric group'). This allowed identification of factors that might account for group differences. CYP were included if they had a paediatric admission between May 2016–July 2020, which covers the period since the service was established to when the database was shared with the trainee clinical psychologist for analysis.

Part 2 involved semi-structured interviews with parents of current service users who had a paediatric admission within the past 18 months. The trainee aimed to interview ten parents of CYP from the community group and ten from the psychiatric group to identify useful components of brief paediatric admissions and where improvements to care are needed. Interviews were also used to identify factors affecting treatment trajectory beyond those routinely collected by the service, and to explore whether there was evidence for the service's hypothesis that brief paediatric admissions encourage some families to become more engaged in their child's care. However, this was not specifically asked about so as not to influence families' responses. Care coordinators within the CAEDS spoke to parents identified as meeting the eligibility criteria, then the service sent an email or letter inviting them to take part in a short interview about their experience of their child's admission to hospital. The invitation highlighted that participation was optional and would not affect current or future treatment. The trainee's email address was provided in the invitation letter and parents were asked to get in touch with her directly to take part. The interviews were audio-recorded on an OHFT iPad for transcribing at a later date, which parents verbally consented to.

In both parts, CYP with any ED (e.g., anorexia nervosa, bulimia nervosa) were included as long as they were admitted to a paediatric ward for medical complications related to ED

symptoms (e.g., critically low weight, cardiac problems); CYP who were admitted for the treatment of self-harm injuries or Avoidant/Restrictive Food Intake Disorder were excluded.

Measures

Patient information was recorded in a secure database by the CAEDS since the service was established. The variables in Table 1 were routinely collected as part of clinical practice, which includes a mixture of observation and self-report data. They were collected to record activity, assess clinical outcomes, and inform service developments, and reflect physical, psychological and social factors that research has shown impacts on ED aetiology and recovery (Vall & Wade, 2015). The interview schedule (Appendix B) was developed by the trainee and research supervisors and centred on parents' experience of their child's paediatric admission.

Table 1. Study variables

Variables	Scale
Demographics	
Age	Years
Gender	Male/Female
Ethnicity	Asian/Mixed White & Asian/Any other Mixed background/White British/Any other White background
Treatment factors	
Duration of paediatric admission	Number of days
Duration of CAMHS crisis team input before, during, and after admission	Number of days
Previous paediatric admissions	Yes/No
Previous psychiatric admissions	Yes/No
Illness severity factors	
Duration of known illness	Number of days between referral to CAEDS and paediatric admission
Weight for height at initial assessment	Percentage median BMI
Physical risk at initial CAEDS assessment	MARSIPAN risk rating: high/medium/low (Junior MARSIPAN, 2012)
Severity of eating disorder symptoms at start of CAEDS treatment	Eating Disorder Examination for Adolescents (EDE-A; Fairburn, Cooper, & O'Connor, 2008)

The impact of eating disorder symptoms on psychosocial functioning at start of treatment	Clinical Impairment Assessment (Bohn & Fairburn, 2008)
Co-morbidity	
Severity of anxiety and depression at initial CAEDS assessment (child and parent-rated versions)	Revised Child's Anxiety and Depression Scale (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000)
Presence of self-harm risk	Yes/No
Presence of suicide risk	Yes/No
Psychosocial factors	
Family functioning at start of treatment (child, parent, and sibling-rated versions)	SCORE-15 (Stratton et al., 2014)

Data analysis

All continuous variables were checked for normality through exploration of histograms and Q-Q plots, skewness and kurtosis statistics, and the Shapiro-Wilk test. Group differences were analysed using a t-test, Mann-Whitney U test and chi square test. The qualitative data was analysed using thematic analysis following Braun and Clarke's (2006) method. This included careful reading of the interview transcripts, noting down initial ideas about the data, systematically coding interesting features of the data, collating codes into potential themes, and reviewing and defining themes. Parents who took part in the interviews were consulted on the accuracy of themes to improve the validity and reliability of the data. For added robustness, the external research supervisor and two assistant psychologists from the CAEDS blindly read one interview transcript and extracted relevant themes, which were compared to the themes extracted by the trainee clinical psychologist.

Findings

Retrospective NHS data

Quantitative data from 102 CYP (N=69 community group, N=33 psychiatric group) were analysed. Table 2 provides descriptive data and test statistics for all variables. The mean age of participants was 14.25 years old and the average length of paediatric admission was 5 days.

The crisis team were involved in seven young people's care for over one year as CYP often stay open to the team during lengthy inpatient stays for support during home leave. Six percent of the sample had comorbid diagnoses recorded in the database, which included autism (3%), anxiety (1%), depression (2%), obsessive-compulsive disorder (1%), and emerging personality disorder (1%). Comorbidity rates may be higher as it is possible that additional diagnoses were not known about or recorded consistently. According to the RCADS data available, 10-18% of CYP scored above the cut-off of 65 for clinical rates of anxiety, and 18-23% for depression (depending on child and parent ratings), suggesting rates are higher than recorded in the comorbidity column of the database. Statistical analyses demonstrated that compared to the community group, the psychiatric group were admitted to a paediatric ward for longer, had more crisis team input before, during and after the admission, had been unwell for longer before the admission, were more likely to have had previous paediatric admissions and psychiatric admissions, and their parents rated their anxiety and depression higher on the RCADS. The groups did not significantly differ on the following variables: age, gender, ethnicity, weight for height, ED severity on the EDE-A, clinical impairment of psychosocial functioning on the CIA, and child-rated anxiety and depression on the RCADS. Data from the SCORE-15 measure of family functioning were not analysed due to the high level of missing data. See Appendix C for the normality data and inferential test statistics associated with the between-group differences.

Table 2. Descriptive and inferential test statistics for all study variables.

Variables		Community group *N*=69				Psychiatric group *N*=33				Inferential statistics		
		N	**%**	***M* (*SD*)**	**Range (min-max)**	***N***	**%**	***M* (*SD*)**	**Range (min-max)**	**Test statistic**	***p*-value**	**Effect size[a]**
Demographics												
Age on admission		69		14.09 (1.98)	7-18	33		14.58 (1.79)	11-17	*U = 993.5*	.296	*r* = .10
Gender (females)		62	89.9%			32	97.0%			X^2 = 1.56	.432	*V* = .12
Ethnicity	White British	55	79.7%			29	87.9%			X^2 = 5.49	.389	*V* = .23
	White (any other background)	4	5.8%			2	6.1%					
	Asian	1	1.4%			0	0.0%					
	Mixed (any other background)	4	5.8%			1	3.0%					
	Mixed White & Asian	0	0.0%			1	3.0%					
Treatment factors												
Duration of paediatric admission (days)		69		4.28 (2.93)	1-18	33		6.55 (4.35)	1-21	*U* = 746.0	.004**	*r* = .28
Crisis input	Before admission (days)	55		6.07 (15.53)	0-93	30		24.73 (46.00)	0-226	*U = 420.5*	<.001**	*r* = .43
	During admission (days)	56		3.55 (3.30)	0-17	28		6.14 (4.88)	0-21	*U* = 566.5	.037*	*r* = .23
	After admission (days)	57		72.96 (130.82)	0-880	30		278.03 (184.62)	0-815	*U* = 208.0	<.001**	*r* = .62
Had previous paediatric admission		13	18.8%			13	39.4%			X^2 = 6.18	.023*	*V* = .36
Had previous psychiatric admission		5	7.2%			15	45.5%			X^2 = 19.52	<.001**	*V* = .46
Illness severity factors												
Duration of illness (days)		63		104.08 (229.42)	0-1106	31		318.58 (476.30)	0-1983	*U* = 498.0	<.001**	*r* = .40
Weight for height on admission		57		81.76 (10.92)	62-109	29		77.52 (9.31)	63.8-95	*t*(84) = 1.79	.078	*d* = .42
Physical risk at assessment	High risk	29	42.0%			18	54.5%			X^2 = 1.77	.629	*V* = .14
	Medium risk	19	27.5%			6	18.2%					
	Low risk	4	5.8%			1	3.0%					

Eating disorder severity (EDE-A)	Restraint subscale	41		3.65 (2.10)	0-6	19		4.10 (1.97)	0-6	*U* = 336.0	.399	*r* = .11
	Eating concern subscale	41		2.30 (1.44)	.2-5.4	19		3.52 (1.32)	.4-5	*U* = 306.0	.187	*r* = .17
	Weight concern subscale	41		3.79 (1.94)	0-6	19		4.12 (1.76)	.6-6	*U* = 346.5	.499	*r* = .09
	Shape concern subscale	41		4.07 (1.86)	0-6	19		4.27 (1.69)	.25-6	*U* = 369.0	.749	*r* = .04
	Global score	41		3.61 (1.72)	.15-5.6	19		4.00 (1.54)	.36-5.75	*U* = 339.5	.433	*r* = .10
Psychosocial impairment (CIA)		32		28.56 (14.81)	0-79	9		31.56 (13.05)	5-43	*U* = 107.0	.252	*r* = .18
Comorbidity												
Anxiety and depression (RCADS)	Child reported anxiety	30		55.17 (12.67)	37-81	10		58.30 (11.91)	44-81	*U* = 119.0	.342	*r* = .15
	Child reported depression	31		63.55 (11.69)	40-81	10		71.30 (14.84)	53-97	*t*(39) = -1.71	.096	*d* = .584
	Parent reported anxiety	30		58.17 (13.51)	37-81	12		69.17 (11.46)	52-81	*U* = 100.0	.024*	*r* = .35
	Parent reported depression	31		70.42 (10.73)	45-81	12		80.50 (10.76)	56-106	*U* = 84.0	.004**	*r* = .44
Self-harm risk present		16	23.2%			6	18.2%			X^2 = 1.62	.263	*V* = .17
Suicide risk present		22	31.9%			10	30.3%			X^2 = 1.45	.259	*V* = .17
Psychosocial factors												
Family functioning (SCORE-15)	Child reported	24		31.83 (11.42)	19-52	6		33.67 (4.97)	30-43	Not analysed due to low numbers		
	Mother-reported	16		30.75 (10.49)	16-52	4		29.75 (14.25)	18-50			
	Father-reported	11		38.73 (9.85)	26-53	3		38.67 (3.79)	36-43			
	Sibling-reported	3		30.00 (8.00)	22-38	2		34.50 (3.36)	30-39			

Note. The community group were participants who had a paediatric admission followed by at least three months of community-based care, whilst the psychiatric group were participants who had a paediatric admission followed by a psychiatric admission within three months of discharge.

[a] Effect size interpretation: *r* – small effect size = 0.1, medium effect size = 0.3, large effect size = 0.5; *V (Cramer's V)* – small effect size = <0.2, medium effect size = 0.2-0.6, large effect size > 0.6; *d* – small effect size = 0.2, medium effect size = 0.5, large effect size = 0.8.

*Significant at $p<.05$

**Significant at $p<.01$

Interviews with parents

Twelve parents participated in the interviews; six had a child in the community group and six in the psychiatric group. It was established that all interviewees were parents, rather than other types of caregivers, and therefore all quotations are derived from parents in traditional parenting roles. Although the aim was to interview a total of 20 parents, recruitment proved challenging and as Braun and Clarke (2006) recommend 10-20 interviews for a UK doctoral project, completion of 12 interviews was deemed sufficient. Four key themes were identified: 1) impact of admission on mental health, 2) communication, 3) role of different systems, and 4) knowledge and skills. Appendix D shows how the themes represent the codes, with example quotes from the interviews. Five parents responded to confirm that the themes accurately captured their experiences and comparison of the trainee clinical psychologist's themes with those extracted by the research supervisor and assistant psychologists showed a high level of overlap.

Theme one: impact of admission on mental health

Impact of ward environment

Several parents reported that the ward environment was loud and busy, which contributed to CYP's psychological distress. Being on a ward with patients of all ages was seen as unhelpful and age-appropriate areas with private spaces were desired. Having single sex wards was suggested by one parent as her child was distressed by a boy being on the ward. The majority of parents described long periods of waiting, which was frustrating and particularly so when they did not feel kept up-to-date by paediatric staff.

Trigger for recovery

For several families, going into hospital was seen to instigate recovery as it allowed access to treatment that enabled their child to start eating. One parent talked about the boundaries of the hospital environment encouraging their child to eat. It was helpful when there was a clear

treatment plan of what to eat and when, and clarity around what happens when the young person does not eat. Many parents reported that the hospital admission made both them and their child realise the severity of the situation. One parent described how being admitted to hospital almost validated the ED and encouraged her child to eat after having reached the goal of a hospital admission.

Child distress

Hospital admissions were in general a distressing experience for CYP and parents reported their children being exhausted and not able to think clearly due to the impact of their low weight. Being around other patients with a variety of illnesses was both helpful in normalising illness and also distressing, particularly when other patients had mental health problems and were admitted for self-harm and suicide attempts. Medical interventions contributed to young people's distress. NG tube feeding sometimes acted as a deterrent to refusing food and was particularly upsetting when it was required. One parent reported that medical interventions such as blood tests contributed to subsequent fearfulness of medical tests.

Parental distress

The hospital admission was understandably upsetting for many parents although some felt relieved being in hospital as it allowed access to treatment and additional support. However, two parents described feeling blamed by professionals for the severity of their child's health. Managing care for siblings and work commitments was challenging, and several parents took turns supporting their child in hospital. This was made more difficult by the Covid-19 pandemic limiting the number of people allowed in hospital. A common concern was that parents felt worried about continuing treatment on their own at home post-discharge.

Theme two: communication

Information sharing

Despite being sent to hospital by a community mental health team or GP, many families reported that the hospital was not expecting their arrival, meaning they had to repeat distressing information often to several staff members. When families were able to go straight to a children's ward this was particularly helpful. A lack of communication from paediatric and CAEDS staff was frequently reported, such as why medical procedures were being administered, and when CAEDS staff were planning to visit. When multiple services were involved, it could be confusing for parents to know who was in charge and who to liaise with. Views on collaborative working between the hospital and community teams varied, with some parents seeing it as seamless and others seeing the teams as very separate. Some parents felt being in hospital allowed their child to open up to them, although some became withdrawn and angry, which was challenging for parents.

Unintentionally unhelpful comments

Most parents felt that paediatric staff were skilled at engaging their child, which was seen to influence the perceived benefit of the admission. A few parents commented that one or two paediatric and CAEDS staff members had made comments that were perceived by their child as unhelpful; saying that they were not the worst anorexic patient and praising them for eating were not received well. One parent commented that staff saying their child's weight out loud was distressing for their child. However, another parent thought it unhelpful when a clinician had suggested their child avoids looking at the weighing scales, which highlights the challenge for staff of attending to individual preferences.

Theme three: role of different systems

Hospital team

The majority of parents felt well-supported by paediatric staff and were extremely grateful for their input. Paediatric treatment was seen to be focused very much on physical health, which parents saw as understandable. However, they felt more psychiatric/psychological input was

needed during the admission. Facilities such as the teen lounge, kitchen, and art materials were very much appreciated by parents particularly when CYP were admitted for longer periods. Some parents found it helpful when the hospital team adopted authority and took control over their child's care, with the exception of one parent who found this overpowering.

CAEDS

Many parents valued the input from the CAEDS whilst in hospital and felt it provided the welcomed psychiatric support they felt was needed. Having the same staff member visit whilst in hospital and following discharge was seen as very useful, and particularly important for young people with autism who can find it difficult to interact with multiple people. Most families had clear plans at discharge that were developed collaboratively with the hospital and community services. Discharge was seen as more confusing when CYP were being transferred to a psychiatric unit and parents reported wanted better communication from the services involved.

Crisis team

Some parents reported that the crisis team's input was helpful in hospital and during the transition home, though some would have liked them to have more ED knowledge and expertise. One parent felt more intensive crisis input was needed at home as their child's ED became very severe following the paediatric admission.

Parents

The majority of parents felt that the responsibility to get their child to eat remained largely with them despite paediatric staff support. However, one parent described how her parental role changed significantly in hospital. Before the admission she spoke of holding an authoritative role as it was her sole responsibility to encourage her child to eat. However,

when the hospital staff took charge, she was more able to support her child emotionally and she felt this was particularly helpful for fostering their relationship.

Theme four: knowledge and skills

Understanding eating disorders

Most parents felt that paediatric staff were skilled and supportive but that there was inconsistency in the level of knowledge of EDs and mental health difficulties. They reported that paediatric staff were not always equipped to manage strong emotions unless they had previous experience or a special interest in mental health, which was particularly valued by parents when evident. One parent shared that medical risks were not always identified before the hospital admission and shared that their child specifically requested for care coordinators in the CAEDS to have more medical training. Three parents felt that the CAEDS did not always pick up when CYP were concealing the ED, such as hiding objects in clothing when being weighed.

Autism

One parent spoke about the importance of prioritising autism when EDs are being assessed as she described how direct leading questions about ED symptoms enabled the development of an ED for her child. She shared how her child had restricted eating due to fears of puberty-related bodily changes and clinicians' assumptions about behaviours being due to an ED overshadowed the identification of autism and taught her child to be anorexic. The ward environment and input from the CAEDS was seen to be inappropriate and harmful for her child. This parent highlighted the need for individualised care as a 'one size fits all' approach can be unhelpful especially for CYP with autism.

Service reactions

The trainee presented the project's results at a CAEDS team meeting and at a national ED research consortium attended by staff from the CAEDS and paediatric hospitals. The service was pleased to have a better understanding of the factors that might influence treatment trajectory and how to improve patient care during paediatric admissions. There was an acknowledgement of the importance of autism awareness when assessing for an ED and they shared recent developments in the service to prioritise this. They were particularly interested in how they could better provide emotional support to parents and improve understanding of EDs among parents and paediatric staff. One of the paediatricians working across community and hospital settings reflected that a key question was how to use paediatric admissions strategically, which would require the criteria for admissions to be adapted and not just based on physical state. The CAEDS is planning to work with paediatric hospital staff to share the results of this project more widely and to find ways of working better together in order to meet the needs of CYP with EDs.

Discussion

This project highlights the important role that paediatric care may play in the treatment of CYP with severe EDs. The data indicate that there are identifiable factors that might explain why some CYP return to community-based care, and some require more intensive psychiatric input following a brief paediatric admission. CYP with longer stays in paediatric hospitals, longer known duration of the ED, increased crisis team input, previous paediatric and psychiatric admissions and higher parent-rated anxiety and depression appear more likely to require intensive inpatient psychiatric care within three months following discharge from a paediatric ward. This suggests that briefer paediatric admissions taking place earlier in the course of an ED are most effective, and that increased service usage and comorbid psychiatric disorders are predictive of subsequent inpatient psychiatric care being required. Although this

may not be surprising - as these factors can be thought of as proxies for heightened distress and poorer health - they may be useful indicators in predicting who may require subsequent inpatient care, allowing clinicians in the CAEDS to reduce the risk where possible and facilitate smoother transitions between services when required.

Most effect sizes were of small to medium magnitude, although one variable was linked to a large effect size: the duration of crisis team input following a paediatric admission. As this variable appears to have a more sizeable effect on treatment trajectory, targeting interventions provided by the crisis team following a paediatric admission may be particularly useful in reducing the risk of longer-term inpatient care. Furthermore, the rates of comorbidities reflected in the study data coupled with the significant impact of parent-reported anxiety and depression on treatment trajectory suggests that attending to comorbidities is important. Treating comorbid anxiety and depression alongside management of an ED and attending to the presence of autism may also be useful approaches in reducing the risk of longer-term inpatient care being required and maximising the effectiveness of interventions for CYP with neurodevelopmental needs. It is important to acknowledge that not all variables differed significantly between the groups; the severity of self-reported ED symptoms, clinical impairment, physical risk, self-harm and suicide risk, and self-reported anxiety and depression were similar across both groups. The finding that severity of ED symptoms does not appear to influence treatment trajectory is particularly interesting and suggests specific illness-related factors other than core ED pathology appear to predict whether longer-term inpatient psychiatric care is needed.

Interviews with parents shone light on the wide variety of views and experiences. The feedback highlighted that paediatric admissions provided valuable input in the management of EDs and their efficacy could be enhanced by bolstering useful components. Paediatric admissions did instigate recovery for some families by helping them to realise the severity of

their child's health. Attending to families' perception of the severity of the illness and their motivation to change may help clinicians use paediatric admissions to maximal positive effect. It may be beneficial to discuss the usefulness of paediatric admissions with families and share factors that others have found helpful. Exploring concerns, pre-empting difficulties around communication, and providing written information about EDs could improve perceptions of support and lead to more positive outcomes.

Briefer paediatric admissions taking place earlier in the course of an ED appear most effective in promoting community-based care, which emphasises the importance of timely access to treatment. These findings serve to reinforce the value of early intervention in EDs, which underlies the ethos of the AWTS and the FREED programme for those aged 16-25 presenting with an ED (https://freedfromed.co.uk) to promote early access to specialist support. CAEDS need to be resourced and supported to actively promote early intervention to reduce the duration of untreated EDs and reduce the number of cases becoming so severe as to need paediatric or psychiatric intervention.

Recommendations

This project highlights the potential value of paediatric admissions for some families and provides useful information about how to harness factors that lead to positive outcomes. This importantly includes the value of CAEDS and paediatric staff working together to meet the needs of CYP and their families, as recommended by the AWTS. Attending to the factors identified as influencing treatment trajectory could help clinicians to identify CYP at higher risk of requiring subsequent inpatient care, leading to opportunities to plan interventions to maximise the effectiveness of community-based care. Table 3 provides recommendations for the CAEDS based on the findings reported above.

Table 3. Recommendations for the service based on the study findings

Recommendation 1	
Strategically using paediatric admissions	Paediatric admissions appear most effective when used for brief periods earlier in the course of illness. Although they are only used when a patient is physically compromised, planned admissions taking place at the earliest opportunity when required could be useful for intervening before the ED warrants longer-term inpatient psychiatric care.
Recommendation 2	
Making transitions between hospitals smoother	When CYP are identified as being at higher risk of requiring subsequent inpatient psychiatric care, clinicians could begin preparing for a psychiatric admission sooner to facilitate smoother transitions between services, which may also perhaps reduce out-of-area admissions. This will require effective communication and collaboration between staff from the CAEDS, paediatric hospital, and psychiatric units.
Recommendation 3	
Treating comorbidities	It would be helpful to prioritise treatment of anxiety and depression alongside an ED through the use of anxiolytic and antidepressant medications or additional psychological support.
Recommendation 4	
Mobilising the family	For some families, brief paediatric admissions made both the young person and their parents realise how severe the illness had become, which instigated recovery. Therefore, it would be useful to attend to families' perception of illness severity and their motivation to change. Clinicians could discuss the usefulness of paediatric admissions with families and share factors that others have found helpful.
Recommendation 5	
Improving collaborative working	Increased contact, for example through regular debriefs, between CAEDS and paediatric staff could help staff to learn from admissions and make good use of the expertise of both teams.
Recommendation 6	
Improving understanding of EDs among staff	Providing training sessions and workshops could improve the knowledge and skills of paediatric staff in managing EDs and psychological distress and could help to improve the provision of psychiatric/psychological care that many parents felt was needed in hospital. Training could be offered through joint training or away days for paediatric and CAEDS staff, and CAEDS staff could contribute to induction training for all new paediatric staff.

Recommendation 7	
Improving understanding of EDs among parents	Disseminate information leaflets and resources about EDs for parents to read in hospital during the admission. It would be useful to include information such as the medical risks of an ED, links to online/written resources, and what other families have found helpful to promote recovery.
Recommendation 8	
Allowing families to bypass A&E when referred by a medical professional in the community	Reinforce existing processes between the hospital and CAEDS through which families can bypass A&E and go straight to the children's ward when it has been pre-agreed that they need to be admitted. This tends to already happen when families are referred by the CAEDS, but it would be helpful to set up this arrangement when referred by other sources, such as GPs.
Recommendation 9	
Providing emotional support to parents	Prioritise the provision of emotional support for parents as well as their children. This could be in the form of pre-planned, regular contact from staff from the CAEDS or the crisis team, information leaflets and links to online/written resources, and parent support forums, such as the psychoeducational support groups for parents recently set up by the CAEDS.
Recommendation 10	
Improving communication	Clinicians should prioritise enhancing communication channels between services and the family during admissions, particularly regarding treatment plans, medical procedures, transfers between units, and when the CAEDS is visiting the family in hospital. It would be useful to provide information to the family about key staff members to liaise with as it can be confusing when multiple services are involved.
Recommendation 11	
Improving autism awareness	Provide paediatric and CAEDS staff with ongoing autism training, make reasonable adaptations to treatment and use appropriate tools that improve communication with CYP with autism and EDs, such as communication passports developed by the PEACE pathway (https://www.peacepathway.org). Autism training could be included in the induction of new paediatric and CAEDS staff.
Recommendation 12	

Targeting support provided by the crisis team	Families receiving support from the crisis team for longer periods following a paediatric admission appear at greater risk of their child requiring psychiatric inpatient care. It would be useful for the CAEDS and crisis team to work more closely together to identify ways of enhancing the support provided by the crisis team. CAEDS staff could provide the crisis team with specialist ED knowledge through ongoing training and closer liaison.

Limitations

Although this project makes suggestions about the factors the affect treatment trajectory, it is important to note the limitations that may impact the findings. First, there was a large amount of missing data in the service's database, which meant that some outcome measures were not able to be analysed, and for those that were analysed the power of the statistical tests is likely to have been reduced. Second, as with all qualitative research the themes derived from the interviews will be prone to bias and will have been influenced by the trainee clinical psychologist's epistemological stance. However, the checking of theme development with parents and the inter-rater reliability check will have mitigated this somewhat. Lastly, the project took place during the Covid-19 pandemic and not all families were routinely approached based on care coordinators' views of families' distress levels, which will have introduced a selection bias for the interviews. The pandemic also limited the ability of CAMHS crisis staff and CAEDS staff to visit CYP and their parents on the ward, which may have affected their perceptions of support.

Conclusions

Notwithstanding the limitations described above, this project is important in helping services to understand the impact of paediatric admissions as a component of the ED treatment pathway for CYP. Collecting parental perspectives offered unique insights into how families experience paediatric admissions and underscores the value of seeking feedback from service users, which could be integrated more into routine practice such as through the use of regular

online feedback forms. It would be useful to evaluate the effect of any changes implemented following this service improvement project, such as the impact of staff training, information leaflets or provision of emotional support for parents. Considering the prevention of long-term inpatient care is an important healthcare objective, further research and service developments will be crucial in understanding how best to maximise the usefulness of brief paediatric admissions and improve the effectiveness of community-based care for CYP with EDs.

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Main Research Project

The impact of traumatic childbirth on new mother's social identity and psychological wellbeing: a cross-sectional observational study

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This journal was chosen as it reports research on psychological, behavioural, medical and social aspects of human reproduction, pregnancy and infancy. It specifically caters for individuals working in clinical and social psychology on issues of health promotion and service organisation.

My supervisors have read and provided feedback on this work and deem it suitable to be submitted for assessment.

Abstract

Objective: To investigate whether traumatic childbirth affected new mothers' social identity and their psychological wellbeing, and whether strength of identity as a new mother protected psychological wellbeing following traumatic childbirth.

Method: 123 new mothers completed digital questionnaires about their birth experience, social identity, mental health and psychological wellbeing.

Results: Compared to women who did not have a traumatic birth (*N*=39), women who had a traumatic birth (*N*=84) had significantly lower psychological wellbeing but did not differ in the strength of their new mother identity, which was generally high across both groups. Strength of identity did not moderate the relationship between traumatic childbirth and psychological wellbeing. All analyses controlled for emotional and practical support, perceptions of healthcare staff, and mode of birth. Having a caesarean section independently reduced strength of the new mother identity. Common reasons for childbirth being traumatic included physical health complications that interrupted mother-and-baby bonding, unanticipated separation from birth partners, and negative interactions with healthcare staff.

Conclusions: Having a traumatic birth does not appear to have a clear effect on the strength of new mother identity and may be mediated by factors such as mode of birth. Further research is needed to understand the relationship between these constructs. Investigating the relationship between caesarean sections and strength of the new mother identity may identify effective ways of protecting new mothers' mental health.

Keywords: traumatic childbirth; postnatal PTSD; new mothers; perinatal health; social identity; wellbeing

Introduction

Traumatic childbirth is a common experience and can have far-reaching and long-term consequences for mental health, wellbeing and relationships (Ayers, Eagle, & Waring, 2006; Byrne, Egan, Mac Neela, & Sarma, 2017; Taghizadeh, Irajpour, & Arbabi, 2013). For mothers having their first child, birth-related trauma occurs when they are already contending with the effects of a major life transition, a time period involving significant change and lifestyle adjustment where mental health and social connections are especially vulnerable (Hammen, 2005). Research demonstrates that fostering a sense of social identity can protect psychological wellbeing during transitions: belonging to multiple social groups, maintenance of pre-existing social identities, and adoption of new identities consistent with the life change that are compatible with pre-existing identities are all thought to buffer against the negative effects of a major life transition (Haslam et al., 2008; Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Praharso, Tear, & Cruwys, 2017; Steffens, Jetten, Haslam, Cruwys, & Haslam, 2016). To the authors' knowledge, no research has yet applied social identity approaches to the field of birth trauma. This study aims to address this gap in the literature by examining the relationships between traumatic childbirth, strength of new mother identity and psychological wellbeing. If a relationship is found between these constructs, it could lead to promising opportunities to protect new mothers at risk of poor mental health, for example through increasing opportunities for social connections with other mothers.

Postnatal PTSD

Postnatal posttraumatic stress disorder (PTSD) is increasingly being identified as a common experience. Research shows as many as one in two mothers perceive birth as traumatic (Abdollahpour, Mousavi, Motaghi, Keramat, & Khosravi, 2017; Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010; Soet, Brack, & DiIorio, 2003), and 1.9–5.6% of all postnatal

women, rising to 15.7–18.95% in at-risk groups, will develop clinically significant symptoms of postnatal PTSD (Creedy, Shochet, & Horsfall, 2000; Grekin & O'Hara, 2014; Soet et al., 2003; Yildiz, Ayers, & Phillips, 2017). Guidance published by the National Institute of Health and Care Excellence defines traumatic childbirth as '*births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage) and births that are experienced as traumatic, even when the delivery is obstetrically straightforward*' (NICE, 2014, p.13). The second part of this definition is important as it is the perception of events, rather than the objective event itself, that is thought to be crucial to trauma reactions. Whilst obstetric complications can increase the risk of postnatal PTSD, studies have clearly shown that subjective experience is more important. A study of 1,499 women found that subjective birth experience had the highest association with PTSD symptoms and mediated the link between fear of childbirth, obstetric factors and PTSD (Garthus-Niegel, von Soest, Vollrath, & Eberhard-Gran, 2013).

Qualitative research has highlighted the effects of postnatal PTSD on mothers, their relationships with their child and partner, and on future reproductive choices (Ayers et al., 2006; Byrne et al., 2017; Taghizadeh et al., 2013). Fenech et al.'s (2014) meta-synthesis explored the existing qualitative evidence for the psychosocial implications of a traumatic birth on maternal wellbeing and discovered three main effects: strong negative emotions and dysfunctional coping strategies following birth, an embodied sense of loss of self and family ideals, and shattered relationships. This highlights the far-reaching effects of postnatal PTSD and underscores its relevance to identity and social relationships.

Social identity: becoming a mother

Becoming a mother can be considered a major life transition that comes with significant change and stress. Literature on life transitions has consistently demonstrated a strong link

with psychological distress and psychopathology (Emmanuel & St John, 2010; Kosidou et al., 2012; Thoits, 2010). Robust causal associations have been found between stressful life events and major depressive episodes (Hammen, 2005). Not only must mothers adapt to changed routines, sleep patterns and responsibilities, they must also renegotiate the social identities they hold. Social identity is conceptualised as the sense of self that people derive from their membership of an important social group (Tajfel, 1978). Group memberships are a key source of social support and have a range of benefits for mental health, such as instilling a sense of control, meaning, coping and resilience (Drury, Cocking, & Reicher, 2009; Greenaway et al., 2015; Haslam, Reicher, & Levine, 2012; Schmitt, Spears, & Branscombe, 2003). During a major life change, certain social identities may be lost, and connectedness to a group is critical to the renegotiation of identity and maintenance of good psychological wellbeing (Jetten, Haslam, Iyer, & Haslam, 2009). New mothers may lose a social identity as an employee, for example, but maintenance of other meaningful pre-existing group memberships, such as being a member of an antenatal group, has been shown to promote wellbeing in the adjustment to motherhood (Seymour-Smith, Cruwys, Haslam, & Brodribb, 2017).

A recently proposed model drawing on social identity approaches (social identity and self-categorisation theories) has been offered as a useful framework for understanding how one's social identity changes during life transitions and related consequences for mental health. The Social Identity Model of Identity Change (SIMIC) posits that life transitions weaken our social identities through loss of contact with social groups, which negatively impacts wellbeing and mental health (Jetten et al., 2009). It makes specific assumptions about ways that the stress of life transitions can be counteracted. Belonging to multiple social groups before a life transition, maintaining pre-existing social identities and taking on new identities consistent with the life change following the transition, as well as compatibility between pre-existing and new identities are suggested as being protective of wellbeing. There is good

evidence for SIMIC in life transitions such as going to university, recovering from stroke, and entering retirement (Haslam et al., 2008; Iyer et al., 2009; Steffens et al., 2016). The model has also been tested in the perinatal field with promising results. Seymour-Smith et al. (2017) found that after having a baby, women reported a decline in important group memberships which was linked to an increase in depressive symptomatology, but that symptoms of depression were reduced by having a stronger identity as a mother and maintaining pre-existing group memberships from pregnancy into the postpartum period. The protective role of social identity in postnatal depression has been replicated elsewhere in research with new mothers (Gilmour, 2021). However, SIMIC has not yet been tested in relation to birth trauma, nor has it been established whether a link exists between birth trauma and social identity in new mothers.

Objectives

In summary, there is good evidence that postnatal PTSD is linked to poorer wellbeing, and that social identity can protect psychological wellbeing during life transitions, such as becoming a mother. However, little is known about the impact of traumatic childbirth on new mothers' social identity and psychological wellbeing. Drawing on SIMIC, the current study aimed to examine whether traumatic childbirth affected new mothers' strength of identity and psychological wellbeing, and whether strength of identification as a new mother moderated the relationship between traumatic childbirth and psychological wellbeing. Considering that previous literature suggests that traumatic childbirth negatively affects women's postnatal mental health and maternal experiences (e.g. Ponti, Smorti, Ghinassi, Mannella & Simoncini, 2020), and the fact that childbirth precedes postnatal outcomes chronologically, directional hypotheses were predicted.

In line with SIMIC and the literature discussed above, three hypotheses were tested:

H_1 *New mothers who have had a traumatic birth will have weaker identities as new mothers compared to new mothers who did not have a traumatic birth*

H_2 *New mothers who have had a traumatic birth will have lower levels of psychological wellbeing than new mothers who did not have a traumatic birth*

H_3 *A new mother social identity will moderate the relationship between traumatic childbirth and psychological wellbeing such that when identity as a new mother is stronger, the effect of having a traumatic birth on psychological wellbeing will be weaker*

Materials and Methods

This study employed a cross-sectional, between-groups observational design, where women who had a traumatic birth (trauma group) were recruited alongside women who did not have a traumatic birth (control group) to identify differences in social identity and psychological wellbeing. Participants completed a confidential online survey on Qualtrics, a secure online platform, containing questionnaires about their birth experience, mental health, social identity and psychological wellbeing. Individuals who accessed the survey were initially asked to read a Participant Information Sheet, which provided details about the study including potential risks and benefits of taking part. If they met the inclusion criteria, they were able to participate by completing the subsequent questionnaires. As participants' names and contact details were not requested by the researchers, participants were made aware that consent was implied by completion of the questionnaires. Participants were informed that they could take a break at any point or withdraw from the study before survey completion by simply closing their web browser. It was not possible to remove data following survey completion as individual participants could not be identified. Advice about accessing mental health support

was provided on each page of the survey and in a pop-up message if participants indicated that they were experiencing suicidal ideation (item 10 on the postnatal depression measure). The study was conducted in the United Kingdom as part of a doctoral degree in Clinical Psychology. Recruitment and data collection ran from October 2020 to March 2021. Ethical approval was gained from the Health Research Authority (IRAS project ID 279433) and from two NHS Trusts acting as Participant Identification Centres. It was made clear that participation was voluntary and separate from any treatment participants were receiving. This paper was written in accordance with STROBE guidelines (von Elm et al., 2008).

In recognition of the value that service users bring to the development of research (National Institute for Health Research, 2018), the researchers connected on social media with 56 women with lived experience of traumatic childbirth to gather feedback regarding the design, procedure, materials and impact of the study. Some felt that the language used to talk about traumatic childbirth could inadvertently place the problem within the individual rather than the experience itself being concretely traumatic. As a result, the researchers replaced sentences such as "women who perceived childbirth as traumatic" with "women who experienced traumatic childbirth". Many of the women reported feeling pleased that research on this topic was being conducted.

Participants

Women were eligible to take part in the study if they lived in the United Kingdom, were over 18 years of age, and had given birth to their first child within the past nine months at the point of survey completion. These criteria aimed to capture a timeframe in which new mothers were transitioning to parenthood and where clinical and subclinical mental health symptomatology could have developed, whilst minimising variation between global maternity services. Women whose child unfortunately died before, during, or after birth or had significant life-threatening illnesses were not eligible to take part in the study as these experiences were

thought to be quite different from the experience of having a traumatic birth alone and including them was thought to make it difficult to attribute observed findings to the experience of traumatic childbirth. Participants were also excluded if they were unable to provide consent or complete questionnaires in English.

Recruitment

Participants were recruited via a range of methods. Three NHS mental health services signposted potential participants to the survey by sharing a study leaflet or sending their clients an email about the study. The research was advertised on social media by the research team and birth-related charities and organisations. These services and organisations were selected to provide access to a wide range of women who had either a traumatic or non-traumatic birth and were displaying a representative and sufficient range of symptoms (i.e., from subclinical to severe postnatal PTSD). The researchers planned to put posters advertising the study in the community, such as venues hosting mother-and-baby groups, but the study took place during the Covid-19 pandemic which meant meeting people in person was not possible due to infection control measures.

Outcome measures

The study measures included a battery of self-report questionnaires (see Table 1). The primary outcome measures were used to test the research hypotheses, whilst the secondary outcome measures allowed the researchers to describe the sample and control for confounding variables. The 'exposure to traumatic childbirth variable' allowed the sample to be split into the experimental 'trauma' group and the 'non-trauma' control group, so that between-group differences could be assessed. Women in the study who experienced a traumatic birth were asked to elaborate on what made childbirth traumatic to provide insight into contributing factors. Appendix F contains the measures not widely available. With the exception of the multiple identity questionnaire (where participants entered up to six affiliated social groups),

participants had to complete every question to proceed with the survey which minimised missing data. If participants did not enter any social groups on the multiple identity questionnaire, the researchers coded the number of groups as missing data, rather than assuming no affiliation to any social group.

Table 1. Outcome measures used within the study

Domain	Measures	Cronbach's alpha
Primary outcome variables		
Exposure to traumatic birth (independent variable)	Dichotomous question of whether childbirth (or the events leading up to or shortly following birth) was traumatic. Participants who indicated their childbirth was traumatic described the nature of the trauma and then chose three factors that contributed most to childbirth being traumatic. A free-text box allowed them to elaborate on what they found traumatic about childbirth if they felt comfortable doing so.	*N/A*
Strength of new mother identity (dependent variable)	The in-group identification questionnaire[1] is a valid and reliable 14-item scale of in-group identification adapted for this study to be relevant to new mothers. Items were scored on a seven-point Likert scale (1=strongly disagree to 7=strongly agree) with total scores ranging from 14-98. Higher scores represent stronger identities as new mothers.	.91
Psychological wellbeing (dependent variable)	The Warwick Edinburgh Mental Well-being Scale[2] (WEMWBS) is a widely used, valid and reliable measure comprised of 14 items scored on a five-point Likert scale (1='none of the time' to 5='all of the time'). Total scores range from 14-70 with higher scores representing higher mental wellbeing. Scores between 45-59 represent average wellbeing.	.94
Secondary outcome measures		
Demographics	Participants provided their age, sexuality, ethnicity, employment status over the past 12 months, postcode, marital status, and their baby's age and health status. Postcodes were used as a rough estimate of the socioeconomic status of the area in which participants lived. Postcodes were converted into a deprivation decile using the governments' Indices of Multiple Deprivation for each country in the UK and then deleted, thereby de-identifying the data. As the researchers only wanted a rough estimate of socioeconomic status in order to describe the sample, the deciles were transformed into a dichotomous variable where the most deprived 50% of neighbourhoods were compared to the least deprived 50% of neighbourhoods nationally.	*N/A*

Postnatal PTSD	The City Birth Trauma Scale[3] has 29 items, with total scores ranging from 0-60 with higher scores representing higher symptom severity. This measure was used in two ways: (1) the total score provided the severity of postnatal PTSD symptomatology, and (2) participants' scores were transformed into a dichotomous variable based on whether or not they met diagnostic criteria for postnatal PTSD according to DSM-V criteria[4].	.94
Postnatal depression	The Edinburgh Postnatal Depression Scale[5] has 10 items and is a widely used, valid and reliable screening tool for postnatal depression. Scores range from 0-30 with higher scores corresponding to increasing symptom severity. Participants scoring 13 or above are likely to be suffering from major postnatal depression[5]. This measure was used in two ways: (1) the total score provided the severity of postnatal depression symptomatology, and (2) participants' scores were transformed into a dichotomous variable based on whether or not they scored 13 or over and were likely to be suffering from major postnatal depression.	.89
Maintenance of group memberships during life transitions	The multiple-identity scale[6] measured changes to group memberships from before to after giving birth. Participants listed up to six social groups they identified with before and after they gave birth. Each group was rated for pre-birth and post-birth importance on a 1-7 Likert scale. Pre-birth compatibility with the other social groups was rated on a 1-7 Likert scale, and post-birth compatibility with the new mother identity was rated on the same scale. Higher scores indicated greater group importance and compatibility.	.99
Risk and vulnerability factors	Previous research has identified a number of risk and vulnerability factors most strongly associated with the development of postnatal PTSD[7]. These include previous psychological problems, history of trauma, fear of childbirth, poor health or complications in pregnancy, type of birth, support during pregnancy, and past treatment/help-seeking for psychological problems. Participants in this study selected which type of birth they had (vaginal/assisted/caesarean) and then selected whether or not they had experienced the other risk and vulnerability factors.	*N/A*

[1]Leach et al. (2008); [2]Stewart-Brown et al. (2011); [3]Ayers, Wright and Thornton (2018); [4]American Psychiatric Association (2013); [5]Cox, Holden and Sagovsky (1987); [6]Haslam et al. (2008); [7]Ayers et al. (2016).

Statistical analyses

Normality of the data was initially checked and then t-tests and chi square tests ascertained significant group differences before controlling for covariates. Next, correlational analyses identified covariates by exploring significant relationships between the dependent variables

and secondary outcome variables; categorical variables with more than two levels were dummy coded for this step. After checking whether the test assumptions had been met, multivariate analyses of covariance (MANCOVA) determined whether the two groups differed in their strength of new mother identity (H_1) and levels of psychological wellbeing (H_2) whilst controlling for covariates. Post-hoc tests were used to understand the direction of differences between groups. Multiple regression and moderation analyses examined whether the strength of new mother identity affected the magnitude of the relationship between traumatic childbirth and psychological wellbeing (H_3). All statistical analyses were conducted in IBM SPSS Statistics, v27. Lastly, women's reasons for birth being traumatic were not formally analysed but were instead screened for common themes.

The study aimed to recruit a sample of at least 82 participants based on an a priori power calculation and allowing for a rate of attrition at 20%. This power calculation was derived using G*Power software (Faul, Erdfelder, Buchner, & Lang, 2009). No power calculation exists in G*Power or other available tools for MANCOVA tests therefore the researchers based the calculation on the multivariate analyses of variance (MANOVA) test. This approach has been adopted by other researchers (e.g., Chrismas, 2021; Çimşir & Tümlü, 2021) and recommended by Dattalo (2008), who suggests adjusting the sample size estimation method in G*Power by adding the number of covariates in the design to the number of groups. This increased the required sample size by two participants. Statistical power (i.e., the probability that it will correctly reject the null hypothesis) was set at .80, supporting an 80% chance of concluding observed effects are true. As there were no comparable studies in existing literature, a medium effect size of f^2=0.15 was chosen, in line with Cohen's (1977; 1988) levels of effect sizes for multivariate analyses of variance. Regression analyses required a sample of 55 participants based on one predictor variable and an effect size of f^2=0.15.

Results

Descriptive statistics

One hundred and twenty-four participants completed the study survey. One participant's baby was over nine months old, so their data had to be deleted, creating a sample of 123 participants (*N*=84 trauma condition, *N*=39 control condition). Table 2 locates the sample in its demographic context and Table 3 provides descriptive data on the dependent variables and secondary outcome variables. Women in both groups had strong identities as new mothers (trauma group mean=71.81/98; control group mean=78.36/98). The trauma group had 'below average' levels of psychological wellbeing (mean=41.55/70), whilst the control group had 'average' levels (mean=48.41/70). Ten participants' babies had health conditions, including allergies, gastrointestinal problems, heart conditions, and poor health related to premature birth. Participants who experienced a traumatic birth rated loss of blood as the factor that contributed most to childbirth being traumatic (*N*=9). Unanticipated separation from a birthing partner was rated as the second strongest factor (*N*=8) and birth injuries caused to the mother, such as episiotomy and perineal tears, were rated as the third strongest factor (*N*=7).

Table 2. Demographics of the sample

Variable		**Trauma Condition (*N*=84)**		**Control condition (*N*=39)**	
		Range (min-max)	***Mean (SD)***	***Range (min-max)***	***Mean (SD)***
Age (years)		20-40	30.86 (4.22)	19-39	30.92 (4.47)
Baby's age (months)		0-9	4.96 (2.30)	0-9	4.59 (2.44)
		N	***%***	***N***	***%***
Number of women whose babies had health conditions		6	7.1	4	10.3
Ethnicity	Indian	3	3.6	0	0
	Bangladeshi	0	0	0	0
	Pakistani	0	0	0	0
	Chinese	0	0	0	0
	Other Asian background	0	0	0	0

	Black African	0	0	0	0
	Black Caribbean	0	0	0	0
	Other Black background	0	0	0	0
	White British	70	83.3	37	94.9
	White Irish	3	3.6	0	0
	Other White background	4	4.8	2	5.1
	Mixed White & Asian	0	0	0	0
	Mixed White & Black African	0	0	0	0
	Mixed White & Black Caribbean	1	1.2	0	0
	Other Mixed background	2	2.4	0	0
	Any Other	0	0	0	0
	Prefer not to say	1	1.2	0	0
Sexuality	Heterosexual	78	92.9	38	97.4
	Gay or lesbian	0	0	0	0
	Bisexual	3	3.6	1	2.6
	Other	0	0	0	0
	Prefer not to say	3	3.6	0	0
Work status over past 12 months	Unemployed	2	2.4	0	0
	Employed	67	79.8	33	84.6
	Retired	0	0	0	0
	Homemaker	1	1.2	1	2.6
	Student	0	0	2	5.1
	Non-paid work	0	0	0	0
	Self-employed	7	8.3	3	7.7
	Non-government employee	1	1.2	0	0
	Government employee	4	4.8	0	0
	Prefer not to say	2	2.4	0	0
Marital status	Married	51	60.7	28	71.8
	Living as a couple	29	34.5	11	28.2
	Divorced or separated	0	0	0	0
	Single	1	1.2	0	0
	Widowed	0	0	0	0
	Other	0	0	0	0
	Prefer not to say	3	36	0	0
Deprivation decile	Most deprived 50% neighbourhoods nationally	22	26.2	9	23.1
	Least deprived 50% of neighbourhoods nationally	62	73.8	30	76.9

Note. The trauma condition contained participants who reported experiencing a traumatic birth, whereas the control condition contained participants who did not report experiencing a traumatic birth.

Table 3. Descriptive data of the dependent and secondary outcome variables

Variable	Trauma condition		Control condition	
	N	***Mean (SD)***	***N***	***Mean (SD)***
Strength of new mother identity	84	71.81 (14.62)	39	78.36 (9.59)
Psychological wellbeing	84	41.55 (9.92)	39	48.41 (9.49)
Postnatal PTSD score	84	24.67 (14.17)	39	8.97 (8.79)
Postnatal depression score	84	11.61 (6.00)	39	8.03 (5.75)
Number of social groups before birth	43	2.33 (1.27)	28	2.57 (1.29)
Number of social groups after birth	49	2.55 (1.36)	28	2.75 (1.58)
Group importance before birth	67	3.98 (1.93)	36	3.87 (1.96)
Group importance after birth	58	4.56 (1.81)	30	4.74 (1.81)
Group compatibility before birth	52	3.52 (1.89)	33	3.92 (1.82)
Group compatibility after birth	51	4.98 (1.77)	27	5.13 (1.80)
		N (%)		***N (%)***
Unassisted vaginal birth	84	21 (25%)	39	32 (82.1%)
Assisted birth (e.g., forceps)	84	35 (41.7%)	39	3 (7.7%)
Caesarean section	84	28 (33.3%)	39	4 (10.3%)
Felt they received adequate emotional support from staff	84	42 (50%)	39	29 (74.4%)
Felt they received adequate practical support from staff	84	58 (69%)	39	31 (79.5%)
Felt they received adequate emotional support from others	84	71 (84.5%)	39	38 (97.4%)
Felt they received adequate practical support from others	84	65 (77.4%)	39	36 (92.3%)
Felt listened to and included in making decisions related to birth	84	46 (54.8%)	39	35 (89.7%)
Felt staff were kind and attentive	84	56 (66.7%)	39	35 (89.7%)
Had a strong fear of childbirth before birth	84	20 (23.8%)	39	9 (23.1%)
Poor health/complications in pregnancy	84	21 (25%)	39	9 (23.1%)
Pre-existing mental health difficulties	84	21 (25%)	39	11 (28.2%)
Previous exposure to trauma	84	12 (14.3%)	39	8 (20.5%)
Previously received professional support for mental health	84	29 (34.5%)	39	14 (35.9%)
Currently receiving professional support for mental health	84	12 (14.3%)	39	4 (10.3%)
Current medical use for mental health	84	9 (10.7%)	39	2 (5.1%)
Met diagnostic criteria for postnatal PTSD	84	24 (28.6%)	39	0 (0%)
Met screening criteria for major postnatal depression	84	41 (48.8%)	39	8 (20.5%)

Note. The trauma condition contained participants who reported experiencing a traumatic birth, whereas the control condition contained participants who did not report experiencing a traumatic birth.

Preliminary between-group differences

Parametric tests were used as the variables were normally distributed with only minor deviations from normality. Before controlling for covariates, the trauma group had a significantly weaker new mother identity ($t(107.15)=2.96$, $p=.004$, $d=.68$), lower

psychological wellbeing ($t(121)=3.62$, $p<.001$, $d=.72$), and higher severity of postnatal PTSD ($t(110.98)=-7.51$, $p<.001$, $d=1.78$) and depression ($t(121)=-3.12$, $p=.002$, $d=.62$), when compared to the control group. The trauma group was less likely to have an unassisted vaginal birth ($X^2(2, N=123)=35.52$, $p<.001$, Cramer's $V=.54$), and less likely to feel they had received adequate emotional support from staff ($X^2(1, N=123)=6.48$, $p=.018$, Cramer's $V=.23$) or other people ($p=.037$, Fisher's exact test), or adequate practical support from other people ($X^2(1, N=123)=4.04$, $p=.074$, $V=.18$). They were also less likely to feel listened to and included in decision-making about their birth experience ($X^2(1, N=123)=14.49$, $p<.001$, $V=.34$) or feel that staff were kind and attentive to their needs ($X^2(1, N=123)=7.37$, $p=.007$, $V=.25$). Appendix G contains data from the normality tests, t-tests and chi square tests.

Correlational analyses identified several secondary outcome measures that correlated with strength of the new mother identity and psychological wellbeing at a significance level of $p<.05$. It would be unfeasible to include so many covariates into the MANCOVA therefore the threshold for the significance level was decreased to $p<.001$. Five variables were selected as covariates for subsequent data analyses: receiving emotional support from staff ($r(121)=.32$, $p<.001$), receiving adequate emotional support from other people ($r(121)=.37$, $p<.001$), receiving adequate practical support from other people ($r(121)=.30$, $p<.001$), feeling staff were kind and attentive to needs ($r(121)=.33$, $p<.001$), and giving birth by caesarean section ($r(121)=-.38$, $p<.001$). The postnatal PTSD and depression variables also significantly correlated with strength of identity and psychological wellbeing at a significance level of $p<.001$, but they were not included as covariates as they were considered to be conceptually too similar to the independent variable such that their inclusion as covariates would likely cancel out any variance associated with group membership. See Appendix H for variables excluded as covariates.

Tests of hypotheses

A one-way MANCOVA compared strength of the new mother identity and psychological wellbeing between the trauma group and the control group after controlling for the five covariates. Conditions of linearity, normality, homogeneity of variance and covariance, and outliers were checked, and the test assumptions were met. Box's test for equality of covariance was significant (p=.031) but as the MANCOVA is fairly robust this violation was not deemed to significantly affect the test results. The MANCOVA revealed that there were statistically significant between-group differences on the combined dependent variables after controlling for covariates (F(2, 115)=3.876, p=.024, Wilk's Λ=.937, partial η^2=.063). Giving birth by caesarean section was the only independent covariate that significantly influenced the combined dependent variables after controlling for the effects of all other covariates and exposure to traumatic childbirth (F(2,115)=5.260, p=.007, Wilk's Λ=.916, partial η^2=.084). Post-hoc power analyses using G*Power and selecting the MANOVA and ANCOVA tests for robustness showed that statistical power of the study was 0.67 and 0.79 respectively, with unequal group sizes included in the calculation.

Traumatic childbirth and strength of new mother identity (H_1)

Between-subjects comparisons showed that exposure to traumatic childbirth did not have a significant main effect on strength of new mother identity (F(1,116)=.668, p=.416, partial η^2=.006). However, having a caesarean section had a significant main effect of medium magnitude on strength of new mother identity (F(1,116)=5.914, p=.017, partial η^2=.049): comparing the estimated marginal means showed that overall strength of new mother identity was significantly lower for the group who had a caesarean section (mean=69.11, standard error=2.24) compared to the group who had a vaginal birth or instrumental delivery (mean=75.57, standard error=1.28).

Traumatic childbirth and psychological wellbeing (H_2)

Between-subjects comparisons showed that exposure to traumatic childbirth had a significant main effect of medium magnitude on psychological wellbeing ($F(1,116)=7.324$, $p=.008$, partial $\eta^2=.059$): comparing the estimated marginal means showed that psychological wellbeing was lower in the trauma group (mean=42.03, standard error=1.07) compared to the control group (mean=47.37, standard error=1.60). Having a caesarean section had no significant main effect on wellbeing ($F(1,116)=.329$, $p=.567$, partial $\eta^2=.003$).

The moderating effect of the strength of new mother identity on the relationship between traumatic childbirth and psychological wellbeing (H_3)

From the multiple regression and moderation analyses, the overall model was statistically significant whilst controlling for the five covariates ($F(8,114)=9.544$, $p<.0001$, $R^2=.401$). Traumatic childbirth had a significant main effect on psychological wellbeing ($b=-3.969$, $t(114)=-2.201$, $p=.030$), as did strength of new mother identity ($b=.530$, $t(114)=3.667$, $p<.001$). Exposure to traumatic childbirth was linked to a 3.969 unit reduction in wellbeing, whilst for every 1 unit increase in strength of identity there was a .530 unit increase in wellbeing. The interaction effect of traumatic childbirth and strength of identity on psychological wellbeing was not statistically significant ($b=-.137$, $t(114)=-.857$, $p=.393$), meaning that strength of identity as a new mother did not moderate the strength of the relationship between traumatic childbirth and psychological wellbeing.

Reasons for childbirth being traumatic

Women who experienced traumatic childbirth frequently reported it being traumatic due to labour being long, painful, and associated with severe blood loss. Many had a high level of medical input during labour including emergency caesarean sections and feared they or their baby would die. A repeated concern was that these experiences interrupted mother-and-baby

bonding, and several women talked about feeling as though they had failed or were responsible for the difficulties encountered. A lack of communication and support from staff led to women feeling abandoned, not listened to, and that procedures were being 'done to' them without being informed or included in decision-making about their birth experience. Several women reported feeling let down and dismissed by healthcare services, particularly when staff did not help to facilitate connections with their babies. Many women also shared that the reality of their birth experience was very different to their birth plan. This seems to have been exacerbated by the Covid-19 pandemic's restrictions on birthing partners being allowed into hospital, which the vast majority of women mentioned as a main contributor to birth being traumatic.

Discussion

This study investigated the impact of having a traumatic birth on women's psychological wellbeing and on their social identity as new mothers. Evidence was found only in support of H_2: having a traumatic birth resulted in lower levels of psychological wellbeing in new mothers, which is consistent with previous research (e.g., Fenech & Thomson, 2014). The null hypotheses were accepted for H_1 and H_3: traumatic childbirth in general did not appear to be predictive of the strength of the new mother identity, and strength of identity did not moderate the observed relationship between traumatic childbirth and psychological wellbeing. Although the preliminary tests of group differences revealed that women who had a traumatic birth appeared to have weaker identities as new mothers, the effect disappeared when controlling for covariates, suggesting that the effect of traumatic childbirth on the strength of new mother identity may be mediated by other variables such as mode of birth. Having a caesarean section (as opposed to a vaginal or instrumental delivery) emerged as one birth-related variable that did weaken the new mother identity. This is consistent with research

demonstrating that caesarean sections, and particularly those that are unplanned, are associated with difficulties in maternal identity formation (Kjerulff & Brubaker, 2018; Van Reenen & Van Rensburg, 2013). Previous systematic reviews and meta-analyses have demonstrated that emergency caesarean sections are also associated with posttraumatic stress (e.g., Benton, Salter, Tape, Wilkinson, & Turnbull, 2019; Chen et al., 2019), which reinforces the hypothesis that mode of birth connects the fields of birth trauma and maternal identity.

Qualitative data from women in the study who experienced a traumatic birth provided some insight into why caesarean sections may weaken new mothers' identity. Birth-related injuries (often linked to having a caesarean section) were identified as limiting opportunities for mother-and-baby bonding due to reduced physical strength and mobility. Additionally, staff were often perceived as unsupportive when women could not care for their babies independently due to their injuries, leading to negative views of the quality of care received. Poor-quality interactions with healthcare providers have been extensively documented in the maternity literature and identified as a significant risk factor for the development of clinically-relevant symptoms of postnatal PTSD (Grekin & O'Hara, 2014; Olde, Van Der Hart, Kleber, & Van Son, 2006; Patterson, Hollins Martin, & Karatzias, 2019; Shorey & Wong, 2020). Healthcare providers supporting their staff to facilitate mother-and-baby connections, particularly after caesarean sections, is an important approach to consider in improving maternal wellbeing and reducing the risk of later psychological morbidity.

The study findings do not provide clear support for the Social Identity Model of Identity Change (SIMIC), which is surprising considering the wider literature suggesting social identities can buffer the negative effects of life transitions and help to maintain health and wellbeing (Haslam et al., 2008; Iyer et al., 2009; Seymour-Smith et al., 2017; Steffens et al., 2016). This may point towards the complexity of maternity identity development; researchers have suggested that formation of the maternal identity is composed of cognitive, behavioural,

emotional and axiological (value-related) aspects (Perun, 2020), and perhaps the in-group identification measure used in this study was not a sufficiently nuanced measure for maternal identity. It tapped into how connected new mothers felt to other new mothers and it may have been more helpful to include new mothers' views and knowledge about the maternal role, their feelings about motherhood, their behaviour in the relationship with their child, and their values formed in the process of gaining social experiences related to motherhood.

Limitations

As with all research, there are limitations that are important to consider when interpreting the findings. First, during the data analysis stage, some deviations to normality were found which may have reduced the power of the parametric tests used. However, the tests used are known to be robust to minor deviations in normality (Field, 2017) and post-hoc power analyses confirmed the study was sufficiently powered. Second, the significance threshold for selecting covariates was decreased from $p<.05$ to $p<.001$ due to the high numbers of significant correlations found. It was necessary to reduce the numbers of covariates and as there are multiple methods for covariate selection (Raab, Day & Sales, 2000), a conservative approach was adopted to only include those that correlated with high significance. In doing so, relevant variables that could explain some of the variance in the dependent variables may have been inadvertently excluded from the analysis, although all correlations excluded at this step were fairly weak (r=-.233–.294). Furthermore, the numerous correlations found at a significance level of $p<.05$ may be evidence of a Type I error. Third, the study was conducted in a relatively small area of England during the Covid-19 pandemic, which may have restricted participation to new mothers living locally with internet access at home. Despite focused efforts to broaden the ethnic and geographical diversity of the sample by publicising the study widely on social media through national charities and individuals with established connections to minority ethnic groups, the majority of participants identified as White British and lived in less deprived areas. The findings may therefore not generalise to new mothers

from different backgrounds. This is particularly important considering the detrimental consequences of being from minority ethnic backgrounds on perinatal health in the UK (Knight et al., 2020). Fourth, the reported rates of traumatic birth were twice fold the rates of non-traumatic birth, which possibly reflects a sampling bias reducing the representativeness of the sample. Women who experience a traumatic birth may be more likely to participate in a study on the topic, leading to a higher incidence of traumatic childbirth in the study compared to the general population. Fifth, the cross-sectional design makes it difficult to draw causal inferences from the findings. It is possible that poorer prenatal wellbeing leads to childbirth being experienced as traumatic, as well as the experience of traumatic childbirth leading to poorer postnatal wellbeing. However, the theoretical rationale based on previous research coupled with the fact that childbirth precedes postnatal outcomes lends weight to the interpretation that experiencing a traumatic birth affects how women cope and feel about themselves as mothers in the postnatal period. Furthermore, although potential recall bias is possible, women's perceptions of childbirth have been found to be consistent over time (Bennett, 1985; Conde, Figueiredo, Costa, Pacheco & Pais, 2008; Simkin, 1992; Waldenström, 2003), therefore the traumatic childbirth perceptions in this study are likely to have been established before social identity and wellbeing were measured. Nevertheless, the causal relationships must be approached with caution.

Conclusions and directions for future research

In summary, this study suggests that the relationship between traumatic childbirth and new mothers' social identity is complex and may have an indirect relationship through specific birth-related experiences, such as having a caesarean section. The findings reinforce the importance of improving interactions between healthcare providers and new mothers as healthcare staff play an important role in women's birth experiences and later psychopathology. This study offers a novel contribution to the literature by advancing understanding of how traumatic birth experiences relate to new mothers' social identity in the

transition to motherhood. However, experimental research will be needed to understand the causal relationship between traumatic childbirth, maternal identity and wellbeing. Investigating in more detail the relationship between having a caesarean section and the development of a new mother identity may be particularly helpful for finding novel and effective ways of supporting new mothers during the perinatal period.

Declaration of Interest Statement

Disclosure of interest

The authors report no conflict of interest.

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Executive Summary

Why the study was conducted

Childbirth is usually a positive, life-enhancing experience. However, some mothers find it traumatic and are more likely to experience poorer mental health, lower wellbeing, and strained relationships as a result. This stage of life involves many changes which can be harmful for women's mental health. During life transitions such as having a child, social identity is particularly important. This is how we define ourselves in terms of the connections we have with others. Whilst our social identity can be vulnerable at times of change, it has also been shown to protect our wellbeing. The Social Identity Model of Identity Change (SIMIC) suggests that life transitions weaken our social identities as we lose contact with social groups, which negatively impacts wellbeing and mental health. SIMIC makes specific assumptions about ways that the stress of life transitions can be counteracted: belonging to multiple social groups before a life transition, staying connected to groups during a life transition, connecting with new groups linked to the life change, and the different groups being compatible with each other. Although previous research has found evidence for SIMIC in different life transitions, such as going to university, recovering from a stroke, and entering retirement, no one has yet investigated whether having a traumatic birth impacts on new mothers' sense of identity, or whether a stronger sense of identity as a new mother during the transition to motherhood could protect their wellbeing from the negative effects of a traumatic birth.

This study aimed to see whether:

1. New mothers who had a traumatic birth had weaker identities as new mothers compared to new mothers who did not have a traumatic birth

2. New mothers who had a traumatic birth had lower levels of psychological wellbeing than new mothers who did not have a traumatic birth
3. The strength of a new mother social identity moderated the relationship between traumatic childbirth and psychological wellbeing such that when identity as a new mother is stronger, the effect of having a traumatic birth on psychological wellbeing will be weaker

What the study involved

The study was conducted online, where new mothers completed digital questionnaires about their birth experience, social identity, wellbeing, and mental health. New mothers who had a traumatic birth were compared to new mothers who did not have a traumatic birth, so that key differences could be identified. The study was advertised through mental health services in Oxfordshire, Buckinghamshire and Buckinghamshire and more widely on social media via national charities and organisations. Women were able to take part if they had given birth to their first child within the past nine months, lived in the UK, and were over 18 years of age. If their child had significant life-threatening illnesses or had unfortunately died before, during, or after giving birth, women were not able to take part in the study as these experiences were thought to be quite different from having a traumatic birth. Participants were also excluded if they were unable to provide consent or complete questionnaires in English. Before the study began recruiting participants, women who had a traumatic birth were consulted on its methods to ensure it was conducted sensitively to the experiences of those taking part.

What the study found

One-hundred and twenty-three new mothers met the inclusion criteria and took part in the study; of these women, 84 had experienced a traumatic birth and 39 had not. Statistical analyses showed that having a traumatic birth did not affect new mothers' strength of identity. However, having a caesarean section interestingly emerged as reducing the strength of their

identity. Having a traumatic birth and a weaker identity as a new mother led to lower levels of psychological wellbeing in new mothers, although how strongly a new mother identified with other new mothers did not alter how much traumatic childbirth affected wellbeing; that is, when new mothers identified more strongly with other new mothers, it had no bearing on how much their experience of birth affected their wellbeing. Women in the study who had a traumatic birth described some of the reasons for their birth being traumatic. Common reasons included labour being long, painful and associated with severe blood loss. Medical interventions such as emergency caesareans were seen to reduce opportunities for mother-and-baby bonding time. Other reasons for birth being traumatic included feeling abandoned, not listened to, and dismissed by healthcare staff. Several new mothers felt that giving birth was very different to their birth plans, which seemed to have been made worse by the Covid-19 pandemic's restrictions on birthing partners being allowed into hospital.

Conclusions

This study investigated the impact of having a traumatic birth on new mothers' psychological wellbeing and on their social identity as new mothers. The finding that having a traumatic childbirth negatively affects new mothers' psychological wellbeing is consistent with previous research. Traumatic childbirth did not affect how strongly new mothers identified with other new mothers and the strength of new mother identity did not affect the relationship between traumatic childbirth and psychological wellbeing, which does not provide support for SIMIC. The relationship between traumatic childbirth and new mothers' social identity seems complex and may be based on specific factors, such as mode of birth. Having a caesarean section (as opposed to a vaginal or instrumental delivery) emerged as one birth-related variable that did weaken women's identity as new mothers, and it may be the case that having a traumatic childbirth affects new mothers' identity indirectly via mode of birth.

The findings highlight the importance of improving interactions between women giving birth and their healthcare providers as many of the participants who had a traumatic birth described negative interactions with staff contributing to their birth being traumatic. Further research will be needed to understand the relationship between traumatic childbirth, maternal identity and wellbeing. Investigating in more detail the relationship between having a caesarean section and the development of a new mother identity may be particularly helpful for finding novel and effective ways of supporting new mothers.

Connecting Narrative

Critical review of the literature

During my training, I was keen to build on my knowledge and skills gained from previous experiences. I wanted to choose a topic that I was keen to learn more about for my critical review of the literature as I thought it would give me a good opportunity to better understand a particular research area or the experiences of a certain population. I was keen to conduct a qualitative review as most of my previous research experience had been with quantitative approaches, but I found it fairly difficult to identify an area of interest where there seemed to be a gap in the literature. My supervisor advised me to choose an area that I was interested in to keep me engaged throughout the process and I found myself moving between various potential projects.

My husband was training as a teacher in mainstream schools at the time and several conversations between us sparked my interest in how young people's mental health and wellbeing are affected by school experiences. Before training I had worked in adult mental health services and research settings and I had little exposure to working with young people or neurodevelopmental conditions. I remember speaking with Ciorsdan Anderson, an academic tutor, who had worked with young people for several years, and she told me about the increasing drive to include young people with autism in mainstream schools. I began reading around the topic of inclusive education and found it particularly interesting that researchers were saying this drive seemed to have been driven by a human rights agenda without acknowledging the lived experiences of children and young people on the autism spectrum. Many of my relatives work in the field of human rights, which is probably why this stood out as being especially interesting. Synthesising the review was challenging considering the wide variety of experiences amongst the literature. However, the systemic teaching on the

course at the time heavily influenced my thinking, and Bronfenbrenner's ecological model remained dominant in my mind as I structured my findings. Conducting the review gave me a better understanding of autistic spectrum conditions, which has been enormously useful in my clinical work.

Service improvement project

This project was particularly meaningful for me as a relative of mine had recently been admitted to a paediatric hospital for an eating disorder. It gave the project a particular significance and highlighted the importance of considering the whole family system as a young person receives mental health treatment, which is likely why I chose to interview parents to better understand the impact of paediatric admissions. Conducting this project proved challenging largely due to the Covid-19 pandemic. Eating disorder services across the country were receiving extraordinarily high numbers of referrals and the process to gain approval from local NHS Trusts took much longer than expected. The service was extremely stretched which made relying on them for data obtainment and participant recruitment difficult. I have so much gratitude for the assistant psychologists who gave their time and effort to keep the project afloat during such challenging times. I had been involved in a service development project before clinical training, but this piece of work helped to strengthen the link in my mind between research and clinical practice. It has given me a quality improvement lens to improving the processes and impact of healthcare services and I hope to continue using my skills learnt in this project within the services I work in post-qualification.

Main research project

Before starting clinical training, I worked in a research centre focused on trauma and I found myself increasingly interested in the link between trauma and identity. I have been interested in the field of identity for many years, and at the time I was developing ideas for my MRP I

remember reading about the intergenerational trauma experienced by African Americans due to the Transatlantic slave trade and how one's social identity can have both detrimental and protective elements. I set up a few meetings with my internal supervisor, Lorna Hogg, and Martina Mueller, a respected trauma researcher and clinician, who kindly shared their time and thoughts on funnelling my interests and ideas into a viable research project. This suggestion of linking my ideas to the perinatal field was somewhat of a light bulb moment and became personally important when my sister fell pregnant with her first child. As I planned to submit this project last, I was able to spend more time designing the study and consulting people with lived experience, which was incredibly useful and showed me the value of involving people with lived experience in research more actively. I would like in future to move towards co-production of research, rather than more of a consultatory method.

Although I had previous research experience, conducting this project helped to develop my skills, particularly in the process of designing a study and obtaining ethical approval. Understanding more about the link between trauma and social identity approaches has also aided my clinical practice in an Early Intervention in Psychosis Service. I have found myself drawing on the Social Identity Model of Identity Change to understand distress in relation to how people connect with social groups, which seems particularly relevant for individuals experiencing their first episode of psychosis which is often traumatic and significantly impacts their sense of identity and connectedness with others.

My enjoyment of conducting research has been strengthened during training and I am keen to be actively involved in research throughout my career. I imagine it will be challenging to juggle research alongside clinical work as a qualified clinical psychologist. However, as my understanding of the various forms of research has expanded during my clinical training, I envisage this could be in less time-intensive ways such as sharing learning from clinical work

at Trust events, publishing case studies, and contributing to smaller-scale service development projects.

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Appendices

Appendix A: CRL search strategy

Example of search strategy used in ERIC database:

1. "mainstream education" or "inclusive education" or "general education" or "regular education" or "normal education"
2. "mainstream school*" or "inclusive school*" or "general school*" or "regular school*" or "normal school*"
3. "mainstream class*" or "inclusive class*" or "general class*" or "regular class*" or "normal class*"
4. "school integration" or "school inclusi*" or "inclusive pedagog*"
5. "inclusive setting*" or "inclusive environment*" or "mainstream setting*" or "mainstream environment*"
6. education or school* or class*
7. autis* or asperger* or ASD or ASC or "pervasive developmental disorder" or PDD
8. *MESH terms:* ("pervasive developmental disorders" or "Asperger syndrome" or "autism") and ("inclusion" or "mainstreaming") and ("education")

Combine: ((((1 or 2 or 3 or 4) or (5 and 6)) and 7) or 8)

Appendix B: SIP interview schedule

1) Can you tell me a little bit about how the paediatric admission was for your family?
    a. Prompt: What was it like having your child admitted to a paediatric ward?
    b. Prompt: What do you think was helpful or unhelpful about the paediatric admission?
2) In what ways did the paediatric admission affect your understanding of your child's difficulties?
    a. Prompt: Did you think or feel differently about your child's difficulties after they had a paediatric admission?
    b. Prompt: Did the admission change how able you felt to support your child in managing their eating disorder?
    c. Were there any other ways in which the admission has an effect on you?
3) In what ways did the paediatric admission have an effect on your child?
    a. Prompt: Did you notice any particular changes in your child's behaviour, thoughts or feelings?
4) Can you tell me anything about how the hospital staff and the community eating disorders team worked together during your child's hospital admission?
    a. Prompt: Did you have contact with the community team during the hospital admission?
    b. Prompt: Could you see that the hospital and community teams were working together to manage your child's eating disorder? How?
    c. Prompt: Was there a clear plan in place when your child was discharged from the paediatric ward? Was the plan developed with input from both the hospital and community teams?

5) If you or your child shared concerns with the medical or nursing teams in the paediatric hospital, can you tell me anything about how your concerns were handled?
    a. Did you feel that your concerns were addressed in a timely and effective manner? If not, why?
    b. Did you and your child feel well supported by the medical and nursing team? If not, why?
    c. Did you feel listened to by the staff team? If not, why?
6) Is there anything else that would have made the paediatric admission more helpful as part of the treatment your child has received?

Appendix C: Data from normality and inferential statistical tests in SIP

Tests of normality										
Variable	***N***	**Mean (*SD*)**	**Trimmed mean**	**Range**	**Skewness *Z* score**	**Kurtosis *Z* score**	**Shapiro Wilk statistic**			**Histogram / Q-Q plot**
							c	***df***	***p***	
Age (years)	Community group N=69 Psychiatric group N=33	14.09 (1.87) 14.58 (1.79)	14.18 14.62	7-18 11-17	-2.592 -.450	2.865 -1.338	.944 .929	69 33	.004 .032	Skewed
Duration of paediatric admission (days)	Community group N=69 Psychiatric group N=33	4.28 (2.93) 6.55 (4.35)	4.02 6.18	1-18 1-21	6.083 3.352	10.312 3.362	.856 .897	69 33	<.001 .004	Skewed
Crisis input before admission (days)	Community group N=55 Psychiatric group N=30	6.15 (15.61) 24.73 (46.00)	3.43 17.22	0-93 0-226	12.233 7.749	29.055 15.337	.456 .573	55 30	<.001 <.001	Skewed
Crisis input during admission (days)	Community group N=56 Psychiatric group N=28	4.39 (5.09) 6.14 (4.88)	3.66 5.75	0-29 0-21	8.624 2.317	16.314 2.103	.722 .915	56 28	<.001 .027	Skewed
Crisis input after admission (days)	Community group N=57 Psychiatric group N=30	72.49 (131.011) 278.03 (184.62)	52.62 266.09	0-880 0-815	14.449 2.513	41.918 1.610	.524 .923	57 30	<.001 <.033	Skewed
Duration of known illness (days)	Community group N=63 Psychiatric group N=31	104.08 (229.42) 318.58 (476.30)	63.58 255.80	0-1106 0-1983	10.156 4.971	15.447 5.307	.502 .691	63 31	<.001 <.001	Skewed
Weight for height	Community group N=57 Psychiatric group N=29	81.76 (10.92) 77.52 (9.31)	81.48 77.32	62-109 63.8-95	1.367 .730	-.178 -.879	.974 .955	57 29	.245 .244	Fine
Eating disorder severity – restraint subscale (EDE-A)	Community group N=41 Psychiatric group N=19	3.649 (2.10) 4.095 (1.97)	3.721 4.216	0-6 0-6	-1.778 -1.941	-1.338 -0.0750	.870 .854	41 19	<.001 .008	Skewed
Eating disorder severity – eating concern subscale (EDE-A)	Community group N=41 Psychiatric group N=19	2.995 (1.44) 3.516 (1.32)	3.02 3.606	.2-5.4 .4-5	-.810 -2.177	-1.403 .766	.955 .877	41 19	.108 .019	Skewed

Eating disorder severity – weight concern subscale (EDE-A)	Community group N=41 Psychiatric group N=19	3.789 (1.94) 4.125 (1.76)	3.877 4.216	0-6 .6-6	-2.016 -1.496	-1.256 -.752	.860 .864	41 19	<.001 .012	Skewed
Eating disorder severity – shape concern subscale (EDE-A)	Community group N=41 Psychiatric group N=19	4.074 (1.86) 4.267 (1.70)	4.189 4.394	0-6 .25-6	-2.369 -1.876	-.692 .062	.864 .875	41 19	<.001 .017	Skewed
Eating disorder severity – global score (EDE-A)	Community group N=41 Psychiatric group N=19	3.613 (1.72) 4.003 (1.54)	3.694 4.108	.15-5.6 .36-5.75	-2.081 -1.968	-1.029 .051	.878 .871	41 19	<.001 .015	Skewed
Clinical impairment of psychosocial functioning (CIA)	Community group N=32 Psychiatric group N=9	28.56 (14.81) 31.56 (13.05)	27.91 32.40	0-79 5-43	2.329 -1.845	4.022 .694	.934 .836	32 9	.050 .052	Skewed
Child-reported anxiety (RCADS)	Community group N=30 Psychiatric group N=10	55.17 (12.67) 58.30 (11.91)	54.70 57.83	37-81 44-81	1.569 1.009	-.690 -.274	.923 .938	30 10	.032 .529	Skewed
Child-reported depression (RCADS)	Community group N=31 Psychiatric group N=10	63.55 (11.69) 71.30 (14.84)	63.77 70.89	40-81 52-97	-.299 .064	-1.223 -.563	.959 .903	31 10	.276 .234	Fine
Parent-reported anxiety (RCADS)	Community group N=30 Psychiatric group N=12	58.17 (13.51) 69.17 (11.46)	58.02 69.46	37-81 52-81	1.237 .911	-.933 -.959	.915 .846	30 12	.021 .032	Skewed
Parent-reported depression (RCADS)	Community group N=31 Psychiatric group N=12	70.42 (10.73) 80.50 (10.76)	71.18 80.44	45-81 56-106	-2.102 .245	-.217 4.209	.876 .673	31 12	.002 <.001	Skewed

Note. The community group were participants who had a paediatric admission followed by at least three months of community-based care, whilst the psychiatric group were participants who had a paediatric admission followed by a psychiatric admission within three months of discharge.

T-test

Variable	*t*	*df*	*p*	Community group mean (SD)	Psychiatric group mean (SD)	Mean difference	95% confidence interval of the mean difference		Effect size (*d*)*
							Lower	Upper	
Weight for height	1.786	84	.078	81.76 (10.915)	77.52 (9.305)	4.24	-.48	8.96	.419
Child-reported depression (RCADS)	-1.707	39	.096	63.55 (11.693)	71.30 (14.840)	-7.75	-16.94	1.44	.584

Note. The community group were participants who had a paediatric admission followed by at least three months of community-based care, whilst the psychiatric group were participants who had a paediatric admission followed by a psychiatric admission within three months of discharge.
*Small effect size=.2, medium effect size=.5, large effect size=.8

Mann-Whitney U test

Variable	Community group median	Psychiatric group median	*U*	N_1	N_2	*p*	*Effect size r***
Age	14	15	993.5	69	33	.296	.104
Duration of paediatric admission	4	6	746.0	69	33	.004**	.280
Days of crisis team input before admission	0	5.5	420.5	55	30	<.001**	.428
Duration of crisis team input during admission	3.5	6	566.5	56	28	.037*	.227
Duration of crisis team input after admission	29	251	208.0	57	30	<.001**	.620
Duration of known illness	20	53	498.0	63	31	<.001**	.398
Eating disorder restraint subscale (EDE-A)	4.2	4.8	336.0	41	19	.399	.110
Eating disorder eating concern subscale (EDE-A)	3	3.6	306.0	41	19	.187	.172
Eating disorder weight concern subscale (EDE-A)	4.8	4.8	346.5	41	19	.499	.088
Eating disorder shape concern subscale (EDE-A)	4.8	4.8	369.0	41	19	.749	.042
Eating disorder global score (EDE-A)	4.3	4.6	339.5	41	19	.433	.103
Clinical impairment of psychosocial functioning (CIA)	28	34	107.0	32	9	.252	.182
Child-reported anxiety (RCADS)	52	55.5	119.0	30	10	.342	.153
Parent-reported anxiety (RCADS)	57	70	100.0	30	12	.024*	.345
Parent-reported depression (RCADS)	72	81	84.0	31	12	.004**	.435

Note. The community group were participants who had a paediatric admission followed by at least three months of community-based care, whilst the psychiatric group were participants who had a paediatric admission followed by a psychiatric admission within three months of discharge.
*Significant at p<.05
**Significant at p<.01
***Small effect size=.1, medium effect size=.3, large effect size=.5

Chi square test					
Variable	X^2	df^1	df^2	***p***	***Effect size Cramer's V*** ***
Gender	*1.563*	1	102	.432	.124
Ethnicity	5.493	5	102	.389	.232
Had previous paediatric admission	6.178	1	94	.023*	.256
Had previous psychiatric admission	19.515	1	92	<.001**	.461
Physical risk	1.765	3	102	.629	.137
Presence of self-harm risk	1.617	1	56	.263	.170
Presence of suicide risk	1.446	1	53	.259	.165

Note. The community group were participants who had a paediatric admission followed by at least three months of community-based care, whilst the psychiatric group were participants who had a paediatric admission followed by a psychiatric admission within three months of discharge.
*Significant at p<.05
**Significant at p<.01
***Small effect size<.2, medium effect size .2-.6, large effect size>.6

Appendix D: Themes and codes derived from thematic analysis in SIP

Key themes	Sub-theme	Codes	Example quotes
Impact of admission on mental health	Impact of ward environment	• Noise[3]	"The whole atmosphere on the ward was scary because you know there's noises all night, people coming in and out"
		• Age-appropriateness[3]	"She went to a ward with elderly people on there and it just wasn't an appropriate setting"
		• Privacy[3]	"It was the wrong environment, it wasn't private, it was overwhelming"
		• Single sex wards[1]	"Having mixed sex wards isn't good"
		• Long waits[3]	"There's a lot of waiting, waiting to see the next person and waiting for the test results, waiting for a nurse to come and take blood and waiting for the consultants to come and tell you about the bloods. But it's understandable in a busy hospital"
	Trigger for recovery	• Admission validating the eating disorder[1]	"It confirmed the voices, it almost said to her 'you've achieved that goal, you've now got that diagnosis', and probably triggered her getting better"
		• Access to treatment[3]	"The paediatric admission was most certainly the catalyst to her recovery" "I think she needed that environment where there was someone there saying 'well, if you don't eat it, then I have to go and tell the nurse'" "My daughter then got the help she needed and started eating"
		• Concrete treatment plan[3]	"As soon as she was in there, she was on a meal plan … which gave us something really solid to work with" "It was that first night that I think was a real wakeup call… [paediatric staff] were really good in terms of how they said to her 'you have to have this amount, this is the meal plan you have to eat, if you don't eat it you have to have the Ensure, and if you don't have the Ensure you have to have a feeding tube, and this is how it's going to be'"
		• Realising the severity[3]	"It really scared her. She didn't realise what she had done to the body and how ill it had made her" "I saw it as CAMHS almost giving a shock treatment to our family as well as for my daughter … it was like, this is a turning point" "It was a bit of a realisation for her that you know this is maybe serious … I think it was that big trigger"

	Child distress	• Impact of low weight[3]	"She wasn't really able to talk about what was going on for her, it was effectively emotional shutdown" "Her mind wasn't working well because of her being under weight and all the rest of it, so I understand why everything was heightened"
		• Strong emotions[3]	"She was in such a bad place mentally and emotionally" "It was just an overwhelming general feeling for a 13-year-old being in that environment"
		• Other patients[3]	"You also get to hear what [other patients] are going through, I think that was quite upsetting for her" "It probably helped a bit having, because there were some younger children there, and you know they got on quite well when she interacted with them, and perhaps with different issues, as they were just general medical weren't they, so that actually helped in some ways"
		• Medical interventions[3]	"It got to the point where if you don't eat you're gonna have a tube put in so when he realised that he had no choice, he started to eat" "But the second [admission] was a much more difficult experience because it involved NG tube feeding and was much more upsetting" "She has a phobia now and is scared to death of doctors and blood tests"
	Parental distress	• Strong emotions[3]	"I had to leave the room to be sick because it was quite traumatic for me" "Going into that paediatric unit, having your child having been given a diagnosis of a very serious eating disorder, there's an element of parental guilt, responsibility, thinking about actually this is just all my fault"
		• Juggling multiple demands[3]	"My husband and I kind of took it in turns to be at the hospital with my daughter, which meant that we didn't really see each other for three weeks because we were always just passing in the car park handing over" "It was quite difficult trying to I suppose comfort [sibling] and to be there for her as well, difficult in terms of our jobs as well, so I had to take some leave from work"
		• Relief[3]	"It was almost like a bit of relief to know that she would be receiving medical care because we had been struggling" "I was relieved actually when we were there, I felt like she was in safe hands and that this is the right place"

		• Blamed by professionals[2]	"We were told by the dietician that you wouldn't allow a toddler to go out the house without eating, why are you allowing your teenage daughter to go out without eating" "They made it feel as though that me and my husband had done something wrong"
		• Covid restrictions[3]	"Because of Covid obviously there are so many restrictions on who's in the hospital" "Her dad tested positive for Covid so we then had to isolate … they had to then put us into isolation and then our experience kind of deteriorated a little bit"
		• Concern about returning home[3]	"I was really anxious about [child] being discharged because I thought I won't have the doctors and nurses there now to get her eating" "When they said after the fifth day she's okay to go home my heart sank because I thought 'oh my gosh she's not going to be able to do this at home'"
Communication	Information sharing	• Repeating information on arrival[3]	"I know lots of children are poorly when they go there, but we'd been told we had to admit her to hospital … we had to wait around in A&E for you know, we had to go through the whole assessment process [child] was having to repeatedly tell everyone why she was there, and I think that was really traumatic for her" "We had to book into A&E and both times they weren't expecting her or us … we'd gone straight from CAMHS and the hospital had been contacted by CAMHS to say that we were coming, so that was frustrating"
		• Bypassing A&E[3]	"What was helpful was that we didn't sit in A&E" "When it came to her actually being admitted they kind of knew a little bit about [child] so it was easier for them to say 'okay come to the children's ward' so we didn't even need to go via A&E, we went straight to the children's ward and then we were admitted"
		• Being kept informed[3]	"It was sometimes difficult when you've got concerns and they don't necessarily feed those onto the next nurses on shift" "I was always told everything, it was all very transparent" "They started doing [child's] pulse and her temperature and they weren't explaining what they were doing, and so she was really scared"

		• Confusion around responsibility[3]	"We weren't quite sure as parents who we were supposed to be talking to, whether it was the hospital, or nurses, nursing staff, or whether it was the consultant psychiatrists, or whether it was the CAMHS care coordinator"
		• Collaborative working[3]	"It just seemed a seamless continuation of CAMHS still even when we were still in hospital it still felt like CAMHS were looking after us" "I think they were really quite excellent … very much worked together, very moulded together" "It did feel a bit like they were two separate entities, and the community team did come to visit during the admissions, but that seemed to be, I don't think that had really any impact on what the hospital team were doing with her, they seem to be separate"
		• Facilitating talking[3]	"She opened up a lot … I was able to then talk through all those things with her in a way that was very different to when we were at home" "It was helpful for us to revisit what happened in hospital and the reasons why a hospital admission happened … it sort of helped facilitate those conversations"
	Unintentionally unhelpful comments	• Comparisons to others with eating disorders[3]	"[Child] said it's not helpful to be told that you're not the worst patient" "[Child] was a little bit upset when she heard in A&E one of the admission doctors saying she's not, you know, not too bad"
		• Praising eating[2]	"My daughter drank some of her replacement shake and the nurse say, 'hey well done that's great' and actually that's not really the kind of language that my daughter really wanted to hear at that stage"
		• Announcing weight[1]	"They said out loud his weight and that was an issue for him because we hadn't been talking about weight" "Our original care coordinator said 'you don't have to see the numbers, you don't have to see the weight', but actually that wasn't helpful because then it is a fixation about numbers rather than actually seeing factual things"
Role of different systems	Hospital team	• Support for parents[1]	"I found it really kind of supportive to have the nurses, they were all really wonderful" "There was a degree to which I needed counselling and I was in shock"
		• Lack of psychiatric support[3]	"It would have been better if, I dunno, if we would have had more of the kind of psychiatric help alongside physical health"

			"What would have been really lovely actually is if we had had a psychiatric doctor there"
		• Access to facilities[3]	"They put a lot of thought into distraction techniques for [child] … and they gave us lots of you know arts and crafts to do" "We had the run of that teen lounge and the TV, and the art materials were great, it was exactly what she needed at that point"
		• Adopting authority[3]	"She just seemed like she was I suppose quite happy to actually have someone to tell her what to do and take control" "She almost became more passive in terms of her input because she had to just had to go along with what they were saying almost automatically without actually choosing to as she does at home"
	CAEDS	• Positive input[3]	"Having CAMHS come in and see a young person whilst still in hospital is excellent" "The CAMHS team were instrumental … enlightening us, informing, telling us where to find resources, and also just being a comforting kind voice"
		• Access to psychological support[3]	"[CAEDS staff member] gave us some tools and techniques … they tried one or two and they could see what would work for her … that was hugely helpful in terms of just lifting the mood a little bit"
		• Clinician consistency[3]	"We had the same person that we'd met come out the first day which was great" "It was a different person each time, when you're autistic you need less people, you need to make connections with key people"
		• Transitions out of hospital[3]	"I must say it all worked very seamlessly" "She went straight from general hospital to the inpatient unit, that was all a bit confusing because I think the hospital had told us okay she's going to be going on Monday, but we hadn't had any information about when she was going and we hadn't heard from CAMHS about when she was going"
	Crisis team	• Positive input[3]	"The crisis team were put in place for when I was discharged … so that I did have someone like on call 24/7 if I was kind of struggling which was again really reassuring" "If we'd had more crisis support maybe that would have helped keep her out of the [psychiatric unit]"

		• Need for eating disorder expertise[3]	"We had so many questions … and they didn't really know… if the crisis team were more, if they have one for eating disorders would be good"
	Parents	• Changing roles[2]	"My role as a mum had completely changed … I wasn't the person saying to her 'okay you have to do this', that was taken away from me, I was only there as a supporting person in terms of watching from the sides"
		• Responsibility[1]	"The responsibility was on us to provide the meals that our daughter would eat" "Ultimately it was down to me"
Knowledge and skills	Understanding eating disorders	• Supportive staff[3]	"Every individual was amazing, every individual doctor and nurse" "They would always listen to [child] … they always tried to engage him … I don't believe they ever made him feel like they belittled him, like that it wasn't anything important, that the anorexia wasn't important" "[Medical doctor] was excellent, he knew everything all about eating disorders, how challenging and tricky it was"
		• Lack of understanding/experience[3]	"The nurses are all absolutely lovely, but they don't quite understand necessarily some of the complexities of anorexia" "I knew very little about eating disorders and we kind of were thrust into this as well, so I didn't know, I hadn't read up yet or been introduced to a whole lot of stuff which I have since"
		• Difficulties managing distress[3]	"The nurses and doctors could not handle that high anxiety" "She had a bit of a panic attack when she was meant to be meeting the nurse specialist and I don't think the nurse really knew how to deal with it"
		• Care coordinators needing medical training[1]	"There were a couple of times when obs were taken by the care coordinator and it was only when they were reviewed by a medic was it highlighted that she was unwell so … and then the consultants coming in and saying actually if I'd taken her obs we would have admitted her straight away"
		• Not noticing deception[3]	"I thought well as an expert you should be able to see through all of this because every anorexic hides food and tells you a load of stories to get out of eating" "A lot of the risks were not picked up CAMHS and our daughter is very honest about how she was able to cheat the system"

	Autism	• Diagnostic overshadowing[2]	"Because when you're autistic it is completely all overwhelming, she was nervous … she then became scared of them completely and of course everyone thinks that's because she's anorexic" "Having [autism] much more on people's radars when an eating disorders assumed [would be helpful] rather than kind of going straight down the eating disorder route"
		• Teaching anorexia[2]	"Because she was autistic, it showed [child] how to have an eating disorder because people were telling her that's what she had"
		• Need for individualised care[2]	"There's no individual care put in" "There's not one way that fits all" "[Paediatric and CAEDS staff] do a difficult, very difficult job, but they don't have the time to do individual care, so it's not their fault … it's the whole process that needs to be looked at, not what any individual has done"

[1]Code contributed to only by parents of CYP who had a paediatric admission followed by community-based care
[2]Code contributed to only by parents of CYP who had a paediatric admission followed by inpatient psychiatric care
[3]Code contributed to by both groups of parents

Appendix E: SIP lay summary

Treatment for eating disorders such as anorexia and bulimia is most effective in the community. However, some young people will require time in hospital for more intensive treatment. Children and young people (CYP) who have medical complications associated with an eating disorder, such as heart problems, may be admitted to a paediatric (children's) ward in a physical health hospital for a short period to manage the physical risks to their health. The Child and Adolescent Eating Disorder Service (CAEDS) provides treatment for CYP with eating disorders up to the age of 18 across Oxfordshire and Buckinghamshire. The CAEDS noticed that some CYP have a brief paediatric admission and return home to receive treatment from them in the community and some will go on to have a longer-term stay in an inpatient psychiatric unit not long after the paediatric admission. This service improvement project aimed to understand whether there are factors that can explain this difference. If specific factors are found, the CAEDS can try to maximise those that reduce the likelihood of longer inpatient care being needed, and to make transitions between hospitals smoother when they are required.

Data from 102 patients collected by the CAEDS were analysed to look for factors that affected whether inpatient psychiatric care was needed or not within three months of discharge from a paediatric hospital. Interviews were conducted with 12 parents to understand which parts of paediatric admissions were helpful and where improvements could be made. When compared to CYP who had a paediatric admission and returned home, those who required subsequent inpatient psychiatric care were in the paediatric hospital for longer, had more input from the CAMHS crisis team, were more likely to have had previous hospital admissions, and their parents were more likely to rate their anxiety and depression as more severe. The groups did not significantly differ by age, ethnicity, gender, weight for height,

severity of eating disorder symptoms, level of clinical impairment (how much their eating disorder affected how able they were to function in day-to-day life), or child-reported anxiety and depression.

Four key themes were identified from the interviews with parents: the impact of the admission on mental health, communication, the role of different systems, and knowledge and expertise. There was a variety of experiences across families, although there were some similarities about useful aspects of paediatric admissions, such as skilled support from staff, and being able to bypass A&E and go straight to the children's ward when referred by a medical professional in the community. For some families, the paediatric admission made them realise the severity of their child's health and was a trigger for recovery. Recommendations to improve the admission include improving hospital staff's understanding of eating disorders, establishing better communication with the family and between services, and providing psychological support for parents as well as the young person.

There seem to be specific factors, which are linked to how severe the illness is, that can explain why some CYP with eating disorders require further inpatient care. When these factors are present, CAEDS could intervene to strengthen the factors that reduce this risk. For example, providing additional treatment for anxiety and depression could be a useful approach. Briefer paediatric admissions that take place earlier on in the course of an eating disorder appear most effective at keeping CYP out of psychiatric hospitals. The findings from this project have been fed back to the CAEDS and hospital staff, who are keen to improve the usefulness of paediatric hospital admissions so as to reduce long periods spent in hospital. Staff working across community and hospital settings are encouraged to work together to best manage the treatment of eating disorders for CYP, which is recommended in national healthcare guidance.

Appendix F: MRP outcome measures

The questionnaires below are provided as they are not widely available elsewhere. Those that were adapted for the study have also been included.

Demographic questionnaire

Sexuality	Heterosexual/Gay or lesbian/Bisexual/Other/Prefer not to say
How old are you? (in years)	Free text
How would you describe your ethnicity?	Bangladeshi/Indian/Pakistani/ Other Asian/Black African/Black Caribbean/Other Black/Chinese /Mixed-White & Asian/Mixed-White & Black African/Mixed-White & Black Caribbean/Other Mixed/White British/White Irish/White Other/Any Other (specify)/Prefer not to say
Which of the following best describes your main work status over the past 12 months?	Unemployed (unable to work), employed (able to work), retired, homemaker, student, non-paid work, self-employed, non-government employee, government employee)
What is your postcode?	
What is your marital status?	Married/living as couple/divorced or separated/single/widowed/other/prefer not to say)
How old is your baby? (in months)	Free text
Does your baby have any health conditions? (if so, please specify if you feel comfortable doing so)	Yes/No with optional free-text box

Risk and vulnerability factors

What type of birth did you have?	Vaginal, assisted (e.g. forceps, ventouse/vacuum), caesarean section
Did you receive adequate emotional support from staff during childbirth?	Yes/No
Did you receive adequate practical support from staff during childbirth?	Yes/No
Did you receive adequate emotional support from other people (e.g. partner, parents, friend, doula) during childbirth?	Yes/No
Did you receive adequate practical support from other people (e.g. partner, parents, friend, doula) during childbirth?	Yes/No
Did you feel listened to and included in making decisions related to your birthing experience?	Yes/No

Did you feel staff were kind and attentive to your needs?	Yes/No
Did you have a strong fear of childbirth before giving birth?	Yes/No
Did you have poor health or complications in pregnancy?	Yes/No
Before you gave birth, did you ever suffer from or get diagnosed with a mental health/psychological problem? (if so, please specify if you feel comfortable doing so)	Yes/No, with optional free-text box
Before you gave birth, did you ever experience trauma, unrelated to your birth experience? (if so, please specify if you feel comfortable doing so)	Yes/No, with optional free-text box
Before you gave birth, did you ever receive professional support for your mental health? (if so, please specify if you feel comfortable doing so)	Yes/No, with optional free-text box
Do you currently receive talking or therapy or professional support for your mental health? (if so, please specify if you feel comfortable doing so)	Yes/No, with optional free-text box
Are you currently taking medication for your mental health?	Yes/No

Exposure to traumatic childbirth questionnaire

Was your experience of childbirth (or the events leading up to it or shortly afterwards) traumatic?	Yes/No

If participants indicate that their birth was traumatic:

Please put a tick next to each the experiences below that you feel contributed to your childbirth being traumatic. This list is not meant to be exhaustive. There may be experiences that you had that aren't on this list. You can tick 'other' and enter other experiences that are not on the list.

Labour-related

- Lengthy labour
- Very short labour
- Induction
- Intense/severe pain during labour
- Poor pain relief
- Loss of blood
- Feelings of loss of control
- Dissociation during birth. This is often explained as feeling disconnected from what is happening around you or from yourself, for example, like watching yourself from somebody else's eyes
- Birth injuries caused to mother, such as episiotomy and perineal tears
- Placenta previa or placenta accrete
- Fear of morbidity/mortality

Birth type
- Medical intervention
- Forceps birth
- Ventouse/vacuum birth
- Emergency caesarean section
- Birth in theatre
- Premature birth

Birth plan
- Plan made to have an assisted birth but not being included in the decision
- Having a home birth or birth at a mid-wife led unit which resulted in being rushed into hospital for an emergency
- Your birth plan not going according to plan
- Procedures performed without informed consent
- Unanticipated separation from birthing partner

Staff relationships
- Problems in relationships and communication with staff
- Not feeling heard by staff
- Feeling unhappy with the treatment or language used by staff
- Lack of information or explanation before/during/after birth

Values
- Lack of privacy and dignity
- Misconceptions of what the birth experience should be, perhaps due to outside/external influences such as birth groups and media portrayal of the "perfect birth"

Baby's safety/health
- Fear for baby's safety
- Baby's stay in the special care baby unit or neonatal intensive care unit
- Birth injuries caused to baby
- Baby requiring resuscitation

Support
- Lack of practical support from staff
- Lack of emotional support from staff
- Lack of practical support from birthing partner
- Lack of emotional support from birthing partner

Post birth
- Poor postnatal care
- Ongoing physical trauma to mother, such as pain, incontinence, mobility problems
- Not being able to see/hold baby straight away
- Guilt of not being with your baby after birth due to medical complications
- Lengthy stays in hospital
- Emergency medical procedures affecting future reproductive choices

Previous trauma
- Memories of previous trauma (e.g. in childhood or domestic violence)
- Previous medical, obstetric or reproductive trauma (which includes but is not limited to surgery, stillbirth, miscarriage, termination of pregnancy)

Pregnancy related
- Poor health or complications in pregnancy

Mental health related
- Pre-existing mental health difficulties before birth (including depression, anxiety, tokophobia (fear of childbirth))
- Stress/anxiety or other mental health difficulties developed during birth
- Stress/anxiety or other mental health difficulties developed after birth
- Sleep deprivation

Out of the experiences you selected, please select three which contributed most to it being traumatic and order in terms of the severity of their impact (
1.
2.
3.

Can you say a bit more about what made the experience traumatic? What was it that made it traumatic? [Free-text box]

In-group identification questionnaire (Leach et al., 2008), adapted for new mothers

(Group-Level) Self-Investment	(Group-Level) Self-Definition
Solidarity	*Individual Self-Stereotyping*
1. I feel a bond with new mothers. 2. I feel solidarity with new mothers. 3. I feel committed to new mothers.	11. I have a lot in common with the average new mother. 12. I am similar to the average new mother.
Satisfaction	*In-Group Homogeneity*
4. I am glad to be a new mother. 5. I think that new mothers have a lot to be proud of. 6. It is pleasant to be a new mother. 7. Being a new mother gives me a good feeling.	13. New mothers have a lot in common with each other. 14. New mothers are very similar to each other.
Centrality	
8. I often think about the fact that I am new mother. 9. The fact that I am new mother is an important part of my identity. 10. Being new mother is an important part of how I see myself.	

City Birth Trauma Scale (Ayers, Wright & Thornton, 2018)

This questionnaire asks about your experience during the birth of your most recent baby. It asks about potential traumatic events during (or immediately after) the labour and birth, and whether you are experiencing symptoms that are reported by some women after birth. Please tick the responses closest to your experience.

What date was your baby born?_____

During the labour, birth and immediately afterwards:	Score 1	Score 0
Q1. Did you believe you or your baby would be seriously injured?	Yes	No
Q2. Did you believe you or your baby would die?	Yes	No

The next questions ask about symptoms you may have experienced. Please indicate how often you have experienced the following symptoms in the last week:

Symptoms about the birth*	NOT AT ALL	ONCE	2 - 4 TIMES	5 OR MORE TIMES
Q3. Recurrent unwanted memories of the birth (or parts of the birth) that you can't control	0	1	2	3
Q4. Bad dreams or nightmares about the birth (or related to the birth)	0	1	2	3
Q5. Flashbacks to the birth and/or reliving the experience	0	1	2	3
Q6. Getting upset when reminded of the birth	0	1	2	3
Q7. Feeling tense or anxious when reminded of the birth	0	1	2	3
Q8. Trying to avoid thinking about the birth	0	1	2	3
Q9. Trying to avoid things that remind me of the birth (e.g. people, places, TV programs)	0	1	2	3
Q10. Not able to remember details of the birth	0	1	2	3
Q11. Blaming myself or others for what happened during the birth	0	1	2	3
Q12. Feeling strong negative emotions about the birth (e.g. fear, anger, shame)	0	1	2	3

* Although these questions refer to the birth, many women have symptoms about events that happened just before or after birth. If this is the case for you, and the events were related to pregnancy, birth or the baby then please answer for these events.

Symptoms that began or got worse since the birth	NOT AT ALL	ONCE	2 - 4 TIMES	5 OR MORE TIMES
Q13. Feeling negative about myself or thinking something awful will happen	0	1	2	3
Q14. Lost interest in activities that were important to me	0	1	2	3
Q15. Feeling detached from other people	0	1	2	3
Q16. Not able to feel positive emotions (e.g. happy, excited)	0	1	2	3
Q17. Feeling irritable or aggressive	0	1	2	3
Q18. Feeling self-destructive or acting recklessly	0	1	2	3
Q19. Feeling tense and on edge	0	1	2	3
Q20. Feeling jumpy or easily startled	0	1	2	3

Q21. Problems concentrating	0	1	2	3
Q22. Not sleeping well because of things that are not due to the baby's sleep pattern	0	1	2	3
Q23. Feeling detached or as if you are in a dream	0	1	2	3
Q24. Feeling things are distorted or not real	0	1	2	3

If you have any of these symptoms:

Q25. When did these symptoms start?		Q26. How long have these symptoms lasted?	
Before the birth	0	Less than 1 month	0
In the first 6 months after birth	1	1 to 3 months	1
More than 6 months after birth	2	3 months or more	2
Not applicable (I have no symptoms)		Not applicable (I have no symptoms)	

Q27. Do these symptoms cause you a lot of distress?	Yes 2	No 0	Sometimes 1
Q28. Do they prevent you doing things you usually do (e.g. socialising, daily activities)?	Yes 2	No 0	Sometimes 1
Q29. Could any of these symptoms be due to medication, alcohol, drugs, or physical illness?	Yes 2	No 0	Maybe 1

Multiple Identity Scale (taken from Haslam et al., 2008)

This questionnaire refers to the types of groups that you belonged to before giving birth and the groups that you have belonged to since giving birth. These groups could take any form – for example, they could be leisure or social groups (e.g., book group or gardening club); community groups (e.g., church group); sporting groups (e.g., rugby club); work groups (e.g., sales team); professional groups (e.g., trade union); or any others you can think of.

In the first column, list up to six groups that you belonged to before you gave birth. Then indicate how much you agree with the items in the next two columns.

Group memberships before giving birth	How important was this group to you before you gave birth? Not very 1 2 3 4 5 6 7 very	How well did this group fit with your other groups before giving birth? Not a lot 1 2 3 4 5 6 7 a great deal
1.		
2.		
3.		
4.		
5.		
6.		

Now, please list up to six groups that you have belonged to after you gave birth. Then indicate how much you agree with the items in the next two columns.

Group memberships after giving birth	How important was this group to you after you gave birth? Not very 1 2 3 4 5 6 7 very	How well did this group fit with being a new mother after giving birth? Not a lot 1 2 3 4 5 6 7 a great deal
1.		
2.		
3.		
4.		
5.		
6.		

Appendix G: Data from normality and inferential statistical tests in MRP

Tests of normality										
Variable	***N***	**Mean (*SD*)**	**Trimmed mean**	**Range**	**Skewness *Z* score**	**Kurtosis *Z* score**	**Shapiro Wilk statistic**			**Histogram/ Q-Q plot**
							c	***df***	***p***	
Strength of identity	Control (*N*=39)	78.36 (9.59)	78.90	41	-1.42	.75	.96	39	.152	Fine
	Trauma (*N*=84)	71.81 (14.62)	72.47	65	-2.28	-1.40	.97	84	.023	
Psychological wellbeing	Control (*N*=39)	48.41 (9.49)	48.51	42	-1.16	-.01	.96	39	.140	Fine
	Trauma (*N*=84)	41.55 (9.92)	41.69	46	-.48	-.88	.99	84	.741	
Age (years)	Control (*N*=39)	30.92 (4.47)	31.00	20	-.55	.13	.98	39	.668	Fine
	Trauma (*N*=84)	30.86 (4.22)	30.93	20	-.76	-.01	.98	84	.345	
Baby's age (months)	Control (*N*=39)	4.59 (2.44)	4.60	9	.37	-1.52	.94	39	.038	Fine
	Trauma (*N*=84)	4.96 (2.30)	4.97	9	.06	-1.45	.96	84	.011	
Postnatal PTSD score	Control (*N*=39)	8.97 (8.79)	8.14	34	3.30	1.45	.86	39	<.001	Fine
	Trauma (*N*=84)	24.67(14.17)	24.34	52	1.45	-1.57	.96	84	.007	
Postnatal depression score	Control (*N*=39)	8.03 (5.75)	7.66	25	2.85	1.42	.92	39	.007	Fine
	Trauma (*N*=84)	11.61 (6.00)	11.47	26	1.06	-1.10	.98	84	.124	
Number of social groups pre-birth	Control (*N*=28)	2.57 (1.29)	2.50	5	1.26	.12	.90	28	.009	Fine
	Trauma (*N*=43)	2.33(1.27)	2.22	5	2.88	1.25	.85	43	<.001	
Number of social groups post-birth	Control (*N*=28)	2.75 (1.58)	2.67	5	1.70	-.08	.86	28	.002	Fine
	Trauma (*N*=49)	2.55 (1.36)	2.46	5	2.14	.07	.89	49	<.001	
Group importance pre-birth	Control (*N*=36)	3.87 (1.96)	3.85	6	-.34	-1.45	.93	36	.021	Fine
	Trauma (*N*=67)	3.98 (1.93)	3.97	6	-.69	-1.75	.93	67	<.001	
Group importance post-birth	Control (*N*=30)	4.74 (1.81)	4.81	6	-1.11	-.96	.94	30	.068	Fine
	Trauma (*N*=58)	4.56 (1.81)	4.63	6	-2.41	-.26	.90	58	<.001	

Group compatibility pre-birth	Control (*N*=33)	3.92 (1.82)	3.91	6	-.86	-1.04	.91	33	.007	Fine
	Trauma (*N*=52)	3.52 (1.89)	3.47	6	.40	-1.61	.92	52	.003	
Group compatibility post-birth	Control (*N*=27)	5.13 (1.80)	5.25	6	-2.05	.34	.88	27	.004	Fine
	Trauma (*N*=51)	4.98 (1.77)	5.09	6	-2.29	-.11	.90	51	<.001	

Note. The trauma condition contained participants who reported experiencing a traumatic birth, whereas the control condition contained participants who did not report experiencing a traumatic birth.

Statistics from the t-tests comparing the trauma and control groups

Variable	***t***	***df***	***p***	**Trauma group mean (*SD*)**	**Control group mean (*SD*)**	**Mean difference**	**95% confidence interval of the mean difference**		**Effect size (*d*)[a]**
							Lower	Upper	
Age (years)	.08	121	.937	30.86 (4.22)	30.92 (4.47)	.066	-1.58	1.72	.01
Baby's age (months)	-.82	121	.412	4.97 (2.30)	4.59 (2.44)	-.37	01.27	.53	.15
Strength of new mother identity	2.96	107.15	.004*	71.81 (14.62)	78.36 (9.59)	-6.55	2.16	10.94	.68
Psychological wellbeing	3.62	121	<.001*	41.55 (9.92)	48.41 (9.49)	6.86	3.11	10.62	.72
Postnatal PTSD score	-7.51	110.98	<.001*	24.67 (14.17)	8.97 (8.79)	-15.69	-19.84	-11.55	1.78
Postnatal depression score	-3.12	121	.002*	11.61 (6.00)	8.02 (5.75)	-3.58	-5.85	-1.31	.62
Number of groups before birth	.79	69	.43	2.33 (1.27)	2.57 (1.29)	.246	-.37	.86	.19
Number of groups after birth	.58	75	.56	2.55 (1.36)	2.75 (1.58)	.199	-.48	.879	.13
Group importance before birth	-.28	101	.78	3.98 (1.93)	3.87 (1.96)	-.11	.91	.69	.06
Group importance after birth	.43	86	.67	4.56 (1.81)	4.74 (1.81)	.18	-.63	.98	.10
Group compatibility before birth	.95	83	.34	3.52 (1.89)	3.92 (1.82)	.40	-.43	1.22	.22

Group compatibility after birth	.35	76	.73	4.98 (1.77)	5.13 (1.80)	.15	-.70	.99	.08

Note. The trauma condition contained participants who reported experiencing a traumatic birth, whereas the control condition contained participants who did not report experiencing a traumatic birth.
[a] Effect size interpretation: small effect size = 0.2, medium effect size = 0.5, large effect size = 0.8.
*Significant at $p<.01$

Statistics from the chi square tests comparing the trauma and control groups

Variables (all *N*=123)	***X²***	***df***	***p (Exact 2-sided)***	***Cramer's V[a]***
Ethnicity	3.77*	†	.788	.20
Sexuality	1.08*	†	.688	.11
Work status	7.27*	†	.336	.27
Marital status	2.16*	†	.634	.15
Deprivation	.14	1	.825	.03
Having a baby with a health condition	*†	†	.724	.05
Birth type	35.52	2	<.001***	.54
Receiving adequate emotional support from staff	6.48	1	.018**	.23
Receiving adequate practical support from staff	1.45	1	.282	.11
Receiving adequate emotional support from other people	*†	†	.037**	.19
Receiving adequate practical support from other people	4.04	1	.074	.18
Felt listened to and included in making decisions related to birthing experience	14.49	1	<.001***	.34
Felt staff were kind and attentive to needs	7.37	1	.008**	.25
Strong fear of childbirth before giving birth	.01	1	1.00	.01
Poor health or complications in pregnancy	.05	1	.828	.02
Pre-existing diagnosis of mental health problem	.14	1	.826	.03
Pre-birth experience of trauma unrelated to birth experience	.76	1	.435	.08
Previously accessed talking therapy or professional support for mental health	.02	1	1.00	.01
Currently accessing talking therapy or professional support for mental health	.38	1	.584	.06
Currently taking medication for mental health	*†	†	.500	.09
Met criteria for postnatal PTSD	13.84	1	<.001***	.34

Scored above cut-off for major postnatal depression	8.90	1	.003	.27

Note. The trauma condition contained participants who reported experiencing a traumatic birth, whereas the control condition contained participants who did not report experiencing a traumatic birth.

[a] Effect size interpretation: small effect size = <0.2, medium effect size = 0.2-0.6, large effect size > 0.6.

*Cells had expected count less than 5, therefore Fisher's Exact test statistic is reported

**Significant at p<.05

***Significant at p<.001

†No statistic provided

Appendix H: Variables excluded as covariates

Variables excluded as covariates			
Dependent variable	**Secondary outcome variable**	***r***	***p***
Strength of new mother identity	Age	-.180	.047
	Received adequate practical support from staff	.251	.005
	Felt listened to and included in decision-making related to birth experience	.266	.003
	Vaginal birth	.242	.007
	Heterosexual	.245	.006
	Bisexual	-.216	.016
	Government employee	-.216	.016
	Postnatal PTSD score	-.51	p<.001
	Postnatal PTSD diagnostic criteria met	-.42	p<.001
	Postnatal depression score	-.51	p<.001
	Postnatal depression screening cut-off met	-.37	p<.001
Psychological wellbeing	Felt listened to and included in decision-making related to birth experience	.241	.007
	Strong fear of childbirth before giving birth	-.199	.028
	Currently taking medication for mental health	-.195	.031
	Number of social groups before birth	.294	.013
	Mean group importance before birth	-.233	.018
	Postnatal PTSD score	-.69	p<.001
	Postnatal PTSD diagnostic criteria met	-.52	p<.001
	Postnatal depression score	-.82	p<.001
	Postnatal depression screening cut-off met	-.66	p<.001

Note. *r* corresponds to the correlation coefficient of the secondary outcome variable and the dependent variable.

Appendix I: CRL author guidelines

The Journal and submission of articles for publication:

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:
    - 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.)
    - 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):
    - data availability statement
    - funding statement
    - conflict of interest disclosure
    - ethics approval statement

- patient consent statement
- permission to reproduce material from other sources
- clinical trial registration

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.

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

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, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Appendix J: SIP author guidelines

Mission: With a mission to advance the scientific knowledge needed for understanding, treating, and preventing eating disorders, the *International Journal of Eating Disorders* publishes rigorously evaluated, high-quality contributions to an international readership of health professionals, clinicians, and scientists. The journal also draws the interest of patient groups and advocates focused on eating disorders, and many of the articles draw attention from mainstream media outlets.

Scope: Articles featured in the journal describe state-of-the-art scientific research on theory, methodology, etiology, clinical practice, and policy related to eating disorders, as well as contributions that facilitate scholarly critique and discussion of science and practice in the field. Theoretical and empirical work on obesity or healthy eating falls within the journal's scope inasmuch as it facilitates the advancement of efforts to describe and understand, prevent, or treat eating disorders. The *International Journal of Eating Disorders* welcomes submissions from all regions of the world and representing all levels of inquiry (including basic science, clinical trials, implementation research, and dissemination studies), and across a full range of scientific methods, disciplines, and approaches.

A complete **overview** of the journal is given elsewhere on the journal's homepage.

The submission should be uploaded in separate files: 1) **manuscript file**; 2) tables; 3) **figures**; 4) if applicable, **supporting Information file(s)**.

1. Manuscript File

The text file should contain the manuscript text, references, and the figure legends. The text should be presented in the following order:

1. Title page

1. Title. The title should be short and informative, containing major keywords related to the content. The title should not contain abbreviations (see Wiley's best practice SEO tips) and should not be phrased inform of a question.
2. A short running title of less than 40 characters.
3. The full names of all authors
4. The authors' institutional affiliations where the work was conducted, with a footnote for an author's present address if different to where the work was carried out
5. If applicable (required for clinical trials): Trial registration number.
6. Word counts (abstract and main text, excl. tables and references)

2. Data Availability Statement
3. Acknowledgements and Conflicts of Interest
    1. If applicable: funding source
    2. If applicable: other acknowledgements
    3. Conflict of interest statement (if none, state "The authors have no conflict to declare")
4. Abstract and Keywords
5. Main text
6. References
7. Figure legends

Title Page

Authorship

For details on eligibility for author listing, please refer to the journal's **Authorship policy** outlined in Section 5 of these Author Guidelines.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. See the journal's policy on **Conflict of Interest** outlined in Section 5 of these Author Guidelines. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

The abstract should be typed as a single paragraph. The word maximum and abstract format vary by contribution type (see above).

Structured abstracts should be organized as follows: **Objective**: briefly indicate the primary purpose of the article, or major question addressed in the study. **Method**: indicate the sources of data, give brief overview of methodology, or, if review article, how the literature was searched and articles selected for discussion. For research based articles, this section should briefly note study design, how participants were selected, and major study measures. **Results**: summarize the key findings. **Discussion**: indicate main clinical, theoretical, or research applications/implications.

Keywords

Please provide about 10 keywords. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **www.nlm.nih.gov/mesh**.

Main Text

- Manuscripts reporting original research should follow the **IMRaD guidelines** (***I***ntroduction, (***M***ethods, ***R***esults, ***a***nd ***D***iscussion), which are

recommended by the International Committee of Medical Journal Editors (ICMJE) (J. Pharmacol. Pharmacother. 2010, 1, 42–58).

- The Methods section should include a statement about sample selection, response rate, and other factors that would impact selection or response bias and, in turn, representativeness of the sample.
- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on Data Storage and Documentation in Section 5 (below).
- If the study involves qualitative data, authors need to include a statement about sample size in relation to theme saturation. It is also important that the sampling strategy is driven by theory rather than convenience, the data analysis procedures are justified, and the advantage of a qualitative (vs. a simple quantitative) approach are well-described.
- For additional detail regarding statistical requirements for the manuscript see **IJED Statistical Reporting Guidelines** and please use the **Statistical Reporting Guidelines Checklist** as you prepare your manuscript.
- Authors should refrain from using terms that are stigmatizing or terms that are ambiguous. For further explanation and examples, see the 2016 IJED article by Weissman et al. entitled "*Speaking of that: Terms to avoid or reconsider in the eating disorders field*" (DOI: 10.1002/eat.22528.)
- To facilitate evaluation by the Editors and Reviewers, each manuscript page should be numbered; the text should be double-spaced; and line numbers should be applied (restarting from 1 on each page). Instructions on how to implement this feature in Microsoft Word are given here.
- The journal uses US spelling. Authors may submit using any form of English as the spelling of accepted papers is converted to US English during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

- It is the primary responsibility of the authors to proofread thoroughly and ensure correct spelling and punctuation, completeness and accuracy of references, clarity of expression, thoughtful construction of sentences, and legible appearance prior to the manuscript's submission.
- Authors for whom English is not their first language are encouraged to seek assistance from a native or fluent English speaker to proof read the manuscript prior to submission. Wiley offers a paid service that provides expert help in English language editing—further details are given below.
- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on Data Storage and Documentation in Section 5 (below).

References

References in all manuscripts should follow the style of the American Psychological Association (6th edition), except in regards to spelling. The APA website includes **a range of resources for authors learning to write in APA style**, including **An overview of the Publication Manual of the American Psychological Association, Sixth Edition**; includes **free tutorials on APA Style basics** and an **APA Style Blog**. Please note APA referencing style requires that a Digital Object Identifier (DOI) be provided for all references where available.

Tables

Each table must be numbered in order of appearance in the text with Arabic numerals and be cited at an appropriate point in the text. Tables should be self-contained and complement, not duplicate, information contained in the text. They should be editable (i.e., created in Microsoft Word or similar), not pasted as images. Legends should be concise but comprehensive—the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as

standard deviation (SD) or standard error of the mean (SEM) should be identified in the headings.

Figure Legends/Captions

Each figure caption should have a brief title that describes the entire figure without citing specific panels, followed by a description of each panel. Captions should be concise but comprehensive—the figure and its caption must be understandable without reference to the text. Be sure to explain abbreviations in figures even if they have already been explained in-text. Axes for figures must be labeled with appropriate units of measurement and description. Include definitions of any symbols used and units of measurement.

2. Figures

Although authors are encouraged to send the highest quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Helvetica typeface is preferred for lettering within figures. All letters, numbers and symbols must be at least 2 mm in height. Courier typeface should be used for sequence figures. Figures should be numbered consecutively with Arabic numerals, and they should be numbered in the order in which they appear in the text.

Figures should be submitted as electronic images to fit either one (55 mm, 2 3/16”, 13 picas), two (115 mm, 4 1/2”, 27 picas), or three (175 mm, 6 7/8”, 41 picas) columns. The length of an illustration cannot exceed 227 mm (9”). Journal quality reproduction requires grey scale and color files at resolutions of 300 dpi. Bitmapped line art should be submitted at resolutions of 600–1200 dpi.

Figures submitted in color will be reproduced in color online free of charge. Authors wishing to have figures printed in color in hard copies of the journal will be charged a fee by the Publisher; further details are given **elsewhere** in these Author Guidelines. Authors should

note however, that it is preferable that line figures (e.g., graphs) are supplied in black and white so that they are legible if printed by a reader in black and white.

Graphical Table of Contents

International Journal of Eating Disorders incorporates graphics and a small piece of text from journal articles into the online table of contents (which are distributed to readers who have signed up to Table of Contents (ToC) alerts). The extra graphic and text, in addition to being eye-catching, gives the reader a much more immediate impression of what each article will cover.

If you would like a graphic to accompany your article in the Table of Contents, please specify one of your figures. You will be given the option to specify a figure during the submission process at the file upload stage.

3. Supporting Information Files(s)

Supporting Information is information that is supplementary and not essential to the article, but provides greater depth and background. Examples of such information include more detailed descriptions of therapeutic protocols, results related to exploratory or post-hoc analyses, and elements otherwise not suitable for inclusion in the main article, such as video clips, large sections of tabular data, program code, or large graphical files. It is *not* appropriate to include, in the Supporting Information, text that would normally go into a discussion section; all discussion-related material should be presented in the main article.

Because the Supporting Information is separate from the paper and supplementary in nature, the main article should be able to be read as a stand-alone document by readers. Reference to the Supporting Information should be made in the text of the main article to provide context for the reader and highlight where and how the supplemental material contributes to the article.

Should authors wish to provide supplementary file(s) along with their article, these materials *must* be included upon submission to the journal. If such materials are added to the

submission as a result of peer review, i.e., during a revision, then the authors should bring this to the attention of the editor in their response letter. If accepted for publication, Supporting Information is hosted online together with the article and appears without editing or typesetting.

Wiley's FAQs on Supporting Information are available on the Wiley Author Services site: **www.wileyauthors.com**.

Note: Authors are encouraged to utilize publicly available data repository for data, scripts, or other artefacts used to generate the analyses presented in the paper; in such cases, authors should include a reference to the location of the material within their paper.

General Style Points

The following points provide general advice on formatting and style.

- **Terminology**: The journal rejects terminology that refers to individuals by their condition. Terms such as "anorexics," "bulimics," "obese," or "diabetic," etc., as personal pronouns, referring to groups of individuals by their common diagnosis or condition, should be avoided. Terms like "individuals with anorexia nervosa," "people with bulimia nervosa," "participants with eating disorders," "patients with diabetes," or "participants with obesity," etc., should be used instead. Note, "participants" should be used in place of "subjects".
- **Abbreviations**: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement**: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.

- **Numbers** under 10 should be spelt out, except for: measurements with a unit (8 mmol/L); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **The word "data"** is plural; therefore, text should follow accordingly (for example, "The data show…the data are … the data were…").
- **Sex/Gender & Age**: When referring to sex/gender, "males" and "females" should be used only in cases where the study samples include both children (below age 18) and adults and only if word limit precludes using terms such as "male participants/female participants," "female patients/male patients"; when the participants comprise adults only, the terms "men" and "women" should be used. In articles that refer to children, "boys" and "girls" should be used.
- **Trade Names**: Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Appendix K: MRP author guidelines

The *Journal of Reproductive and Infant Psychology* is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

The *Journal of Reproductive and Infant Psychology* accepts the following types of article: original articles.

Open Access

You have the option to publish open access in this journal via our Open Select publishing program. Publishing open access means that your article will be free to access online immediately on publication, increasing the visibility, readership and impact of your research. Articles published Open Select with Taylor & Francis typically receive 32% more citations* and over 6 times as many downloads** compared to those that are not published Open Select.

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*Citations received up to Jan 31st 2020 for articles published in 2015-2019 in journals listed in Web of Science®.

**Usage in 2017-2019 for articles published in 2015-2019.

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer reviewed by independent, anonymous expert referees. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing Your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 3500 words.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use British (-ise) spelling style consistently throughout your manuscript.

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Queries

Should you have any queries, please visit our Author Services website or contact us here.

Appendix L: MRP ethical approval letter

Ms Shama El-Salahi
Oxford Institute of Clinical Psychology Training and Research
Isis Education Centre, Warneford Hospital
Oxford
OX3 7JX

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

24 September 2020

Dear Ms El-Salahi

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The impact of traumatic childbirth on identifying as a new mother and the implications for psychological wellbeing**
IRAS project ID:	**279433**
Protocol number:	**000000**
REC reference:	**20/LO/0956**
Sponsor	**University of Oxford / Clinical Trials and Research Governance**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **279433**. Please quote this on all correspondence.

Yours sincerely,

Thomas Fairman
HRA Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *CTRG*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Study Advert]	1.1	03 September 2020
Copies of advertisement materials for research participants [Study Leaflet/Poster]	1.1	03 September 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance]		29 July 2019
IRAS Application Form [IRAS_Form_28082020]		28 August 2020
IRAS Application Form XML file [IRAS_Form_28082020]		28 August 2020
IRAS Checklist XML [Checklist_21092020]		21 September 2020
Letter from funder [Confirmation of Funding Support]	1.0	23 April 2020
Letter from sponsor [Sponsor letter]	1.1	26 August 2020
Letters of invitation to participant [Social Media Invitation to Participants]	1.1	11 August 2020
Other [Risk Information for Participants]	1.1	11 August 2020
Other [PIC Agreement Berkshire NHS]	1.0	17 June 2020
Other [PIC Agreement Oxford Health NHS]	1.0	17 June 2020
Other [Response to REC Provisional Opinion]	1.0	14 September 2020
Participant information sheet (PIS) [Participant Information Sheet]	1.1	11 August 2020
Research protocol or project proposal [Research Protocol]	1.1	14 September 2020
Research protocol or project proposal [Research Protocol]	1.1	11 August 2020
Summary CV for Chief Investigator (CI) [CV for Chief Investigator]	1.0	07 November 2019
Summary CV for supervisor (student research) [CV for Research Supervisor LH]	1.0	01 March 2020
Summary CV for supervisor (student research) [CV for Research Supervisor RKB]	1.0	23 April 2020
Validated questionnaire [Measures]	1.1	11 August 2020
Validated questionnaire [Psychometric Properties of Measures]	1.1	11 August 2020

IRAS project ID	279433

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All NHS organisations will participate as Participant Identification Centres. Therefore there is only one site type.	PIC activities should not commence until a PIC Agreement is in place. HRA and HCRW recommend use of the standard Participating NHS Organisation to PIC agreement available here.	HRA and HCRW recommend use of the standard Participating NHS Organisation to PIC agreement, available here.	External study funding has been secured from the Oxford Institute of Clinical Psychology Training and Research.	The Chief Investigator can be responsible for all research activities performed at study sites of this type	It is expected that the researcher is working under supervision with a memorandum of understanding in place in which case no HR Good Practice arrangements are required

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix M: MRP local Trust approvals

Oxford Health
NHS Foundation Trust

Professor Andrea Cipriani
Associate Director of Research & Development
Warneford Hospital
Oxford
OX3 7JX

Email: research@oxfordhealth.nhs.uk
13.11.2020

Confirmation of Capacity and Capability

Re: The impact of traumatic childbirth on identifying as a new mother and the implications for psychological wellbeing
Research and Development Reference: 15001
IRAS Reference: 279433
Research Ethics Committee Reference: 20/LO/0956
Sponsor: University of Oxford

Dear Shama,

On behalf of Oxford Health NHS Foundation Trust, I am pleased to confirm Trust Capacity and Capability for the above research as outlined in the application received.

I note that Oxford Health NHS Foundation Trust will be a Patient Identification Centre.

Approved Documents

Protocol Version 1.1 dated 11/08/2020 is recognised as the most current to date.

The documents approved for use at this Trust are as listed in the following approval documents:

PIC C&C letter v1, September 2019

Health Research Authority Letter dated: 24/09/2020
Research Ethics Full Approval Letter dated: 23/09/2020

Any subsequent, relevant amendments are additionally included to date.

Conditions of Approval

Oxford Health
NHS Foundation Trust

The following conditions apply to this approval:

a) The study is conducted in compliance with all the relevant legislation and the relevant OHFT policies.

b) All staff working on the study have the appropriate training and experience and have responsibilities formally delegated to them.

c) Should you plan to leave your position in OHFT, you will notify R&D immediately of your plans, to enable discussions around the future of study conduct.

d) All relevant documents will be maintained and will be sent to research@oxfordhealth.nhs.uk, to facilitate compliance checks, formal audits and regulatory inspections.

e) You will notify R&D via the email above of any protocol amendments.

f) You will promptly inform R&D via the email above of the end of the study.

I wish you every success with the study.

Yours sincerely,

Professor Andrea Cipriani
Associate Director of Research & Development

Ms Shama El-Salahi
Oxford Institute of Clinical Psychology
Training and Research
Isis Education Centre, Warneford Hospital
378 5650
Oxford
378 5705
OX3 7JX
research@berkshire.nhs.uk

Research & Development
Psychology Department • University of Reading
Whiteknights Road • Earley • RG6 6AL
t: **0118**
f: **0118**
e:

Date: 22nd October 2020

Dear Shama El-Salahi

Confirmation of Trust Management Approval

Study title: The impact of traumatic childbirth on identifying as a new mother and the implications for psychological wellbeing

Our Ref: 2020-36 **REC Ref:** 20/LO/0956 **IRAS:** 279433

Start date: 22/10/2020 **End date:** 16/04/2021

On behalf of Berkshire Healthcare NHS Foundation Trust, I am pleased to confirm Trust Management Approval for the above research on the basis described in the application, protocol and other supporting documents. Approval is conditional on reporting up-to-date recruitment on monthly basis and the submission of a brief final report of research findings. Trust approval will cease on the end date above. Failure to do so may result in approval being withdrawn.

It is the Trust's expectation that the study will comply with all applicable and relevant laws, such as the General Data Protection Regulation (GDPR) May 2018, the Human Tissue Act (2004), the Mental Capacity Act (2005) and adheres to the UK Policy Framework for Health and Social Care Research (2018), the principles of (ICH) Good Clinical Practice (GCP) and the NHS Confidentiality Code of Practice (Nov 2003) and if applicable the Clinical Trial regulations. You are required to submit a brief final report of research findings at the end of your project.

If there are any changes to the study protocol and/or recruitment period, the R&D Office must be informed immediately and supplied with any amended documentation as necessary, including confirmation that the amendments have been favourably reviewed by the Sponsor and the Ethics Committee.

If you have any questions about the above, or you require any other assistance, then please contact the R&D office research@berkshire.nhs.uk.

I wish you every success with the study.

Yours sincerely

Stephen Zingwe
Research and Development Manager

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www.berkshirehealthcare.nhs.uk

Appendix O: SIP local Trust approvals

Friday, 29 November 2019 at 10:30
From: Ronja Bahadori <ronja.bahadori@admin.ox.ac.uk>
To: Shama El-Salahi <shama.el-salahi@hmc.ox.ac.uk>
Cc: Franklin Jo (RTH) OUH <Jo.Franklin@ouh.nhs.uk>

Re: Study classification

Dear Shama

We have reviewed your study with the title (The impact of brief paediatric admissions on treatment trajectory in children and young people with eating disorders) in our classification meeting yesterday and we can confirm the project is a service evaluation.

You should ensure that your department leads are aware of the project and are happy for the activity to take place. You may also need to register the project with the clinical audit team. Details can be found here: http://ouh.oxnet.nhs.uk/SafetyQualityRisk/Pages/Welcome.aspx

All service review activity should comply with clinical governance requirements.

Please do get in touch if you have any further questions in the meantime.

Kind regards

Ronja

Dr Ronja Bahadori
Senior Research Support Specialist
Clinical Trials & Research Governance | Research Services
University of Oxford
Joint Research Office
Boundary Brook House
Churchill Drive
Headington
OXON, OX3 7GB

Office: 01865 616482
Email: ronja.bahadori@admin.ox.ac.uk
https://researchsupport.admin.ox.ac.uk/ctrg

Date: Thursday, 5 March 2020 at 14:57
From: Tan Christine (RNU) Oxford Health <Christine.Tan@oxfordhealth.nhs.uk>
To: Shama El-Salahi <shama.el-salahi@hmc.ox.ac.uk>

Dear Shama

Good afternoon, wishing you well.

We are delighted to inform you that your proposal for the clinical study below has been approved:

Title : The impact of brief paediatric admissions on treatment trajectory in children and young people with eating disorders.

Please keep us updated on the findings and the completion report.

Thank you and wish all goes well for you.

Kind regards,

Christine Tan

Interim Quality and Clinical Standards Facilitator
MH Directorate Governance Team | Oxford Health NHS Foundation Trust | AG Palmer Directorate Office | Littlemore Mental Health Centre | Mobile: 07876 038126 |
Email: Christine.Tan@Oxfordhealth.nhs.uk

Date: Wednesday, 4 March 2020 at 10:25
From: Wild Julie (RTH) OUH <Julie.Wild@ouh.nhs.uk>
To: Shama El-Salahi <shama.el-salahi@hmc.ox.ac.uk>
Cc: Lannigan Robert (RTH) OUH <Robert.Lannigan@ouh.nhs.uk>

Dear Shama,

I am pleased to inform you that your project 'The impact of brief paediatric admissions on treatment trajectory in children and young people with eating disorders' has been registered on Datix with an **ID number of 5923**. Please use this number in any communication about your audit.

I note you have December as your final report date and we should therefore be grateful if you would complete our audit report template (attached) for the purposes of OUH Datix completion process by **31 December 2020**; do let me know if that may not be possible. In particular your findings, results and SMART actions are much appreciated on the template when the time comes.

Good luck with your project Shama.

Best wishes,

Julie.

Julie Wild RN Adult and Children's, BA SPGP, SCPHN - School Nurse
Children's Governance Nurse (2-3 days per week)
Room 30, Tom's Ward, Children's Hospital,
John Radcliffe,
Headley Way, Oxford OX3 9DU.
Tel: 01865 (2)23388

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www.buckshealthcare.nhs.uk

Shama El-Salahi
The Oxford Centre for Psychological Health
Isis Education Centre,
Warneford Hospital,
Oxford,
OX3 7JX

23 April 2020

Dear Ms El-Salahi

Project title: The impact of brief paediatric admissions on treatment trajectory in children and young people with eating disorders
Date of Submission to Project Classification Group: 27 February 2020
Project Classification Group Reference: PCG012

The Buckinghamshire Healthcare NHS Trust Project Classification Group has reviewed the above project and has determined that it is **Service Evaluation**

It has been registered with Buckinghamshire Healthcare NHS Trust Research and Innovation Department and you may now begin working on the project.

Condition
We request that all data that is transferred between both sites is via a secure method for example excrypted emails such as nhs.net to nhs.net

If, for any reason, the project changes after the date of this letter please inform the Research and Innovation Department

To allow us to monitor project output please can you send the Research and Innovation Department a summary of the results within 90 days of the project completion.

Best wishes

James Cooper

Signed on behalf of the Buckinghamshire Healthcare NHS Trust Project Classification Group