

A study to explore teachers views and experiences
of children with bowel and bladder problems in
school

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Teachers views and experiences of children with bowel and bladder problems in school

June Rogers

Abstract

Although an increasing number of children with 'special needs' are entering the main stream school population, including those children with bladder and bowel problems, there still appears to be an 'ad hoc' approach to the integration of these children. Practitioner experience had identified that some schools appeared less accepting than others in respect of those children with bowel and bladder problems, resulting in a number of these children either being 'excluded' or parents having to come into school to help meet their needs. This study aimed to explore any relationship between teachers' knowledge and experiences of children in school with wetting and soiling problems, the resultant identified issues and their views regarding the inclusion of such children.

A questionnaire was sent to a number of primary school teachers, which consisted of both closed and open-ended questions to allow teachers to put down their thoughts and feelings in their own words regarding the challenges and demands of having children with bowel and bladder problems in school. The results of the questionnaire identified, that although there was a lack of teacher awareness regarding the causes of bowel and bladder problems in children, the main factors which appeared to negatively influence teachers were lack of both appropriate facilities and teacher support for changing and managing children in schools and very little integrated working and liaison from health services.

The results of the study will be used to support the need to develop an information/resource pack for schools regarding the inclusion of children with bladder or bowel problems and recommend the importance of planning and appropriate support for such children.

Chapter 1

Introduction

1.1 Background to study

Wetting and soiling problems affect 2-4% of five year olds (Hjalmas 1992, Rutter 1970) with up to 15% of three year olds not having yet acquired full bowel and bladder control (Welford 1993). Daytime wetting also accounts for 5% of 5 year olds and soiling 5-11%. As a result, there is a not insignificant number of children with bowel and /or bladder problems entering the mainstream school population. With the push towards inclusion there is also an increasing number of children with both physical and learning difficulties entering the mainstream school population and these children also often have associated continence problems, including stomas and requiring catheterisation.

As a paediatric continence adviser and stoma care nurse I was aware of the increasing issues being raised in relation to these children with bowel and bladder problems in school. Both parents and teachers were contacting me requesting advice and support despite the following statement, which was designed to facilitate trouble free inclusion.

“ Health and local authorities should put in place arrangements that ensure children are not excluded from normal pre-school and school educational activities, solely because they are incontinent”.

This is a quote from the recent document produced from the Department of Health – Good practice in continence services (2000). The document put together joint targets for both health and education regarding supporting and managing children in schools with continence problems. However despite this statement of good intent from practitioner experience it is clear that a considerable number of children are still being either denied access to school because of delayed toilet training or having difficulties with inappropriate support and lack of adequate resources in school.

The above document also looked at the issues for schools regarding children who have toileting problems but who will not have the support of a ‘Statement of needs’, for a variety of reasons. This ‘Statement of Needs’ would have enabled the identification and targeting of funding for any support required. Lack of a ‘statement’ means any extra support the child requires in relation to toileting would need to be provided from within the schools own resources. Four groups of children were identified and included :-

- those ‘normal’ younger children who have delayed bowel and bladder control, for no other reason than immaturity, who with time will eventually become toilet trained
- children with ‘global’ delay who will probably require a period of assessment before a decision on their individual needs can be made
- children who have a purely physical problem, such as spina bifida
- children who develop toileting problems due to emotional reasons

However practitioner experience both locally and from networking with colleagues nationally had identified that the recommendations were not being implemented within local authorities. At the ERIC (Enuresis Resource and Information Service) International Conference, held at York at the end 2001, a number of school nurses from around the country were asked to complete a questionnaire. This was to identify any issues they had experienced in relation to children being 'exclusion' from school due to toileting problems.

The first question asked if the school nurses were aware of any written guidelines within local education admission policies, which clearly stated that *'they reserved the right to delay admission for any child who was not yet toilet trained'*. Of the 51 school nurses who completed a questionnaire 27 said they were aware of such a policy. They were then asked if they were aware of any schools having an 'unwritten' rule which would cause parents to delay sending their child with 30 replying that they were. The number of schools cited by the school nurses within their case-load having such a rule ranged from *"quite a few"* to *"all of them"*

The question was then asked if the nurses were aware of any children who had actually been denied access to school because of toileting problems. The majority of school nurses reported that they had had experience of children being excluded with the number of children currently identified as being 'excluded' as 54. This obviously goes against the recommendations of the Good practice Guidelines. The comments from the nurses included that it was a *'big problem'* and that it was *'important to educate the teachers'* and that *'playgroups are just as bad'*.

The inclusion of children with special needs within the mainstream population is increasing. However as a paediatric continence adviser I am aware that this is causing some problems relating to children with bladder and bowel problems. For those children with wetting and soiling problems in mainstream school there are often issues relating to how well they are accepted and fully integrated. From personal experience I have found that the issues raised, such as who is responsible for changing the child, varies between schools. Some schools appear very accepting and will arrange support for the child, while other schools appear less accepting and will expect the parent to provide support otherwise the child will be unable to attend. This is obviously difficult for parents who work full time and when I questioned the Education department regarding the apparently differing schools policy towards admission they stated that individual schools make their own decisions regarding providing 'in house' support.

When discussing support for children with bowel and bladder problems with individual schools it appeared that teachers had very different ideas about the wetting and soiling problems and those that understood it was not the child's fault were more understanding. So perhaps attitude towards the problem affects how accepting the teachers are. However there may be other factors involved and in order to facilitate trouble free integration and provide support for

the teaching staff I wanted to look into this issue further. What this study aimed to find out is what factors were involved with shaping teachers attitude towards accepting and supporting children with toileting problems.

1.2 New Duties for schools

Children with wetting and soiling problems in school have long been the cause of great anxiety for teachers, distress and embarrassment for the child and concern for the parents, with many children being 'excluded' as a result (Rogers 2002). However from September 2002 it is now unlawful for schools to exclude children with a 'disability' without adequate reason. The Disability Discrimination Act 1995 part 4 has been extended to incorporate The Code of Practice for Schools, brought in by the SEN (Special Educational Needs) and Disability Act 2001.

This identified new duties from 2002 not to discriminate against disabled pupils, not only those currently in school but also prospective pupils, both in the provision of education and in respect of admissions and exclusions. For the terms of the Disability Discrimination Act a disabled pupil is defined as "*someone who has a physical or mental impairment, which has an effect on his or her ability to carryout normal day-to-day activities*" (section 4.2). The test of whether an impairment affects normal day-to-day activities is reviewed in relation to one of the broad categories of capacity listed in section A1 of the document. Continence is listed as one of the categories, and whether this will in fact apply to all children with bowel and bladder problems will remain to be seen.

The discrimination of the child is identified as potentially occurring in two ways, firstly by treating the child less favourably for a reason relating to their 'disability' in comparison to their 'normal' peers. Secondly, by the school failing to take steps, to ensure that any disabled pupils are not placed at a disadvantage in comparison with their non-disabled peers. The document cites an example of a young boy with Hirschsprung's disease (a congenital abnormality of the bowel) who was originally denied access to school because of delayed bowel control which resulted in soiling. Under the terms of the Act this was considered to be unlawful as another child of a similar age without Hirschsprung's disease would not have been denied access. The school was advised that they would need to put in place systems to enable the child's needs to be met in school This is identified in the document as the 'reasonable adjustment duty'.

1.3 The role of the school nurse

The school nurse has an important role in helping to facilitate a smooth school entry for children with continence problems. Early liaison with school to help identify potential problems and arrange support and 'packages of care' to meet individual children's needs is crucial, waiting until the child is already in school is often a recipe for disaster. The school nurse is also in a good position to offer 'in house' training for teachers regarding not only children's general health problems but also specific training relating to identified problems within the current school population.

Chapter 2 Literature review

2.1 Search Strategy

A computer search was carried to identify relevant literature using the following key words

- Inclusion
- Teachers attitudes
- Mainstreaming
- Exceptional children
- Special needs

Several databases were searched including

- CINAHL
- Medline

An internet search was also used to identify any other relevant literature/journals/articles using the following search engines

- Yahoo
- Google

A hand search was also carried out in the University Library to identify Education Journal not previously known to me

2.2 Inclusion in mainstream school

Inclusion of children with 'medical' and other health needs into the mainstream school population is increasing. The rationale for inclusive education is multifaceted and stems from legislative, ethical and empirical domains (Cole et al 1991). However many barriers to inclusion still exist and despite the increasing frequency of inclusive placements, positive outcomes for such pupils have not been consistently associated with inclusive reforms (Cook et al 1999). Previous studies have identified that the success or failure of mainstreaming may be largely dependent on the attitudes of teachers towards inclusion (Larrivee 1981, Leyser and Lessen 1985, Parish et al 1982). Leyser and Lessen (1985) reported that there was evidence that indicated teachers were not particularly supportive of mainstreaming, however it was felt that if certain requirements were met then they would be more accepting. Those requirements included the provision of additional training aimed at developing the knowledge skills and attitudes required in order to work effectively with disabled pupils. Other studies have also suggested that the effective implementation of mainstreaming in schools is dependent on a number of factors (Center and Ward 1987, Leyser et al 1994, Thomas 1985). These were identified as firstly, adequate preparation and updating of teachers in the skills needed to provide appropriate education for children with differing needs, strong commitment and support within the school system and finally the availability of support services in the classroom (Lewis and Doorlag 1991, Myles and Simpson 1989).

2.3 Legislation and inclusion

The issue regarding inclusion and the dilemmas subsequently created has been recognised internationally. In the United States of America in 1997 the United States congress passed an amendment to the Individuals with Disabilities Education Act calling for joint planning for individualised programmes for students with disabilities between general (mainstream) and special school teachers (Buell et al 1999). It mandated that states develop personnel systems that prepare all teachers to work with individuals with disabilities. Historically in the United

States teachers who worked in either mainstream or special schools received training and support separately which served to create two systems of education, the amendment aimed to address this issue.

From September 2002 in the UK it will be unlawful for schools to exclude children with a disability without adequate reason. The Disability Discrimination Act 1995 part 4 has been extended to incorporate The Code of Practice for Schools, brought in by the SEN (Special Educational Needs) and Disability Act 2001. This identified new duties from 2002 not to discriminate against disabled pupils, not only those currently in school but also prospective pupils, in the provision of education and in respect of admissions and exclusions. The document identified discrimination occurring in two main ways:-

- treating the child less favourably for a reason relating to their 'disability' in comparison to their 'normal' peers
- the school failing to take steps to ensure that disabled pupils are not placed at a disadvantage in comparison with their non-disabled peers. This is known as the 'reasonable adjustment duty'.

Leyser et al (1994) stated that even though a national policy may be in place which may positively influence mainstreaming a number of other more specific variables may have an impact upon teachers acceptance of integration. These included age and the number of years of teaching experience, with younger teachers and those with fewer years of experience found to be more supportive of integration by some authors (Berryman 1989, Center and Ward 1987) but not by others (Leyser , Volkan , Ilan 1989). It has also been theorised that attitudes towards inclusion vary as a function of the proximity of the implementation of inclusion policies (Semmel et al 1991). Those mainstream Head Teachers, for example, who are not directly involved with children in the class room, are predicted to hold positive attitudes towards the inclusion process compared with the classroom teachers in special schools for example, who are more directly involved with the children.

2.4 Influence of previous experience on teachers' attitude towards inclusion

Previous teaching experience has been found to affect teachers attitudes with half of the teachers surveyed by Shechtman et al (1993) reporting that they felt their teaching experience helped them cope with integration. Hayes and Gunn (1988) found that teachers at a primary school who had experienced integration for less than a year were more negative towards integration than

teachers at a non-integrated school. However whether the length of time teachers experience integration or the quality of that experience is more important perhaps needs to be explored. In the study by Hayes and Gunn (1988) teachers with very limited experience (less than a year) felt just as inexperienced in teaching disabled students as did mainstream teachers who had had no experience at all.

The teachers studied by Giangreco et al (1993) were shown to have developed a more positive attitude towards integration and their integrated students after being very involved with the integrated pupil. Llewellyn (1995) proposed that the quality of social interaction with integration is the key factor for improving the situation. Opportunities for quality interaction was found to significantly improve teacher attitudes towards integration and mainstreaming in a cross-cultural study (Leyser et al 1994). Nabuzoka and Ronning (1997) undertook a study to investigate attitudes towards disability of children in a Zambian primary school that integrated children with learning difficulties. It was found that attitudes were only modified if interventions deliberately ensured contact of non-disabled children with integrated disabled pupils. This study therefore perhaps highlights the complexity of attitude development. Merely working in a school that integrates disabled pupils does not necessarily mean that a teacher has contact with these children.

The extent of experience is therefore not the only possible influence on attitudes. It has also been proposed that school 'ethos' is important (Ward et al 1994). Bender (1980) hypothesised that contact and information giving are optimal ways to improve attitude towards disability. It has also been found that teachers need to feel empowered to apply new skills and competencies to successfully teach students (Buell et al 1999). The concept of efficacy has been used to describe both a belief that an action will lead to an outcome and that one has the ability to perform the action that will lead to a positive outcome (Bandura 1977).

For example, if a teacher believes that learning in school can positively affect a student's success in life and that he or she has the ability to teach the student successfully, the teacher feels self-efficacy. Fletcher (1990) found that of 6,173 teachers in 315 schools efficacy was related to the influence of teachers over school policy and to the degree to which teachers were involved in decisions regarding instruction and student grouping.

Sachs (1990) applied the concept of efficacy to the training and preparation of special and mainstream teachers and theorised that efficacy develops through experiences of success. For example, teachers may feel effective in inclusive classrooms if they have had opportunities to experience some success in these settings through training and education.

Cook et al (1999) found significant differences of opinion regarding inclusion between school Principals and special education teachers. They hypothesized that the negative attitudes of special education teachers towards inclusion are in the least part based on negative experiences regarding the outcomes of inclusion or the conviction that inclusion will not produce appropriate outcomes. It was suggested that reformers take direct measures to secure the support of special educators and other direct service providers before implementing inclusion.

2.5 Does gender result in differing attitudes?

Although some studies had noted that female teachers had greater tolerance for integration than male teachers (Aksamit et al 1987, Eichinger et al 1991, Thomas 1985), others did not report gender as being a significant variable (Berryman 1989, Leyser et al 1994). The literature overall however provides a mixed picture of gender influence with Taverner et al (1997) reporting that male teachers were more positive and Pearman et al (1992) reporting that female teachers were more positive. Other studies reported that attitudes did not appear to differ between the sexes (Hayes and Gunn 1988, Barnett and Kabzems 1992).

In a study comparing children's attitudes towards their disabled peers according to whether the children attended an integrated or non-integrated school it was found that gender did not significantly influence attitudes to disability (Thomson and Lillie 1995).

2.6 The effect of the level and type of disability

Although teachers' attitudes towards inclusion has been shown to vary and be dependent on such factors as inclusive teaching experience, amount of relevant training, amount of collaboration, amount of in-class support and class size, Cook et al (2000) felt that student variables, rather than teacher and classroom variables, might be more closely associated with teacher attitude. A later study carried out in 2001 looked at comparing teachers attitudes between disabled pupils who had either obvious (severe) or hidden (mild) disabilities (Cook 2001).

A model of differential expectations has been applied to generate differential predictions regarding teachers' attitudes toward included students with mild and severe disabilities. Those children with continence problems will usually fall within the mild or 'hidden' disability group and in some cases the problem is so well hidden by the child that the teacher is unaware of the true extent of the child's distress. Traditional thinking has held that students with mild disabilities would be accepted by their peers in inclusive classes, due to their similarity with non-disabled peers. Whereas students with more severe disabilities would be rejected due to the ways in which they noticeably differ from their non-disabled peers. It has been theorized that the seemingly counterintuitive findings of high peer acceptance of students with severe disabilities and low acceptance of students with mild disabilities are a function of differential expectations (Cook and Semmel 1999).

Certainly within the authors experience mainstream children have been more accepting of toileting problems with children with a severe disability such as spina bifida than their 'able bodied' peers with whom wetting your pants in class for example is seen as a major taboo. It is felt that this is because that such behaviours associated with children with severe disabilities do not violate, and in fact accord with, peers expectations. This is because expectations, such as acquisition of bowel and bladder control, have been adjusted in reaction to the child's obvious disability and therefore do not engender rejection. Furthermore, individuals who are extremely atypical often hold a protected role within the social group and are often nurtured and protected (Cook 2001). Students with severe and obvious disabilities may therefore be accepted because of, rather than despite of their obvious difference. In contrast children with mild or 'hidden' disabilities do not exhibit obvious signs of their disability and are therefore expected to attain model performance and behaviour standards. Therefore when seemingly 'normal' children engage in atypical behaviour, such as wetting or soiling, they are frequently rejected for violating the normal 'model' of behaviour. It is paradoxical then that such children with 'hidden' less obvious problems are rejected precisely because they are perceived to be 'just like everyone else' for which such behaviour is considered unacceptable .

It is felt that teachers also hold this differential expectation of children with obvious and hidden disability (Cook 2001). It is posited that teachers are likely to hold attitudes of attachment towards children with obvious disabilities over and above those children with a mild or 'hidden' disability. Indeed 'rejection' rates by teachers of children with a 'hidden' disability are likely to be high (Cook et al 2000). It has been found that teachers' perceptions of the severity of the disability influence the attitude they hold towards the particular pupil with a disability – attitudes which have been empirically demonstrated to correspond with the frequency, duration and quality of teacher-pupil interaction (Cook 2001).

2.7 The child's perspective

Being accepted by your peers is said to be a primary outcome of schooling with important consequences for the quality of life of students with disabilities (Haring 1991). Low acceptance by peers deprives children of the opportunities to learn normal adaptive modes of social conduct and potentially undermines academic progress as well. In fact low peer acceptance at school has been associated with loneliness, truancy and dropping out of school (Parker 1987). Peer group acceptance is based on recognition of similarity with those who do not conform being pressurised through measures such as peer rejection to either conform or leave the group. However as previously noted group members appear to differentiate their expectations of individuals who obviously do not conform to the 'norm' and thus anticipate and excuse any aberrant behaviour (Cook and Semmel 1999). Children with 'hidden' disabilities resulting in bowel or bladder problems are therefore at risk of being singled out and bullied by their peers.

School attendance can be problematic for some children with bowel and bladder problems due to a variety of reasons including attending clinic appointments and exacerbation of the symptoms. It has also been shown that parents of children with underlying problems are more likely to keep their children at home for minor illnesses than parents of 'healthy' children. In addition teachers of children with long standing problems often tend to presume that any absences are associated with the child's 'problem' and will pay less attention to the absence (Shiu 2001).

2.8 Influences on teachers attitudes towards inclusion

Previous research on mainstreaming had found that teachers attitudes towards inclusion was reflected in the level of confidence they felt in teaching children with special needs (Center and Ward 1987). It was found that mainstreaming was most effective when teachers, with appropriate training and adequate resources, successfully adapt teaching practices to meet a wide range of individual needs. If, however, teachers lack both the relevant expertise and assistance, by raising their levels of anxiety the process of mainstreaming may actually inhibit use of their full range of teaching skills so that innovative teaching solutions tend to be replaced by more conservative approaches (Lortie 1975). This can further raise teachers' anxiety towards inclusive teaching (Center and Ward 1987)

The importance of positive attitudes towards disability has been particularly evident in a number of surveys regarding integration and mainstreaming (Ward and Le Dean 1996). Leyser and Lesson (1985) found that pre-service training programmes can be successful in improving attitudes of trainee teachers towards mainstreaming. This was facilitated in two

ways, firstly by providing information about the disability and planned exposure to children with 'handicaps' and also by just providing information only. This replicated an earlier study by Johnson and Cartwright (1979) who found that attitudes towards mainstreaming improved significantly, both as a result of a combination of information about and experience with the 'handicapped' and as a result of an information only approach.

Very few studies were identified that looked at inclusion of children with medical problems and no studies were found that looked specifically at inclusion of children with bowel and bladder problems.

2.9 The importance of training and preparation for successful inclusion

Despite the sometimes conflicting finding regarding teacher variables in the development of attitude towards inclusion what was noted to be consistent in the majority of the studies was the importance of additional training and preparation for inclusion (Avramadis et al 2000, Esperat et al 1999, Leyser and Lesson 1985). However more information is needed to as to the level of support and preparation currently available to mainstream school teachers in relation to the inclusion of a child with a bowel and/or bladder problem.

Also it has been proposed that acceptance of inclusion depended on whether a teacher's beliefs were 'restorative' which assumed the answer to the problem was within the child, or 'preventative' which considered that different environments and interventions would affect the child's progress (Jordan et al 1993). Teachers lack of awareness and misconceptions regarding the underlying causes of wetting and soiling could therefore strongly influence their attitude towards inclusion of such children. The proposed study aims to explore the gap in the current literature to explore teacher's knowledge and their own experience of inclusion..

Chapter 3 Methodology

3.1 Statement of intent

The intention of this study is to investigate any relationship between teachers' knowledge and past experiences of children with wetting and soiling problems and their acceptance of such children in school.

3.2 Aims

1. To identify teachers' past experiences and knowledge of wetting and soiling problems in children

2. To identify the level of involvement of a health professional (e.g. school nurse) in the inclusion process of such children
3. To explore teachers views and acceptance of inclusion in school of children with wetting and soiling problems

It is hoped that this study will provide valuable information on any relationship between teachers' previous knowledge and experience of children with continence problems and their acceptance of such children. That information will ultimately be used in the development of specifically targeted educational resource packs so that in the future both teachers and children will benefit from a smoother supported inclusion procedure.

3.3 Personal location as a researcher

Positivism and post-positivism are well recognised as two differing philosophical positions which underpin the methodological approach chosen for a research study (Robson 1993). Quantitative approaches are said to aim to test theories deductively from existing knowledge, while qualitative approaches aim to develop theory inductively from the acquired data (Field and Morse 1985). As this study was to explore teachers experiences and views of inclusion it was to be very subjective in nature and therefore the study was approached from a largely qualitative perspective. However data was also to be collected in terms of facilitating the relationship amongst such variables as age and gender which is also a feature of quantitative research (Burns and Grove 1999).

Previous research has identified a wide range of problems, which may be seen as barriers to the provision of appropriate schooling for children with special needs and these have included such things as organisational and technical problems (Gow et al 1987). However what I felt was important is the relationship between the teachers' experience (or lack of) of inclusion of children with special needs and the success of such a placement. Within nursing much is concerned with the understanding of the complexity of human experience in relation to how individuals perceive such issues as illness and well-being. Therefore a deeper understanding of teachers' feelings towards inclusion and what influenced those feelings will perhaps help, towards more positive outcomes of inclusion.

What I felt was important therefore was to be able to explore and describe experiences including the thoughts and feelings from the perspective of those participating in the study in their own words rather than simply reducing them to just completely quantifiable categories. The introduction of a qualitative aspect to the study allowed me to do that. I felt the study needed to focus on the way teachers interpret and make sense of their experiences in order for me to understand and make sense of the issues from the teachers' point of view.

Our subjective experience of the world is said to filter through an unquestioning acceptance of its form and content – the 'natural attitude' (Bryman 1995) How individuals then construct their views in order to make sense of the world would appear to be the key in attitude development. Schutz (1967) called this a phenomenological approach although there appear to have been a number of debates since then regarding the true meaning of phenomenology (Heap and Roth 1973). I feel teachers' previous experiences (good or bad) of inclusion of a child with a toileting problem will influence their future acceptance of such children. The goal of such inquiry is to understand the basic structure of experienced phenomena by analysing the written explanations of the experiences from the perspective of participants (Parse 1985). This is an approach that has been incorporated into nursing research as a way of allowing them to interpret and understand the clients' experiences (Munhall and Oiler 1986, Watson 1988).

Phenomenology is therefore concerned with experiences; with the individual being viewed as having a stock of knowledge, that is used to make sense of the world and guide his or her own actions (Talbot 1995). Although I feel my method of inquiry for this study could be said to reflect a phenomenology approach I am aware of the limitations of this study in relation to it.

However rather than the actual 'labelling' which is the focus of much debate and theorising in the literature I felt what was more important was the link between the theory and the research method. For example certain theories may contain concepts that imply types or classes of variables, which in turn recommend certain methods of research as being more appropriate than others. Also, certain research methods may be better suited for gathering data on specific types or classes of variables. I felt restricting oneself to a singular method or theory may have limited the actual research undertaken. I certainly felt there is was good argument for multi method research .

An emerging dialogue, particularly in the nursing literature, is the development of 'critical multiplism' which is a form of methodological plurism that gives way to both qualitative and quantitative methods (Letourneau and Allen 1999). 'Critical' refers to the rational and empirical social efforts to identify the assumptions and biases present in the methods and theories chosen to investigate a phenomenon. 'Multiplism' refers to the fact that research questions can be approached in several different ways using both quantitative and qualitative approaches, depending on the questions being asked. Critical multiplism has been described as an approach with several strategies or options. Qualitative inquiry is said to be an interactive and transformational process in which the researcher seeks to interpretate specific life experiences.

The study aimed to not only produce some quantitative data, in the form of a number of structured questions but also qualitative data by exploring teachers experiences using more open ended questions which allowed the teacher's to express their own feelings and experiences.

Although quantitative research draws on the positivist paradigm I do not believe that all quantitative research has to be labelled as purely 'positivism'. Many of the concepts in health and social research are not amenable to objective measurements and as a result phenomena are explained by relying largely on subjective ratings by respondents. The assumption that science is the most appropriate theoretical framework for all quantitative studies has ignored the philosophical difficulties the application of the positivist perspective presents outside the 'scientific' domain. To this extent I feel I have to reject positivism from an epistemology perspective towards a more post-positive view. This is because I believe that phenomena are experienced and interpreted by individuals through their own understanding and past experiences. Also I thought it was important to get an 'insider' view of the problem rather than taking a detached outside view of the subject under study. I go with the belief that we each construct our view of the world based on our perceptions and that therefore the teachers view of inclusion will be based on their personal perceptions and experiences of it.

3.4 Overview of study

The purpose of this study was to explore teacher's own personal experience of inclusion and investigate the level of planning and support involved in the admittance to school of a child with a bowel/bladder problem. This was to see if there was a correlation between the level of teachers' knowledge regarding bowel and bladder problems in children, including the level of any support provided, and the teachers' attitude towards inclusion.

This study involved a purposeful sample of Primary School teachers with the aim of obtaining as many 'information-rich cases' as I could, in order to, learn more about and illuminate the questions under study. The decision to target primary school teachers was made on the basis that they are more likely to have come across a child with a bowel or bladder problem and be therefore more able share their experiences. A questionnaire was posted via email to the web site for Inclusive Education. This site is aimed at teachers who are involved with inclusion and on that basis was hoped that they will be able to provide the necessary data for the questionnaire. Previous studies had identified an increased response rate to questionnaires when targeted towards a network 'group' (Walsh et al 1992). However as the initial response rate to the questionnaire was in fact poor a further group were identified via the RCN School Nurses Forum and a small number (10) of postal questionnaires were later sent out.

3.5 Methodology Discussion

The decision regarding which method of data collection was made after considering the advantages and disadvantages of a range of methods such as questionnaires, focus groups or face to face interviews. My main concern regarding using a focus group was that participants, i.e. the teachers, may influence each other regarding their answers. I am aware that what is said in theory does not always relate to practice, for example teachers tell me they would never exclude a child from school that was not toilet trained but I know from experience that they do! I felt therefore that I would not have got an accurate picture of the teachers' views as they may not have wished to expose what happens within their own schools, with some children, to their colleagues. The anonymity of a questionnaire I thought therefore to be the best option.

I had also considered interviews as a way of collecting the data. Interviews have the advantage of being a flexible and acceptable way of finding things out. With face-to-face interviewing it allows the interviewer to expand questions and follow up any interesting responses. During the interview the interviewer is able to build up and maintain a rapport with the subject with non-verbal cues helping to expand the verbal response and reflect the true meaning of the reply. The interviewer is also able to hand out pictures or samples to enhance the replies. Types of questions can vary from relatively unstructured ("how do you feel about...?") to the more structured ("Do you feel happy or sad about...?") (Fairweather and Davidson 1986).

Thus interviews encompass a continuum of methods which range from the totally unstructured, where the interviewer and interviewee have an open ended conversation about a specified topic to a relatively structured procedure in which questions are asked and responses are specified in great detail (Wiggins 1973). The common feature of interviews is

that an interviewer presents questions to a respondent and records results in a variety of fashions from descriptions to scaled structured responses. Therefore the interview method can vary in its directiveness and relative activeness, and typically focuses on obtaining a sample of behaviour (Bell 1999).

There are however some disadvantages to this face-to-face technique which have influenced my decision to use questionnaires. The interviewer may inadvertently give an inkling of their own opinions, which could affect the response and unwittingly influence the responders answers, the interviewer could also unconsciously communicate their own attitude by the responder picking up on 'non-verbal' cues. Probing answers with leading questions and being seen to agree with the respondent could introduce a notion of researcher bias towards the answers. Subject bias could also be a threat to the validity of the findings if certain interviewees have particular strong feelings regarding the subject (Burns and Groves 1999). It is also a costly and time consuming process. Although I was drawn to using interviews I felt that again, like the focus groups, I would not get as 'true' a response as I would have liked as this subject is quite emotive (Milburn et al 1995).

3.6 Sampling

This study involved a purposeful sample of primary school teachers on the basis that this group of teachers had more experience of younger children with delayed toilet training and bowel and/or bladder problems than secondary school teachers, and were therefore, able to provide the necessary data for the study. Purposive sampling involves the researcher making a judgement regarding the type of subjects needed to provide the most useful information about the phenomenon being studied.

Bernard (1998) cautions that in purposive sampling, it is necessary to decide the purpose you want informants to serve and then determine a set of criteria for selection of appropriate participants before identifying and soliciting their participation. Andranovich (1995) emphasises that in order to secure meaningful participation in a survey, the study problem, and the questions posed by the survey must match the interests of the participants. Solution of the problem should also be of benefit to them. What is of consequence is the fact that the quality of the results of the survey is highly dependent on the relevant knowledge, skill or level of information of the respondents.

I aimed to target not just teachers per se but teachers who had had experience of inclusion in order to obtain the information required for the study. However I am aware that this might bias the results in that the sample of teachers are from an 'inclusion' web site and therefore may all fully support inclusion regardless of the child's problems. To get round this I also sent out

some random postal questionnaires to see if there was a difference in the results, which in fact there was not.

The respondents were self-selected as those teachers having either experienced inclusion of children with a bowel and/or bladder problem or were concerned about such issues were requested to respond to the initial request letter posted on the Inclusion web page and complete the questionnaire.

A limitation of this sampling approach however, is that it is impossible to assess the representativeness of the individuals who participate (Parahoo 1997). In my case I felt justified to do it, on the basis that these teachers are the best available people to provide data on the issues being researched

3.7 The questionnaire as the data collection tool

The questionnaire approach therefore, I felt, clearly had its advantages for this particular study. The study involved, using a questionnaire, to mainstream Primary school teachers with the aim of finding answers to three main questions:

1. To identify teachers' past experiences and knowledge of wetting and soiling problems in children
2. To identify the level of involvement of a health professional (e.g. school nurse) in the inclusion process of such children
3. To explore teachers views and acceptance of inclusion in school of children with wetting and soiling problems

The questionnaires were sent out initially via e-mail. The idea of using e-mail arose following a discussion with colleagues and tutors and interested me as it challenges the classical dimensions of sociological research. E-mail has been said to go some way to transcending the traditional biases that beset 'face to face' techniques with the concept of race, gender, age and sexuality do not necessarily apply when communicating electronically (Spender 1995). Also the internet allows access to groups of individuals more easily than ever before (Coomber 1997). As I wanted to target teachers who had had experience of inclusion the inclusion web site is an ideal opportunity to gain access to as many 'information-rich cases' as I can.

There does in fact appear to be an increasing move towards using e-mail as a research tool in the form of electronic questionnaires (Mehta and Silvadas 1995). The principal feature of

using e-mail as a research tool is the speed and immediacy it offers (Selwyn and Robson 1998). However one main problem with e-mails that had been identified, unlike paper questionnaires for example, is that they can be deleted by a touch of the button (Thach 1995)!

Another factor for using the internet was the fact that earlier studies had identified that 'electronic' questionnaires had a favourable response rate when compared with the typical mail surveys (Frankfort-Nachmias and Nachmias 1996). Walsh et al (1992) attained a 76% response rate with a randomly selected sample and 96% with a self-selected sample responding to their own 'computer network group' and other studies reporting similar findings (Anderson and Gansneder 1995).

An other advantage is that e-mail questionnaires cost considerably less to administer, both in terms of money and time. Using the group network I was able to send the e-mail questionnaire to multiple addresses in one action.

Clearly when using the internet generally for survey research there may well be a bias in terms of who is responding and a relative lack of representation of those who do not have access to the internet. A number of previous surveys into the demographics of Internet users have consistently found that Internet users are more likely to be white, male, relatively affluent and relatively well educated in comparison to the general population (Kehoe and Pitkow 1996). This would, in theory, make generalising the research findings of an Internet survey to the general population problematic. Other studies, however, have identified that Internet users overall characteristics are becoming more in line with the general population and Internet access and use is becoming more mainstream (Commercenet and Nielson 1996, Fisher et al 1996).

However in terms of obtaining a purposeful sample I felt that this was an ideal way of finding those teachers who have been involved with inclusion of a child with a toileting problem.

Data quality is also dependent on the accuracy and completeness of responses to questions (Moser and Kalton 1997). The key issue here being the motivation of the respondent to complete the questionnaire. I therefore needed to make sure that the letter written to accompany the questionnaire explained the importance and potential benefit of the information obtained in developing future support information and advice for teachers (Appendix 1). This, I had hoped, would have encouraged a large number of them to reply.

The context of question answering may be another problem if respondents seek the views of other people before answering the questions. If the respondents ask colleagues to comment on their answers or fill in the questionnaires together it will cause a bias in the replies as it will not be a true reflection of the respondents own private opinions (Judd et al 1991). As a result I tried to ensure in the explanatory letter that the questionnaire is not a 'test; with no right or

wrong answers and that if possible they were not to discuss it with colleagues to try to get a true reflection of individual teachers views.

The questionnaire encompassed both qualitative and quantitative approaches. Quantitative measures are said to be succinct and easily aggregated for analysis, while qualitative data are systematic, standardised and easily presented in a short space (Letourneau and Allen 1999). The quantitative structured questions in the questionnaire will aim to identify such things as the demographics of the teachers such as age and gender, for example. Also any involvement of a health professional, such as the school nurse, and the teachers knowledge of wetting and soiling problems.

By contrast, the qualitative findings are often longer, more detailed and variable in content. Although analysis can therefore sometimes prove difficult because responses are neither systematic nor standardised, the open –ended questions permitted the understanding of the world as seen by the respondents. The purpose of gathering responses to open-ended questions is to enable the researcher to understand and capture the points of view of individuals without predetermining those points of view through prior selection of questionnaire categories. As I wanted to explore teachers' views this I feel, was one way of doing it. There was opportunity for teachers to describe their experiences of inclusion of a child with a toileting problem – either positive and/or negative and what they felt influenced those experiences

As qualitative and quantitative methods involve differing strengths and weaknesses they constitute alternative, but not mutually exclusive, strategies for research. Both qualitative and quantitative data can therefore be collected in the same study, which is what I am aiming to do. This question of mixing quantitative and qualitative has stimulated much debate within research (Sandelowski 1995, Tashakkori and Teddlie 1998). However this approach of combining aspects of both qualitative and quantitative research is identified as being both appropriate and acceptable (Robson 1993). Combining the two approaches at the method level will be used to expand the scope of the study. While structured questions will give me a set of quantifiable data the inclusion of open-ended questions and opportunity for free text will allow me to gain a deeper understanding of the problems encountered.

The questionnaire was developed so that it contained both closed and open ended questions. The closed questions pertained to such things as age and gender of the respondents and the open ended questions were structured in such a way as to make sure the answers fulfilled the aims of the research

3.8 The Questionnaire

The first part of the questionnaire reflected the qualitative approach to the study by including demographic data of the respondents such as age, sex, years of teaching experience for example. Also the level of teachers' knowledge in relation to bowel and bladder problems was also included in this section .

The middle part of the questionnaire focused on open-ended questions to find out the level of support and school nurse involvement and the teachers' perception of that support.

The final part of the questionnaire allowed for free text answers to help gain a greater insight of the teachers' views of inclusion. The teachers were encouraged to share their experiences of working with children with bowel and bladder problems and any subsequent issues this raised.

The questionnaire (Appendix 2) was initially sent to the Inclusive Education list which is a web based group of teachers involved in the inclusion of pupils (from primary to further education) into mainstream education (Appendix). This has 268 members, however it is difficult to estimate what percentage of this group are primary school teachers and in fact the response rate was very poor. There were only 20 replies (7.5%) and as a result a further 10 questionnaires were sent to the RCN School Nurses Forum and 5 to neighbouring Educational Authority with a request for them to be given to primary school teachers for completion. There was a 100% return rate to the 15 postal questionnaires which made me think perhaps if I had considered postal questionnaires as the main process of obtaining information I may have had a better overall response rate.

What I felt was important however was that those that did respond had all had experience of children with bowel and or bladder problems and as a result were able to provide a lot of information and record their views.

3.9 Pilot Study

A small pilot study was carried out to enable the questionnaire to be refined if necessary. This involved sending out, via post 5 questionnaires to a neighbouring educational authority to be sent on to a selection of anonymous teachers for comments regarding, ease of completing the questionnaire and any ambiguity of questions. The completed questionnaires were returned with the comment that they felt there were no problems and did not feel the questionnaire needed any amendments. These 5 questionnaires were therefore included in the final study

3.10 Ethical issues

Ethical issues obviously needed to be addressed as all social research involves collecting data both from people and about people. However ethical issues are more likely and more acute in some qualitative approaches than others (Punch 1998). This is because while all social research intrudes to some extent into peoples' lives, qualitative research often intrudes more. Some qualitative research deals with the most sensitive and innermost matters in peoples' lives, and ethical issues inevitably accompany the collection of such data. Fetterman (1989) describes the various ethical issues which can arise during the different stages of the research project, using the life cycle terms of 'inception and prenatal care', gestation and birth', childhood', adolescence and adulthood and retirement and last rites.

Punch (1998) summarises the ethical issues, which can arise in research including harm, consent, deception, privacy and confidentiality of data. It is important therefore to be aware of and sensitive to the ethical issues involved in the proposed research, and to think about them during the planning stage of the project. Problems of maintaining confidentiality and anonymity occur throughout the research process and include the finished report. It may happen that an individual who participates in research remains anonymous, but that his or her data contributes to averages reported for a group to which the person belongs. The teachers were therefore be informed about what will happen to the results with the proviso that they will be used for good ends rather than bad.

For this particular study the important point for the respondents was that the eventual data will be anonymous and confidentiality will be maintained at all times. The e-mailed questionnaire replies were copied in a separate file and the original e-mail deleted ensuring anonymity through the rest of the process. The postal questionnaires were sent via a local education authority to unnamed schools not known to the researcher. However such was the interest and keenness of the teachers for support regarding the research topic a number of them included their name and contact details so that they could take part in any pilot work relating to future information/support package development.

The risk of bias is always present in research and represents the greatest threat to the reliability and validity of data with the main sources including both respondents and researcher (Parahoo 1997). In order to reduce respondents bias by only targeting teachers from an inclusion web site altogether 20 questionnaires (50% of returned questionnaires) were sent out via post and completed by a random set of teachers. On evaluation there was in fact no difference in the answers between the two groups. As a researcher I have also strived

to put my own feelings to one side in order to reduce the risk of bias by ensuring there were no leading questions in the questionnaire and doing my best to objectively interpretate the results.

Ethical approval for the study was obtained by submitting the research proposal and completed application form to the local research ethics committee (Appendix 3).

3.11 Data analysis

The purpose of data analysis is to impose some order on a large body of information so that the data can be synthesized, interpreted and organised into a research report. Although one aim of the study questionnaire was to quantify the problem statistically in terms of numbers and percentages what I also want to be able to do is structure the data in a way that make sense of the findings and help towards developing a resource pack for schools.

The questionnaire consisted of a number of structured questions with some open-ended questions and space for comments. The structured questions within the questionnaire were originally to be analysed using a suitable statistical package. The reason why I intended originally to use a computer based statistical package to analyse the data is because computers have the capacity to not only produce a range of statistical tables and analysis but also to do it at great speed.

However when the questionnaires were completed it was felt that the number returned, which was forty, was a manageable enough number to input into a spread sheet data base by hand and also because a substantial part of the data was qualitative.

The qualitative data derived from the open-ended questions was analysed separately. There are three major purposes of data analysis in qualitative research (Wilson 1985). The first is to explore and describe, the second to discover and explain and the third to extend an existing theory. I carried out a thematic analysis by sorting the data into categories and identify different themes. In developing such a category scheme related concepts are grouped together to facilitate the coding process. The important concepts that emerged from closer examination of the data were given a label that formed the basis for the category scheme. Morse and Field (1995) suggested several innovative strategies for coding data. One approach is to use highlighter pens, with a different colour for each major category, which is what I did.

The data from qualitative studies are subjective and by their very nature incorporate the perceptions and beliefs of the researcher and the participants (Burns and Grove 1999). The awareness by the researcher that this could lead to the potential for bias can help reduce the risk of this happening.

Chapter 4 Results and discussion

These will be integrated due to the nature of the data collected and will be linked to pertinent literature

4.1 Findings of study

Forty completed questionnaires were returned and it was felt that this number was manageable enough to analyse using a data base spreadsheet without using a statistical computer package. The returned questionnaires were numbered and the responses collated on a spreadsheet. A number of queries were then set up to analyse the quantitative part of the questionnaire such as the teachers gender, age, whether they had had children or not and whether they had had further training. The rest of the questionnaire was reported textually supported by relevant quotes from respondents.

4.2 Gender

Of the 40 questionnaires returned 35 (87.5%) were female teachers and only 5 were male teachers. The ratio of respondents I feel is more a reflection of the female to male staffing ratio in infant and primary schools rather than the willingness of females to complete the questionnaire and the questionnaires only being picked up by females. A recent study looking at teachers careers identified that in fact almost 70% of teachers are female (Powney et al 2003). So the chances are that the majority of teachers who were targeted to respond were in fact female.

In a study by Keyser et al (1994) the gender of the teachers did not appear to have an influence on their attitudes towards inclusion of special needs children in mainstream schools. However other studies had identified that female teachers held more positive views towards disabled individuals and mainstreaming than did males (Askamit et al 1987, Hannah and Pliner 1983).

There was an insufficient numbers of male to female teachers in this study to come to any firm conclusions regarding whether gender influence attitudes.

4.4 Age of respondents

The age range of the teachers ranged from under 25 to over 55 with only one teacher in the youngest age group of 25 or under. There were 17 teachers in the 26-35 age group, 5 teachers in the 36-45 age group and 17 teachers in the 46-55 age group

In the literature the age of teachers had been found to relate to attitude with younger teachers and those with fewer years of experience being found to be in fact more supportive of integration (Hayes and Gunn 1988). This could possibly be related to the fact that those younger teachers started their teaching career when there was already a climate of integration within mainstream schools and therefore it is not seen as something very new or different.

This also may be the result of more disability awareness training which is now filtering into teacher education so those younger teachers may have had some awareness training whereby their more older colleagues have not. Tavener et al (1997) found in their study that teachers with less than 11 years teacher training were more likely to have had relevant training and as a result were more accepting.

However in this study the teachers in the age groups 36 years and over had undergone significantly more training in special needs (15) than the teachers in the age groups under 35 years (5).

4.4 Did they have children of their own ?

Twenty respondents (50 %) reported that they had children of their own. There appeared to be no real distinction between the group of teachers who had children and those that did not in their responses to the questions, for example, regarding their knowledge of age of acquisition of bowel and bladder control or understanding of the cause of wetting and soiling. However one teacher wrote –

“Non-parent teachers have unreasonable expectations of age for children to be toilet trained, as I was before becoming a parent myself”

4.5 Had further training been undertaken ?

Twenty five respondents had undergone further training in relation to ‘special needs’. Nine teachers (36%) had undertaken a Certificate in Special Educational Needs, 6 Teachers (24%) a Diploma in Special Educational Needs and 9 teachers (36%) had undertaken various training days. These training days had included Autism training – 5 days, Advanced Diploma

including modular training, B.Ed Advanced Diploma in Special educational Needs, Barrier free co-ordination, Behaviour training (not specified) and various days on behaviour/autism/speech and language problems with a number of 'various seminars (not specified)'.

The majority of teachers therefore had undergone some form of post-graduate training. A study by Avrimidas et al (2000) found that the level of professional development of teachers, included in their study of mainstream teachers attitudes towards inclusion of children with special educational needs, was significantly relates to their attitude towards inclusion. Other studies have identified that mainstream teachers are sometimes reluctant to accept children with 'special needs', which may be the result of lack of teacher training (Haye and Gunn 1988). Teachers with substantial training in special education held significantly higher positive attitudes than those with little or no training regarding inclusion. Also the teachers with substantial training demonstrated more confidence in meeting the needs of children with special needs (Avridas et al 2000).

This was notable with one teacher in this study, who recorded a Masters in counselling and a PhD in early intervention. He stood out as having a very sympathetic attitude with apparent good understanding of the issues involved, and who gave a very positive account of his personal experience of inclusion.

“My experience has been that both bladder and bowel control learning can be positive experiences in inclusive settings; it is VERY important to normalise the experience and to ensure other children that this is the normal variation that we see in all skill. We need to ensure that children with bowel and bladder concerns are given the language to talk about their concerns, the skills to care for themselves, and the confidence to do so. Finally, we need to reduce the reliance on special caregivers (carers) – this is a normal situation – ...”

Recognising the limitations of the study in terms of small number of questionnaires returned, it does however highlight several important practical implications for teacher training. Previous evidence has shown that the training of teachers is critical for the formation of a more supportive view about mainstreaming. Training should therefore be provided to all teachers by designing specific modules, particularly in relation to continence and bowel and bladder issues, that can be filtered into special educational needs courses.

Previous studies had identified that school principals were more positive towards students with a disability when they had received formal training in special education (Forlin et al 1996). It has been stated that teachers who were fully trained in special needs had more realistic

attitudes towards placement decisions (Forlin et al 1996) and negative attitudes towards inclusive practices have also been linked to ignorance regarding disabilities (Elkins 1994).

A previous study (Taverner et al 1997) looking at teacher attitudes towards intergration and found 68-70% of teachers participating in the study had not received initial teacher training in special needs and between 60-79% of teachers had not had in-service or post-graduate training in special education.

It was also found that teachers with less than 11 years of teaching experience were most likely to have had relevent training and that these teachers were more positive about integration. Other studies reported similar findings in regard to teachers who had training in special education were the least resistant to inclusion (Center and Ward 1987, Leyser et al 1994). However in a study by Shechtman et al (1993) only 25% of teachers studied felt that special educational studies had helped them. However it was not clear whether this reflects dissatisfaction with training standards or lack of training opportunities.

While it is clear there is strong support for teacher education a debate is also evident between some researchers regarding when the education should take place. Some advocate pre service training (Elkins 1994, Mittler 1992) others recommend in service training (Glomb and Morgan 1991). Quite clearly any training undertaken must meet teachers needs if it is to be effective. However in respect of specific training for teachers in relation to working with children with bowel and bladder problems no such specific training currently exists, either pre or post graduation.

4.6 What do you generally think is the cause of wetting problems in children?

Children may present in school with a variety of 'bladder problems' ranging from children who need to go to the toilet frequently to those children who experience a range of wetting episodes from damp pants to those that require almost a complete change of clothes.

Quite clearly teachers need to have an understanding of the sorts of problems children may encounter in order to accommodate free access to the toilet and drinks and be sympathetic and supportive towards the child's problem. Those teachers who feel any wetting problems are purely the fault of the child will obviously have a different attitude to any wetting episodes in school than those teachers who are aware of the underlying causes.

To try and gain some insight into what teachers felt was the main cause of some of the children's toileting problems teachers were asked what they felt was the main underlying reason why children wet.

Twelve (30%) teachers thought the cause of wetting problems was due to immaturity and quite clearly in those children under the age of 5 years this may well be the case, however seven (17.5 %) teachers felt that the general cause of wetting in children was due to psychological problems. Attributing the wetting to a psychological problem may be a reflection of the teachers beliefs that the wetting is the result of some 'behavioural' problem and therefore the wetting is some how within the child's control and if the child improved or corrected their 'behaviour' the wetting would stop.

One teacher commented

"...there are issues involved with behaviour – why does the child do this?"

This teacher obviously felt the wetting was in the child's control and almost implying that they were doing it on purpose.

Two teachers felt that it was a combination of psychological and medical problems, two teachers felt it was a combination of medical problems and immaturity and three teachers felt it was a combination of psychological, medical and immaturity. Five teachers felt it was impossible to generalise with one teacher commenting that as it could be any of the factors stated it was inappropriate to force a choice.

At nursery age (3 years) there is not an insignificant number of children who may well present with toileting problems. Although most children are toilet trained at 3 years around 20% will be reported to have wetting and soiling problems ranging from one accident per week to accidents occurring every day (Welford 1993). These children in fact could be considered to have a 'normal' delayed acquisition of bladder control (diurnal enuresis). This is not uncommon in nursery aged children and is usually the result of the child falling within the tail end of the normal range. It is not generally related to an underlying problem and with time the child will acquire the necessary skills. These children typically present as never having been fully toilet trained which contrasts with the older child who has actually been toilet trained at some stage but has regressed and started wetting or soiling as a result of an underlying problem that requires treatment.

The school staff need to be reassured that the majority of these nursery children will be able to remain clean and dry provided they are 'prompted' and reminded to go to the toilet at suitable regular intervals (such as play/break times). No other management /treatment is usually required. With time the child will develop independent control – most children have achieved full bladder control by the time they are 4-5 years (Rogers 2001). The structured day within the school setting and the wish by the child to conform will help speed up the learning process as most children do not like to be seen to be different.

A small number of children however may go on to continue to have a wetting problem into infant school. This is a problem affecting approximately 5% of 5 year olds when the child may present with 'an unstable bladder' typically demonstrated by frequency (needing to empty their bladder often) and/or urgency (feeling a sudden desire to empty their bladder with little or no warning) (Hjalmas 1992). Teachers need to be aware that this problem is outside the child's control and that most children will require some sort of formal intervention, including medication in some cases, to achieve normal bladder control.

Treatment usually involves a bladder training programme necessitating free access to drinks and the toilet. A typical programme may involve the child going to the toilet 'by the clock' (usually every 90 minutes to fit in with school break times). Those children who have an 'unstable bladder' are encouraged to go to the toilet as soon as they feel the 'urge' therefore systems should be put in place to enable the child going to the toilet as often as necessary.

Bed wetting is another wetting problem children may experience and although this does obviously not occur during the school day the results of the wetting and the treatment involved will often have an impact on the child the next school day. It would be beneficial for the class teacher therefore to have an insight into the problem.

Wetting the bed will often require the child to have a bath or shower in the morning before school, which may on occasions, result in the child turning up late. Treatment will almost certainly include encouraging the child to drink and void (pass urine) regularly during the day which school should help facilitate. If

an enuretic alarm is being used the teacher may need to be aware that the child may be tired the next day if they have been woken up and disturbed during the night.

4.7 What do you generally feel is the cause of soiling problems in children?

Soiling in school is obviously a difficult problem for teachers to cope with and these children are often at risk of bullying and name calling. When asked eight teachers (20%) thought that the cause of soiling in children was due to psychological problems and a further eight teachers thought it was due to immaturity. However soiling in school aged children is most commonly related to constipation when the resultant soiling is due to 'overflow' (that is liquid faeces leaking around the retained stool and into underclothes) and is therefore outside the child's voluntary control. The child is often unaware that the soiling has taken place and also of the associated smell. Children need to be treated sympathetically when this occurs.

Only one teacher thought the soiling was due to constipation, but also in combination with psychological problems and medical reasons . The majority of teachers showed an apparent lack of understanding why children soiled with three teachers recording that they felt the soiling was due to a combination of psychological and medical problems, and one teacher felt it was due to a combination of psychological problems and immaturity. A combination of medical problems and immaturity was felt to be the cause of soiling by two teachers. Four teachers felt it was difficult to generalise with one teacher reporting that they could not answer as they did not know what the underlying cause could be.

Many children suffer from low self -esteem and shame because of the soiling and the often long protracted course of treatment can evoke apathy and eventually behavioural problems. (Buchanan and Clayden 1992) However any behavioural issues are usually the result of the soiling and not the cause (Buchanan 1990). From the written comments the teachers made the soiling was obviously a problem that they felt difficult to cope with in the classroom particularly in terms of the time it took in getting the child cleaned and changed

“ Changing involves taking an adult away from other children for at least _ hour (soiling themselves especially)”

“ Teachers cannot leave the class to change somebody. Children do not have a change of clothes in school – underwear not provided”

The comments from the teachers however generally suggested a more sympathetic attitude towards the child with soiling than with children with just a wetting problem.

“...preserving the self-esteem and dignity of the child important...providing discreet support from a social and emotional perspective in addition to physical care”

“Other children need to be encouraged to be understanding of the difficulties the child is experiencing”

Practitioner experience and the findings off a number of studies report that mainstream teachers may have not developed an empathetic understanding of ‘handicapping’ conditions (Berryman 1989, Vitello 1991). There does appear to be some link between teachers’ awareness regarding the underlying cause of the child’s problem and their support for these children to be included in the mainstream population. Certainly, from the authors’ experience, the attitude of teachers was found to change once their understanding of the child’s problem has been made clearer and the problem attributed to an underlying ‘medical’ condition outside the child’s control rather than a problem brought on by the child’s behaviour or reluctance to use the toilet.

There is also the issue of school toilets! Many children are also reluctant to use the school toilets to open their bowels. This may be due to lack of privacy school toilets afford and also some children are worried about the smell they may leave behind. However, as the majority of children who soil do so as a result of an underlying constipation (Loening-Baucke 1997) most of the children are on large doses of laxatives and are told not to ‘hold on’ so easy access to a toilet is an important part of the treatment programme.

Schools need to understand that treatment of this problem involves an holistic team approach often involving the prolonged use of laxatives. This in turn can cause problems relating to the child’s need to have easy access to a toilet. Only two teachers in fact commented on the child’s need to have access to the toilet

“ Child should go to the toilet when they need to”

“ ...child should have the freedom to go to the toilet when necessary...”

Teachers need to find a way of ensuring the child has access to a ‘user friendly’ toilet that affords privacy and has good ventilation and a generous supply of soft toilet paper! Some schools have made use of redundant staff toilets for such children. Schools also need to safeguard children from bullying which often takes place around the toilet area (Vernon et al 2003).

One teacher wrote

“dim dismal, dirty toilet facilities (especially outside the building) are definitely unhelpful”

An increasing number of children with physical disabilities are entering the mainstream school population. Some of these children may have a condition, for example spina bifida, which affects their bowel and or bladder, potentially resulting in incontinence if left untreated. Modern approaches to treatment ensures that the majority of children with such conditions are able to manage their bladder/bowels so that they are able to stay clean and dry independently. In the early stages, however, these children may require additional support in school to help carry out their management. Again any individual involved with the care of a child should have appropriate training.

4.8 At what age would you expect the majority of children to be toilet trained?

Teachers were then asked at what age did they expect children to be fully toilet trained. One teacher thought most children would be toilet trained at 2 1/2 years, and three teachers felt it would be between 2-3 years. Ten respondents felt by 3 years most children would be toilet trained and 5 felt it would be between 3-4 years. Seven teachers felt it would be by the age of 4 years and six teachers replied that they thought it was between 4-5 years. Seven teachers thought most children would be trained by the age of five years with one teacher replying that they thought it was not until a child was eight that they would be fully toilet trained.

In fact recent figures suggest that although most children would be toilet trained by the time they were three, a significant number (20 %) would still be struggling to be out of nappies and fully trained up till their fourth year (Rogers 2003). As the majority of children will be entering

the school nursery at age 3 that means a percentage of these will still fall within the normal age range for acquisition of bowel and bladder control but not be toilet trained. This obviously will have implications for nursery staff.

“There are issues regarding cover during periods when the child is being changed...there is unreasonable expectation in a school nursery”

4.9 Did you have any children in your class with any sort of bowel/bladder problems?

Only three teachers reported that they had not had previous experience with a child with a bladder or bowel problem. The remaining teachers had had experience of children with a variety of problems. This included:

Six teachers reported experience with children with ‘bladder problems’ including 1 child with urgency and frequency (experiencing a sudden desire to empty their bladder with little or no warning), and also 4 children with reported wetting. Sixteen teachers had had experience of children with bowel problems of these 4 were identified as having constipation, 1 with diarrhoea and 1 child with Crohns’ disease, the teachers reported that 8 of the children with bowel problems also soiled.

Four children were recorded as being ‘not toilet trained’ and there were 2 children identified as having spina-bifida and having problem identified as ‘not toilet trained and ‘soiling/wetting problems’. Seven teachers recorded experience with children with both wetting and soiling problems but did not specify what was the underlying problem.

One teacher reported a vast experience over the years with children with bowel and bladder problems with an estimated experience of 80-100 children with a wide range of problems including spina bifida, cerebral palsy, autism and a number of other problems.

“... with proper training, there is no reason why a teacher can not address these issues, learn to do CIC and why children themselves can not learn the skills they need for care for themselves; again, in my experience I have taught numerous four year olds to catheterise themselves and to care for their own equipment; this is very useful and empowering.”

4.10 Did the health professional involved with the child give you information and advice regarding the child's problem?

Sixteen (40 %) of the respondents replied that they had been given some advice from a health professional regarding the child's problems. However the remainder of the teachers had not been given any professional advice at all in relation to the child's problems. Lack of information was an obvious problem for some teachers and they were asked to comment regarding the associated issues. A small number of the comments reflected a positive response from the teachers regarding the amount of information given.

"Health professional very supportive and came to all the reviews"

"The school nurse was helpful but no help from school doctor"

"Copy of hospital letters and general info given"

The vast majority of the teachers however felt that they were not given sufficient information and advice regarding the child's problem. A number of teachers reported the difficulty they had in obtaining any information at all and often the information that was given was only minimal and written in very medical terms that was difficult for them to understand.

Another issue one of the teachers commented on was the difficulty in accessing the school health service for any information or advice due to their inability to make direct referrals to them. One teacher in fact blamed a cut in the school nursing service as a contributory factor. As well as having limited access to initial health information and advice one school commented on the fact that they were never automatically informed of any change in either the child's health needs or any action to take.

One of the schools reported that in the end they had to contact a London Hospital for toilet training advice and more information on the child's condition however at the time of completing the questionnaire they were still waiting for a reply !

Due to apparent lack of information from health services a number of teachers resorted to relying on the parents alone to provide medical information.

"Parents informed me of the medical problems the child was experiencing"

“Information tends to be obtained ‘3rd hand’ mum passes on information from child’s consultant”

Obtaining information relating to the child’s condition was obviously felt to be important by the teachers and a number of them reported spending time to seek out information themselves by reading up in medical books on the child’s condition and actively questioning more experienced colleagues.

4.11 Did you feel you were provided with sufficient information to understand and deal with the child’s problem?

Altogether twenty teachers felt they had been given sufficient information from a variety of sources, including parents although only nine teachers reported they had involvement from a professional in writing an individual ‘care plan’ for the child to help direct management in school. This obviously then meant that half the teachers questioned had not been given sufficient information to enable them to deal with the child’s problem.

Having sufficient understanding of the child’s problems is obviously important as has been seen many teachers perceive that the problem of wetting and soiling may be due to the child’s behaviour and therefore within their control to stop it. An awareness of the underlying problems will also give the teachers an insight regarding the child’s toileting and fluid intake needs in school.

“Would have preferred more information about how to ‘manage’ the situation, help the child establish a routine, how to help the child deal with his difficulties independently (empower him rather than create dependency)”

One school commented that they were still unclear to what the problems were with a particular child who was still waiting for health service referrals to be made for further investigations in hospital. Although lack of information about how to manage the child appropriately in school was a common thread through many of the teachers comments, there were also comments regarding that when information was provided regarding how to deal with the child in school there was still lack of information regarding the underlying problem.

“Solutions such as star charts given but no info about cause”

Another issue for many teachers with children with toileting problems is that

often the nature of the problem is not disclosed until the child actually starts school. This may be for a variety of reasons including, embarrassment on behalf of the parents who may feel their child's toileting problems reflect a deficit in their parenting skills or they have somehow failed as a parent because their child is not yet fully toilet trained. What most parents do not realise that they are not the only ones to have a child with this problem but because it is often kept a 'secret' that no-one discusses then they are not aware that other parents have similar problems. Practitioner experience suggests parents will stand at the school gate and discuss most other health issues regarding their child, how they coped with chicken pox or sleepless nights for example, but most parents would not discuss the fact that their child wet or soiled their pants. The result is that because no-one talks about it everyone assumes that if it happens to their child then they must be the only one!

Also practitioner experience suggests that many parents admit later that they did not disclose their child's 'problem' for fear of the child being refused school entry or they hoped that once the child started school the 'problem' would resolve by itself.

A study by Esperat et al (1999) identified lack of information as a major issue in supporting children with special health needs. They found that any health related information was not always readily available and what was available was often insufficient and incomplete. This makes provision of services to these children, not only more challenging, but also the development of individual care plans a formidable task.

The providers of care for these children in school must be ready to deal with the routine as well as the unpredictable and any potential unforeseen circumstances that are bound to occur in the course of their day. An individual health care plan for each child will be able to address many of the concerns and identify any action to be taken if an unforeseen incidence occurs.

4.12 Did a professional help with the development of an individual care plan to identify child's needs and outline management in school?

Only 9 teachers reported that a care plan had been developed to help meet the child's needs in school. This meant that a significant percentage (77.5%)

of children were being managed in school with no written guidelines to help staff or to ensure children's individual needs were being met.

The lack of a robust health care plan can lead to increased anxiety and confusion on behalf of school staff if it is not clear what to do if something out of the ordinary occurs. From the authors own experience where individual health care plans have been developed in conjunction with the health professional, parent and school staff schools have felt much more able to cope with the child's day to day needs (Rogers 2003).

In some cases it may be necessary to have a multi-disciplinary approach to the care plan development, for example, involving the occupational therapist and physiotherapist to ensure the toileting environment is suitable for the child and assess if any specialist equipment is required. Advice can also be given regarding toileting aids and adapted clothing and treatment interventions put in place to improve physical ability such as sitting balance and bi-lateral co-ordination. It must be emphasized that the child's privacy and dignity must be maintained at all times and independence promoted.

4.13 Was any 'named carer' provided to help you with the child e.g. taking to the toilet?

Fourteen teachers (35 %) responded yes that there was a named carer to support the child in the classroom, however this meant that over half – 65% of children had no extra support to meet their toileting needs. Of the carers employed five were employed as 'extra' class room support and five were already employed within the school. One carer was employed from 'health' funding and the remaining three carers were employed via 'statement funding'.

"Only when child was 'statemented' was support given"

"We also have children with physical disabilities (eg cerebral palsy) who are incontinent. This is less of a problem as they/we are entitled to occupational and physio support and advice. It is children with undiagnosed problems and without SEN Statement who are more difficult to manage in school".

The 'Statementing' process occurs when a child has been identified as having a 'special need' that affects their ability to learn. As a result the child undergoes a series of assessments to identify the child's individual needs and sets out a plan of care, which includes access to funding in some cases, to provide extra support for the child to enable them to access and make the

most of all aspects of their education. The problem however for most children with a bowel or bladder problem is that as it does not usually affect their ability to learn and is classed therefore as a 'health' problem not an 'educational' one. They do not have therefore access to any 'statement' funding which would pay for extra classroom support to meet their toileting needs.

Lack of classroom support was strongly commented upon by the teachers as there appeared to be great difficulty created if a child need to be taken out of the classroom to be changed. If the teacher was on their own then that would mean leaving the rest of the class unattended. This was a particular problem if the child had soiled and often resulted in the child having to sit in soiled clothes to wait for a parent to come into the school to change the child. This is obviously also a problem for parents who sometimes have to be called in from work. One teacher commented that changing children was definitely not in their job description and was something therefore they felt they should not have to do!

4.14 Was any specific training undertaken by the named carer to help them deal with the child's needs?

Only five teachers reported that the carers had been given any training to help them meet individual children's needs. The training was carried out, by a nurse in two cases and a 'medical advisor' in one. The training in the two remaining cases was carried by the local authority inset days. One other teacher reported that they had been given some training by a parent although they did not feel it was sufficient. Nine classroom support workers therefore were dealing with a child's problem for which they had had no formal training which raises some concern. Also the training that the carers had undertaken appeared to be very superficial. When asked what the training involved the responses included 'common sense', 'health and safety', 'special needs services', 'nappy changing', and 'explanation by nurse including training and showing a video'.

Lack of formal training is obviously a health and safety issue for both the child and the school staff particularly if they have to care for a child with complex needs which they have had no formal training to deal with.

Although a number of teachers had reported receiving training regarding children with 'special' educational needs (SEN) non had received any formal training regarding managing common problems relating to delayed bladder and bowel control. If this topic was to be included in all

SEN teacher training courses it would go partway to help resolve some of the issues both for the child and teacher.

4.15 If a child does not require regular everyday support, who do you think could provide the 'ad hoc' help some children with bowel and bladder problems require?

Many children who have a bladder/bowel problem do not require extra support all day, everyday, and some children are able to cope very well for most of the time. For these children the majority of schools do not feel justified to employ a carer for the child even if funding was available. This does cause a problem however if the child does experience problems regarding who would be available to support the child at these times. The teachers were given a number of options regarding who they felt could provide this 'ad hoc' support including :

- a) The teacher
- b) Nursery nurse
- c) Classroom assistant
- d) Parent
- e) Other person

Only one respondent felt it was the teachers' responsibility to support a child with a wetting or soiling problem and one other respondent said that both the teacher and nursery nurse could provide the support. Two respondents felt a nursery nurse could provide support, nine respondents replied they thought it should be a combination of a nursery nurse or classroom assistant and seven respondents felt it was the responsibility of the classroom assistant alone.

Four replied they felt the parent could come in to provide the 'ad hoc' support, and two said it could be a combination of the classroom assistant and parent. Another respondent replied it could be the classroom assistant and any other willing member of staff.

The remaining replies stated that a 'health auxiliary' could provide the support and three respondents felt it could be the school nurse with another teacher replied that it would be a 'team approach'. Two replied it depended on the child's needs and whether it was a bladder or bowel problem. One teacher felt 'some one from the office' could provide the support however this raises a number of concerns. Children need to be taught that they have the right to say no in relation to adults 'touching' them as a child protection issue. If the school does not have a 'named' carer policy so that the child is taken to the toilet or have nappies changed, for example, by any adult available, then it does not teach the child that it is OK to say no if they do not feel comfortable with what the adult is asking them to do.

In addition in order to meet individual children's needs whoever is caring for the child must have an understanding of the child's problem and the agreed outcome aim of any treatment intervention. Most toileting programmes introduced for children have an outcome aim of helping the problem to be resolved or if that is not possible then to help the child to manage the problem independently. Unless there are named members of staff who have appropriate training to meet individual children's needs then the child is not going to be managed appropriately and in a consistent way in school, particularly if everyone who deals with the problem does it in a different way. The adult also may not allow the child to be involved with toileting/changing themselves, thereby actually delaying them developing their independence, in the mistaken belief they are 'helping' the child by doing it for them!

4.16 Respondents were then asked to put down any comments they had regarding specific issues for children with bowel and bladder problems in schools.

The comments were collated into three broad themes. Firstly issues relating to the problem of having to change a child in school, secondly relating to the issues for teachers and finally the issues for the child.

4.17 Comments relating to changing a child in school

The availability of staff to change the child was a strong theme throughout the comments, but there were also some comments regarding staff willingness to get involved with changing children. The majority of negative comments in this respect was around if a child had soiled as this obviously involved extra time as the child would need to be washed as well as changed. One teacher commented that it would take at least _ hour out of the classroom, which would be very disruptive to the rest of the class.

A number of teachers reported that they would be willing to change a wet child but would call a parent in if a child had soiled and that if the soiling happened during dinner times the staff on duty would be reluctant to change any children

The issue of changing children was compounded by the reported poor facilities in schools in relation to school toilets and changing facilities. Again

there were a number of comments regarding lack of quality toilets in school and no shower facilities.

“Need to have good facilities such as large sink/shower/cubicle”

From a practical point of view it is obviously very difficult for school staff to cope with a child who frequently soils if they do not have the basic facilities to change the child. One school that had installed appropriate changing and shower areas commented on how much easier it has made it for them to cope with a child who soiled on an almost daily basis.

Schools appeared to have mixed feelings regarding dealing with children who soiled with one school commenting that they felt it was alright to change a child who had accidentally soiled but not if they had ongoing soiling problems!

4.18 Comments relating to issues for teachers

The comments relating to issues of children with toileting problems in schools for teachers reflected how emotive this issue is for them. A number of teachers commented on the extra strain this problem resulted in on managing these children on a daily basis with many of them feeling that changing children was not their responsibility.

Smaller schools commented on the difficulties they faced because of few additional available staff to deal with taking children out of class to change them. They felt it was unrealistic to expect the class teacher to leave the class to deal with the child and there were clear issues regarding cover during periods when children when the child was being changed.

Teachers, perhaps rightly, are reluctant to take over this role and yet schools are not prepared to take on extra staff. There are clear issues regarding who is going to support these children in school Certainly with the increasing inclusion agenda this problem is going to get worse not better!

One teacher commented

“We were allocated a SEN Nursery nurse (facilitator) but if she was absent the student was still in school so I took the role – can’t ask anyone to do a job if you’re not willing to do it yourself. My auxiliaries were originally employed to work with students with mild to moderate LD or dyslexic type difficulties but as the Inclusion policy has moved forward they are being asked to take on tasks they find physically and emotionally overwhelming. I have lost good people because of this.”

There appears to be no statutory guidelines for schools regarding changing children in relation to whose responsibility it is with each school apparently making their own rules.

This obviously leads to confusion and uncertainty with no one taking responsibility – this results in a very ‘ad hoc’ approach with parents having to trail around a number of schools before they find one willing to take their child.

A number of schools also commented that staff taken on as classroom assistants were now having to take on the responsibility for changing children. This they felt was inappropriate as it meant time taken out from children’s learning and the assistants support time. Also the ratio of children to teachers in nursery is increasing putting more strain on the teachers’ which is further increased if teachers have to take time away from teaching duties to deal with changing a child.

Interestingly basic practical issues such as lack of a change of clothes in school was a common problem that teachers reported as a major issue that made dealing with the situation even more of a problem. However one school commented that school uniform was a big help as *"we could easily provide a change of clothes without the rest of the class noticing."*

A number of teachers felt very isolated in dealing with these children with perceived lack support from health services. One school reported that liaison between health services and schools was very limited – and almost always had to be pursued by them. There was also a perception from schools that a cut in school nursing services was a contributory factor to the lack of support.

"School [nursing] services in London have been drastically eroded"

"More information is needed to help schools with this problem"

Although overall it appeared to be a big issue for schools regarding having a child with a bowel or bladder problem one teacher made the following comment

"I think it is important to reassure parents that it is not a problem in school, and not let the child become worried about it – make as little fuss as possible and treat it gently."

This was the only comment regarding the issues for the parents, which appeared to reflect some understanding of the impact of having a child with such a problem has on parents.

4.19 Comments relating to issues for the child

From the general comments from the teachers it was apparent that a number of them empathised with the problems children with bowel and bladder problems experience with many commenting on the effects on the child's self esteem. One teacher commented on the problem children with toileting problems had in terms of *'having an odour about them'* this meant that that other children did not want to sit near or play with them which resulted in the child having low confidence.

"Low self esteem, fear of wetting/soiling in front of others. Anxiety over being 'smelly' anxiety in case others find about problem."

Preserving the self esteem and dignity of the child was mentioned frequently in the comments. One school felt one way of working towards this was by ensuring any support provided to the child was to be done discreetly so other children would not be aware of the child's problems. Clearly how the child's problems impacted on other children was an issue with the risk of bullying and being teased a concern. Certainly previous studies have suggested that not being accepted by peers could deprive children of the opportunities to learn normal adaptive modes of social conduct and potentially undermines academic progress as well. In fact low peer acceptance at school has been associated with loneliness, truancy and dropping out of school (Parker 1987).

A number of schools appeared to be concerned regarding the reaction of other pupils to the child with a bowel or bladder problem, however whether that concern was related to the feelings of the child with the problem or their fellow class members was unclear. However the risk of being bullied was clearly identified as a potential problem by a number of teachers with that risk increasing as the child gets older

“Emotional stress plus as the child gets older, he/she will begin to feel different and may get bullied.”

A number of teachers also commented on how they felt staff generally within the school should support such children and the general issues within school. One teacher reported that there are sometimes an attitude problem regarding the child with some fellow teachers within the school who are not directly involved with the child. This may well be a reflection of their lack of understanding of the child's underlying problems, which perhaps reinforces the argument for basic 'health' information to be included in special needs education training for all teachers.

From the comments made there also appeared to be some recognition that although a child's needs could be identified schools struggled to meet those needs for a variety of reasons including low staffing levels, lack of previous experience in dealing with such problems and lack of time. In general the teachers appeared to struggle in coping with the problems the children were experiencing, particularly with those children with bowel problems.

“I would welcome any advice/support/training. Always a difficult and sensitive issue and each child's needs can be very different.”

4.20 Study limitations

The return rate of the questionnaire sent out via the internet was very poor (7.5%). Although the targeted web site was for teachers interested and involved in inclusion it covered the whole age range of pupils from primary up to further education and the exact number that were involved with primary aged child was unknown to me. On reflection perhaps it was not a good choice as although the site fitted the criteria for information rich respondents it may not have done so in terms of primary school criteria selection. The postal

rate return was very good (100%) so perhaps I would have got a better overall return rate if I had used all postal questionnaires.

One of the main aims of a qualitative study is to obtain information that is both useful and credible and a perceived limitation of this study may be the small sample size. However there appears to be no strict criteria for sample size (Patton 1990) with no statistical test of significance available to see if results 'count'. What seems to be of importance is whether the researcher and reader judge the findings to be both useful and credible (Eisner 1991). Borg and Gall (1983) commented that a study that probes deeply into the characteristics of a small sample often provides more knowledge than a study that attacks the same problem by collecting only shallow information from a large sample. From my point of view despite the small sample I feel as though the information given was enough for me to draw some conclusions.

I felt it was difficult at times to be objective regarding evaluating the results due to my closeness to the subject. However closeness to the subject could be viewed as a positive element, as factors such as the personal quality of the researcher in terms of the ability to give meaning to the data, the capacity to understand and the capability to separate the pertinent from that which isn't is said to be important (Stauss and Corbin 1990). Strauss and Corbin (1990) believed that the skills to make sense of and evaluate qualitative data comes from a number of sources including professional literature, professional experiences and personal experiences. So in fact my closeness to the subject could be said to be an advantage, not only in terms of evaluating the data but also in the ability to be sensitive to the data and to make appropriate decisions in the field (Eisner 1991, Patton 1990).

Despite all that I am aware of the importance of myself as the researcher to remain detached and not influence the study with my own perceptions and values in order to guard against biasing the study towards those perceptions and values. In reporting the findings I tried to use the teachers actual own words as much as I could rather than putting my own interpretation on what they said.

The results of the study I feel are important not only to the teaching profession but also to health professionals as it is clear from the findings that lack of support, perceived or real, from health professionals is cited by the teachers as a real issue in terms of the ability of schools to deal with some of the problems children with bowel and bladder problems present. Although it would be difficult to say how generalisable the findings were from this one small study I feel it is useful in terms of raising an awareness of an issue that previously was perhaps viewed as a lack of empathy on the part of schools rather than an apparent lack of support from health services.

Chapter 5 Conclusion and Recommendation

5.1 Conclusion

For schools supporting children with bowel and bladder problems the resultant issues obviously appeared to cause some difficulties. The original aim of the study was to investigate teachers' views and experience of inclusion of a child with a bowel and bladder problem and the overall findings appeared to reflect that this was often a stressful experience for both the child and teacher. However, what appeared to result from the findings was that the attitude of the teachers towards the inclusion of children with bowel and bladder problems was largely shaped by the associated issues and was less to do with inclusion per se and more to do with the apparent lack of support both within school and from health services.

All but three teachers in the study reported previous experience in the classroom with children with bowel and bladder problems and in the majority of cases this raised lots of issues. Nearly 50% of teachers felt that wetting problems were due entirely to immaturity or behavioural problems and comments made reflected that the child was somehow in control. However these teachers had had no specific training regarding bowel and bladder

problems and it is perhaps an issue that should be taken up and addressed by health professionals. If teachers are not provided with the appropriate information regarding toileting problems it is difficult to expect them to know all the answers.

Soiling in school raised the most concerns but again it is very difficult to 'know what you don't know' and teachers obviously need more support in managing these problems. The main issue for the teachers appeared to relate to the practical problems with actually dealing with a child who has soiled. From a teachers perspective there are obviously hygiene problems if a child soils in the classroom in terms of who is going to clean it up and having to remove children from the area. So although their comments reflected sympathy for a child with such a problem in practical terms these children were very difficult to manage.

If a child had a learning problem then they could have a 'Statement of needs' prepared which would identify the resources a child would need in order to gain the most from his education and quite often this included funding for a classroom support worker. If the child also had a toileting problem then this would also be identified and the support worker would be someone who could also support the child's toileting needs. Many teachers in fact commented that if the child was 'Statemented' then toileting issues were not such a problem.

However in reality if the child is only deemed as having a 'medical' problem then they would not have the benefit of an educational statement with its accompanying funding. As a result any extra support that a child might need would have to be found within the schools own resources and this is where the problem lies. A number of schools commented that they were a small school with few additional staff available to take children out of the class room. From a practical point of view if you are a teacher with 30 young children in your class and one of them has a wetting or more importantly a soiling accident which involves the child needing to be washed and changed how are you going to cope?

The teacher obviously cannot leave the rest of the children in the classroom unattended and although most children could manage to change wet pants the majority of children would struggle to change soiled clothes and clean themselves up. The teacher then has a dilemma if no-one in school is willing to change the child and what usually happens from practitioner experience is that the child is put to one side and the parents called to come into school to 'sort out' the problem. This is obviously not satisfactory from everyone's point of view.

Teachers also commented that not only were there problems in terms of staffing levels but even if they had extra staff the often poor changing facilities within schools made it dealing with a soiled child difficult. Most of the schools reported that they did not have facilities such as showers which would help a child who had soiled and the majority did not have specific changing areas. The other issue was the availability of a change of clothes for the child. Although one school commented they kept a good supply of old school uniform for that purpose which was not only helpful for the school staff but also the child did not stand out by having different clothes on if they had to be changed.

Although many teachers reported on the lack of practical resources to deal with children's needs, the main issue they felt was that they did not feel it was the teachers' responsibility to help change a child with a bowel or bladder problem. A number commented that they felt it was not their role as they were there to teach not to change children. One teacher commented that the class room support workers who were originally employed to help support the educational needs of children with learning difficulties were now being asked to undergo duties, such as changing children, that they found both physically and emotionally overwhelming and as a result decided to leave. This has obvious implications for all school staff who are asked to take on duties that were not originally in their job description.

Despite all this the teachers appeared to have an understanding of the issues from a child's point of view with loss of self-esteem and being able to provide

discreet support being commented on by teachers as being important. However when asked directly would they support a child with a toileting problem by helping them get changed all but one of them said it was not their responsibility. Schools therefore need to look at ways of providing non-teaching staff to support the needs of such children.

Lack of support from health services in terms of explanation and information regarding the child's problem was evident with only half the schools reporting getting any information at all regarding the child's problem. Schools therefore tended to rely heavily on obtaining medical information from non-health sources and often it was provided third hand from the parents. Individual health care plans were also not commonly developed. Lack of support from health services appeared to be evident and yet the school nurse is ideally placed to provide information and advice acting in liaison between home school and specialist nursing and medical services.

Many of the schools reported that they felt very isolated in dealing with children with such problems, with a clear perceived lack of support from health services. The main issue teachers commented on was lack of information and the fact that more often than not they had to search out the information for themselves. Although 50% of teachers reported that that they felt that they had been given enough information, from their comments the information obtained was often not sufficient to enable them to meet all the child's needs. Keeping that information up to date was also considered an issue by the teachers.

Approximately two thirds of teachers had undergone further training in relation to 'special needs' which meant that a third of teachers had had no extra training. Previous evidence has shown that the training of teachers is critical for the formation of a more supportive view of mainstreaming (Buell et al 1999). However currently no specific training courses exist for teachers which relates directly to children's health needs. With the increase of inclusion of children with 'health needs' into mainstream school it would appear sensible therefore that in house training be set up to help teachers have an

understanding of the child's problems. However currently there appears to be statutory requirement regarding post-graduate training for teachers.

The teachers commented frequently about the importance of not letting the child's peers find out about any wetting or soiling problems because of the risk of name calling and bullying. However practitioner experience has found that when children have an understanding of their fellow pupils difficulties they are much more accepting. Keeping a child's problem a 'secret' when there is great risk of that 'secret' being found out could be counterproductive. Previous studies have identified that when seemingly 'normal' children engage in atypical behaviour, such as wetting or soiling, they are frequently rejected for violating the normal 'model' of behaviour (Cook 2001).. It is apparent then that such children with 'hidden' less obvious problems are at risk of rejected precisely because they are perceived to be 'just like everyone else' for which such behaviour is considered unacceptable. There is therefore a good argument therefore, with the child's permission, for giving to the rest of the child's class mates an acceptable explanation of the child's difficulties.

To date, there appears to be no research focused directly on health-related support in school for children with bowel and bladder problems, yet these children are known to be at increased risk for psychosocial and emotional problems which can impact directly on their ability to learn (Meyer 2001). Perhaps this could be the focus for further research.

5.2 Recommendations

Any child attending school with a bowel or bladder problem that is likely to require attending to during the school day should have the benefit of an individualised care plan. This should identify the extent of the problem, the level of care required and the child's ability level to participate in their own care. This plan should be drawn up in conjunction with the parents, and child if appropriate, the school nurse, school doctor, class teacher, school head and any other relevant professional involved with the child to ensure all their needs are identified.

Named carers should be identified to help support the child in school. The Good Practice Guide in Continence Care (2000) recommended that these carers should be school based

and undergo training specifically for each child within their care. These named carers should be identified in the care plan.

In order for teaching staff to approach the child's problem sympathetically they need to have an understanding of the problem. School nurses play a pivotal role in providing information regarding the child's condition and liaising between the school, the child's family and those other health professionals involved with the child's care, such as paediatric continence advisors and stoma care nurses. However it is important that the nurse obtains the child and families consent to share any information with the school. Providing the school with information regarding the child's condition and helping in the development of an individual care plan has been proven to help smooth the child's entry into school (Rogers 2003) (Appendix 4).

The results of the study will be used to support the need to develop an information/resource pack for schools regarding the inclusion of children with bladder and or bowel problems and recommend the importance of planning and appropriate support for such children.

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Dear Colleague

As a paediatric continence adviser I am aware of the increasing issues raised when a child starts school with a bowel and/or bladder problem. I am aiming to develop a resource pack for schools to help teachers with this problem and a guidance pack for school nurses to ensure that adequate planning is undertaken if the problem is identified before the child starts school.

In order to do this however I need to find out from teachers what problems have been encountered in the past and what issues have been raised. I would be most grateful therefore if you could complete the enclosed questionnaire and return it to me either via email junerogersmbe@hotmail.com or fax: 0161 214 5961

The questionnaire is not a test! For example, it is important that you answer the bowel and bladder questions without checking on the answers with colleagues as this will help us to identify what information needs to go in the resource pack for schools.

The questionnaires are aimed to be anonymous and confidentiality will be assured at all times. No respondents details, including area of work, will be identified in the data analysis. However if you would like to have feedback from the questionnaires and would be interested in piloting any resources that are developed then please include you name and address.

Many thanks in anticipation

June Rogers MBE
Paediatric Continence Adviser

7. At what age would you expect the majority of children to be fully toilet trained? (please indicate)

.....

7. Have you had any children in your class with any sort of bowel / bladder problems yes..... no.....

8. If yes what were the problems ?

.....

.....

9. Did the health professional involved with the child give you information and advice regarding the child's problem?

yes..... no.....

Any comments.....

.....

10. Did you feel you were provided with sufficient information to understand and deal with the child's problem

yes.....no.....

Any comments?.....

.....

.....

...

11. Did a health professional involved with the child help prepare with you an individual 'care plan', to identify needs and out line management in school ?

yes..... no.....

Any comments

?.....

.....

.....

12. Was any 'named carer' (extra support) provided to help you with the child e.g. taking to the toilet, changing , catheterising, etc.

yes..... no.....

13. If yes, was the 'named carer' employed :

- a) as an 'extra' classroom support
- b) already employed as a member of classroom support
- c) from 'health' funding
- d) other.....(please specify)

14. Was any specific training undertaken by the named carer/s to enable them to deal with the child's needs

yes..... no.....

15. If yes who carried out the training? e.g parent/nurse

(please indicate).....

16. What did the training involve?

(please indicate).....

.....

16. If a child does not require regular every day support, who do you think could provide the 'ad hoc' help some children with bowel and/or bladder problems require ? (please tick)

- a) teacher
- b) nursery nurse
- c) classroom assistant
- d) parent
- e) other (please state).....

17. What do you feel are the specific issues involved with a child with a wetting and/or soiling problem in school ?

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18. Any other comments ? (please continue on a separate sheet if necessary)

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Thank you for your help.

June Rogers

Successful inclusion of a child with a stoma in mainstream schooling.

British Journal of Nursing, 2003, 12:10, 590-599

The inclusion of children in schools with medical issues, such as stomas, has been the cause of much disruption and anxiety in the past. Many of the problems were the result of misconceptions and lack of understanding of the issues involved along with an often, irrational fear of 'bodily fluids'! By developing closer links with the education department and opening up clear lines of communication it was possible to raise awareness and reassure school regarding related issues. This paper discusses the inclusion of a child with ulcerative colitis, following stoma formation, into mainstream school and demonstrates how with appropriate staff training and the development of a structured individual health care plan that inclusion can proceed smoothly.

The movement towards mainstreaming for all children involving school based support, including those with medical needs, obviously brings with it challenges for the school system. The basis for the movement is to provide fully supportive inclusive education for all children. Schools are now therefore challenged to admit and support these children but how successful this will be appears to depend on a variety of factors.

Previous studies have identified that the success or failure of mainstreaming may be largely dependent on the attitudes of teachers towards inclusion (Larrivee 1981, Leyser and Lesson 1985, Parish et al 1982). Other attitude studies have suggested that mainstream teachers have not developed an empathetic understanding of disabling conditions (Berryman 1989), and some teachers do not appear ready to accept children with 'special needs' (Hayes and Gunn 1988). The explanation for this was that the integration had often taken place in an 'ad-hoc' manner without proper advice and support (Avramidas et al 2000). Center and Ward (1987) also suggested that teachers' attitude to integration reflected lack of confidence in the quality of support personnel available to them. They were positive about integrating only those children whose disability resulted in them not likely to require extra instructional or management skills on the part of the teacher.

Leyser and Lesson (1985) reported that there was evidence that indicated teachers were not particularly supportive of mainstreaming, however it was felt that if certain requirements were met then they would be more accepting. Those requirements included the provision of additional training aimed at developing the knowledge skills and attitudes required in order to work effectively with 'disabled' pupils. Other studies have also suggested that the effective implementation of mainstreaming in schools is dependent on a number of factors (Center and Ward 1987, Leyser et al 1994). These were identified as firstly, adequate preparation and updating of teachers in the skills needed to provide appropriate education for children with differing needs, strong commitment and support within the school system and finally the availability of support services in the classroom (Lewis and Doorlag 1991, Myles and Simpson 1989).

From September 2002 it will be unlawful for schools to exclude such children without adequate reason. The Disability Discrimination Act 1995 part 4 has been extended to incorporate The Code of Practice for Schools, brought in by the SEN (Special Educational Needs) and Disability Act 2001. This identified new duties from 2002 not to discriminate against disabled pupils, not only those currently in school but also prospective pupils, in the

provision of education and in respect of admissions and exclusions. The document identified discrimination occurring in two main ways:-

- treating the child less favourably for a reason relating to their 'disability' in comparison to their 'normal' peers
- the school failing to take steps to ensure that disabled pupils are not placed at a disadvantage in comparison with their non-disabled peers. This is known as the 'reasonable adjustment duty'.

The document gives an example of a child with Hirschsprung's disease who had been denied access to school because of delayed bowel control and soiling. The parents successfully took the education department to court who found the school had been acting unlawfully in excluding the child.

Leyser et al (1994) however stated that even though a national policy may be in place, which may positively influence mainstreaming, a number of other more specific variables may have an impact upon teachers acceptance of integration. These included age and the number of years of teaching experience, with younger teachers and those with fewer years of experience found to be more supportive of integration by some authors (Berryman 1989, Center and Ward 1987) but not by others (Leyser et al 1989).

Although some studies had noted that female teachers had greater tolerance for integration than male teachers (Aksamit et al 1987, Eichinger et al 1991), others did not report gender as being a significant variable (Berryman 1989, Leyser et al 1994). Despite the, sometimes conflicting findings, regarding teacher variables in the development of attitude towards inclusion what was noted to be consistent in the majority of the studies was the importance of additional training and preparation for inclusion (Avramadis E et al 2000, Esperat et al 1999, Leyser and Lesson 1985).

For inclusive practices to successfully address the individual needs of both the pupil and teacher, teachers' must therefore feel more supported and empowered (Mercer 1996, Trump and Hange 1996). Teachers' lack of awareness and misconceptions regarding, what a stoma is and how it can be managed in school could therefore strongly influence their attitude towards inclusion of such children. The increased theoretical risk of exposure to 'bodily fluids' has resulted in some teachers being fearful of dealing with children who are 'incontinent' on health and safety grounds. This may well increase teachers' negative attitudes towards mainstreaming.

To this end as part of the authors' role as Paediatric Nurse Specialist for children with bowel and bladder problems closer links were made with the local Education departments to carryout joint working to help support pupils with such problems in school. Good communication is the key to reduce potential problems and early referral to our service was highlighted as a major factor in a pro-active approach to effective development of individual health care plans. Our role in helping to support such pupils in school was identified to the education department with a request that contact to be made with us for any child entering the school population with a bladder or bowel problem.

Case history

Child A is a 5 year old boy who had 12 month history of intermittent profuse diarrhoea containing blood and mucus in association with lower abdominal pain and cramps. There were also periods of tiredness, weight loss and a general feeling of being unwell. An Initial diagnosis of inflammatory bowel disease (IBD) was made with ulcerative colitis strongly suspected. Blood and stool tests were initially carried out to look for evidence of inflammation, disease activity and to exclude any other underlying pathology.

The blood tests carried out included a full blood count results of which showed a low red blood count, which suggested that he was anaemic and an elevated white blood cell count indicated an active immune system. An erythrocyte sedimentation rate (ESR) was also done to check

for the presence of inflammation. A check on serum albumin was done as inflammation of the gastrointestinal tract can cause serum proteins to leak from the inflamed gut lining. As specific nutrient deficiencies can be identified with blood tests, tests for iron and vitamin deficiencies were also done.

Stool tests are important for such children as the presence of blood is one of the major findings in IBD. Stool samples also provide information about micro-organisms which may result in similar symptoms to IBD such as certain parasites and infections.

The resultant laboratory findings were inconclusive as was an abdominal Xray and so it was decided to carry out an endoscopy under a general anaesthetic in order to find out if it was Ulcerative colitis or in fact Crohn's disease that was the cause of child A's problems. Child A was admitted to hospital and was kept on clear fluids for 24 hours prior to the investigation and he also underwent a series of enemas and laxatives to clear the bowel out.

A number of biopsies were consequently taken and a few days later a diagnosis of ulcerative colitis was made.

Ulcerative colitis is a relapsing and remitting disease of the bowel characterised by acute non-infectious inflammation of the colorectal mucosa and begins in early childhood in 4% of overall cases (Nagar and Rabau 2000). In children with ulcerative colitis, approximately 25% present with proctitis alone, 30% have left sided colitis and in almost half of the children the disease extends to the transverse colon or beyond (Ghosh et al 2000).

There are a number of theories about what causes ulcerative colitis but the most popular ones include the result of the body's immune system reaction to a virus or bacteria, causing ongoing inflammation in the intestinal wall, although there is conflicting evidence regarding this (Cantrell et al 1990), defects in the mucous gel barrier, either primary or acquired by bacteria sulphates (Tsai et al 1995) or colonic sulphate reducing bacteria (Pitcher and Cummings 1996).

The treatment of children with this condition aims to reduce or eliminate symptoms, optimise nutritional status, promote normal growth and development and prevent complications including any psychological problems associated with a chronic debilitating condition (Ringheanu and Markowitz 2002). Unfortunately for child A medical treatment given to help control the inflammation, including steroids, failed to result in long term remission and it was decided to operate and form a stoma to allow the affected part of the bowel to rest.

Issues for School

The family contacted school to advise them of the impending surgery following which the SENCO teacher contacted our department to make plans for child A's return to school. A meeting was held in school to help and advise them regarding the issues for schools in supporting a child with a stoma. A doll with a stoma was shown to the staff and examples of different types of appliances were demonstrated with time given for the staff to handle the products. Written information regarding what a stoma is and the common problems that could be encountered discussed. As child A was only just 5 years it was felt he would need initial full support and supervision regarding emptying and possibly changing the appliance in school. Two members of staff (class room support assistants) volunteered to provide the support child A would need with the class teacher providing backup if necessary. A further meeting including training sessions were arranged for when child A was discharged from hospital.

Following the surgery child A's school was contacted and informed that an ileostomy had been performed. The expected date of discharge and subsequent return to school was discussed and a meeting planned with child A, the parent, school nurse, head teacher, SENCO teacher, class teacher and the two carers who would support Child A with stoma management in school.

A home visit was also arranged following Child A's discharge to discuss issues to be included in the care plan. Child A had coped very well with the surgery and accepted the stoma with no apparent fears or anxieties. He had a one-piece appliance in situ and following discussion

with dad it was felt appropriate to change it to a two piece system which would make any necessary bag changes in school more easier. The week before Child A was due to re-start school the planning meeting was held.

Child A was also brought in to school by his dad and was quite happy to show the staff his stoma and although it was not envisaged that any full appliance changes would have to take place in school it was demonstrated by dad so that the staff were fully aware of the principals involved and to enable them to see what the stoma looked like. (This in fact proved very useful as the staff were able to quickly identify a change in the stoma size and colour when it prolapsed in school several months later)!

The main care that child A would require in school would be help with emptying his appliance and the training session for the staff was done in conjunction with the child and parent, with dad first demonstrating the procedure. A check list was completed and individual training skill checklist developed (fig 1). Discussions also took place regarding any potential problems that may occur and an individual care plan developed (fig 2). A consent form for treatment in school was completed and signed by the parent (fig 3). Copies of which were given to the parent, one held in the child's school health records and the other copy kept in school.

By providing a structured inclusion programme with clear health care planning and staff training child A's return to school was smooth with no undue concerns by either the family or school. The family were reassured that the care their child would receive in school was equal to the care he would receive at home and the school staff were confident in their management of the stoma and their earlier fears and misconceptions regarding exactly what a stoma was and how it was managed were allayed.

Their training and confidence was put to the test several months later when child A's stoma prolapsed suddenly in school with a compromised blood supply. The care plan for such an event was quickly put into action and within an hour child A had been transferred to the local A&E Department where an application of sugar soon had the problem sorted!

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